#HealthNow

#HEALTHNOW LITERATURE REVIEW UPDATE

How has patient experience changed for people who are homeless?

September 2022

Groundswell
Out of homelessness

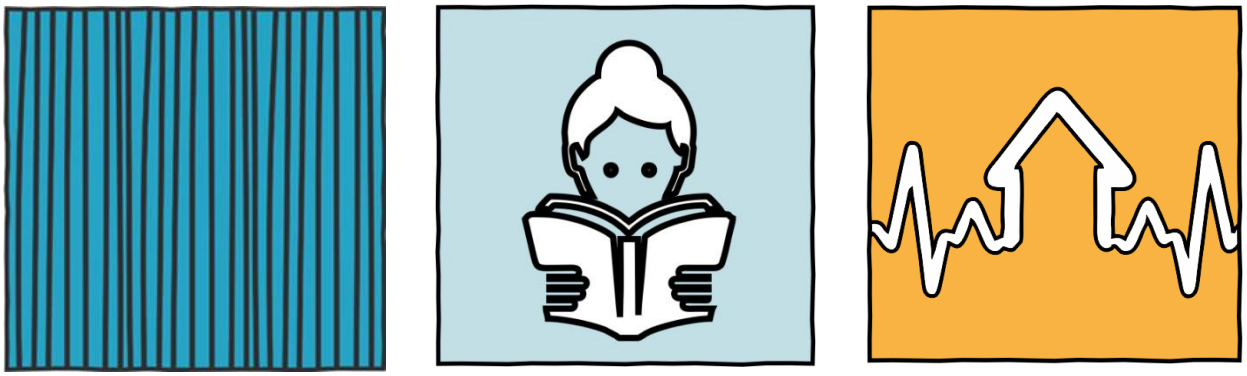
COMMUNITY FUND

CONTENTS

Summary

People experiencing homelessness face significant health inequalities. They encounter barriers to accessing the healthcare they need and often have poor experiences of engaging with healthcare services. This report examines research published since our 2020 #HealthNow literature review and outlines the findings from our five #HealthNow research reports. Key findings are:

- **Proof of address requirements still present a barrier to registering with GP services.** Recent research suggests limited progress towards ending this practice, which prevents people experiencing homelessness from accessing primary care, despite clear NHS guidance.
- **Access to dentistry is severely limited for people experiencing homelessness.** New data, including that obtained through our #HealthNow research, suggests that most people who are homeless are not registered with dental practices, or are otherwise unable to receive treatment.
- **Digital exclusion continues to affect people who are homeless.** Digital means of accessing and engaging with services rolled out during the COVID-19 pandemic created new barriers and exacerbated existing ones.
- **The pandemic also led to positive changes.** In drug and alcohol services especially, changes in how professionals and patients interacted resulted in improvements in trust and in service access for women.
- **Continuity of care is extremely important for people experiencing homelessness.** Seeing the same doctor on repeat visits helps to build a trust in health services that is often otherwise lacking.
- **Dedicated 'inclusion health' and outreach services can promote engagement and reduce feelings of stigma.** Specialised health services are better able to foster positive relationships than mainstream services, although little is known about their long-term impacts.
- **Powerful new evidence links homelessness to premature death.** A disproportionate number of people who are homeless die from treatable and preventable causes.



Background

The #HealthNow Partnership

In 2019, Groundswell and homelessness charities Crisis and Shelter formed the #HealthNow Partnership to take a national approach to overcoming health inequalities for people experiencing homelessness. Funded by the National Lottery Community Fund, the partnership is delivering the four-year #HealthNow campaign across the UK. It works towards an inclusive health system where everyone has access to the health care they need, ultimately moving people out of homelessness.

The #HealthNow Partnership created local #HealthNow alliances. These are formed of people experiencing homeless or who work in housing and homelessness, health and social care, and voluntary and community organisations in Birmingham, Greater Manchester and Newcastle. Alliances tackle local barriers to accessing healthcare for people experiencing homelessness by informing and acting on insights from peer-led research and from pilots of Homeless Health Peer Advocacy (HHPA) in those areas. Local #HealthNow alliance members use this insight to coproduce solutions to overcome homeless health inequalities in their area. The local activities, insight and changes inform a national #HealthNow alliance, leading to nationwide actions being adopted to improve homeless health. Each area also set up and now operates a Homeless Health Peer Advocacy (HHPA) service to provide ongoing practical support to people experiencing homelessness to address their health needs directly.

The 2020 literature review

At the outset of the #HealthNow programme, Groundswell published a literature review[1] of existing research into patient experiences of using healthcare, highlighting knowledge gaps for the campaign to address. The report found that:

- People experiencing homelessness often had poor experiences of accessing, interacting with, and discharge from healthcare services. People experienced this throughout the healthcare system but the evidence was particularly strong in primary care (including general practice and dental services).
- Key barriers to accessing healthcare included lack of phone credit, poor access to the internet, reduced ability to travel to healthcare centres, lack of accessible information, and assumptions by healthcare professionals that patients provide a fixed address to access services.
- People experiencing homelessness often felt dismissed by healthcare practitioners because of judgement about addiction, stigma, and discriminatory attitudes and behaviours.
- Healthcare plans for people experiencing homelessness were fragmented and paternalistic, often failing to consider the barriers to accessing appointments and long-term treatment.

The literature review also identified key gaps in the evidence around end-of-life care, eye care, inpatient and outpatient care, and the experiences of further marginalised groups such as sex workers or ex-military personnel.

#HealthNow peer research

Informed by research gaps highlighted by the literature review, each of the local #HealthNow alliances worked with peer researchers to co-design and deliver research into homeless health inequalities. Across Birmingham[2], Greater Manchester[3] and Newcastle[4], peer researchers interviewed 160 people experiencing homelessness.

The research fieldwork coincided with the early stages of the COVID-19 pandemic. While this meant that planning face-to-face interviews was much more challenging it also created an opportunity to reveal ways in which existing health inequalities were exacerbated by the pandemic.

[1] Groundswell (2020). *#HealthNow literature review 2020: Trends in patient experience when experiencing homelessness.* Found at https://groundswell.org.uk/wp-content/uploads/2020/12/HealthNow-literature-review-2020.pdf
[2] Crisis and Groundswell (2021a). *Understanding homeless health inequality in Birmingham*. Found at https://groundswell.org.uk/wp-content/uploads/2021/03/Crisis-and-Groundswell-HealthNow-Birmingham-research-March-2021.pdf
[3] Shelter and Groundswell (2021). *Understanding health inequality in Greater Manchester*. Found at https://groundswell.org.uk/wp-content/uploads/2021/08/Shelter_HealthNow_Manchester-report-2021_Final.pdf
[4] Crisis and Groundswell (2021b). *Understanding homeless health inequality in Newcastle*. Found at https://groundswell.org.uk/wp-content/uploads/2021/05/Crisis_Health-Now-Newcastle-Report_FINAL.pdf

In 2020 Groundswell also published a report capturing COVID-19-specific experiences of people experiencing homelessness which was informed by interviews with 93 people experiencing homelessness.[5]

In 2021, a fifth piece of research was delivered in West Yorkshire, funded by West Yorkshire Health and Care Partnership.[6] This continued to track the effects of the pandemic on homeless health inequalities and added fresh evidence to highlight which health service experiences were national issues for people who are homeless.

Aims and methods

This report examines literature published since the initial #HealthNow literature review and summarises the lessons from the five #HealthNow research reports, contextualising them within the greater body of homeless health literature in order to identify where further knowledge and evidence is needed.

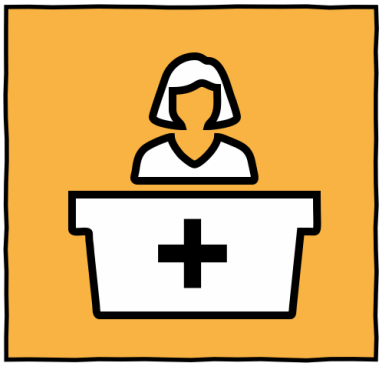
We searched academic journal articles using Google Scholar and publications indexed by the Patient Experience Library, which contains over 60,000 publications on patient experience and involvement. These include surveys, studies and policy documents from sources including government bodies, patient voice organisations and health charities. Only literature published since January 2020, when the initial literature review was written, is included. The search covered:

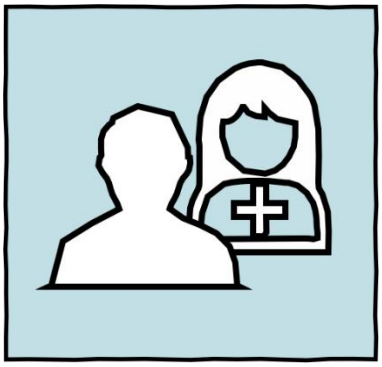
- Literature that directly addressed the healthcare experiences of people who are homeless, and
- Literature that addressed related issues - for example, inequality or social determinants of health.

We also launched a call for evidence asking organisations across the sector to submit additional research focused on the patient experience of healthcare whilst experiencing homelessness. Six organisations submitted reports that met the search criteria, which we included in this review. While we additionally included as much relevant research from the charity sector as we could identify, we recognise that these publications are not indexed, so some insights on health and homelessness inevitably escaped our attention.

[5] Groundswell (2020) *Monitoring the impact of COVID-19 on people experiencing homelessness*. Found at https://groundswell.org.uk/wp-content/uploads/2020/12/Monitoring_Impact_COVID_Groundswell-Executive-Summary-FINAL.pdf

[6] Groundswell (2022). *Understanding homeless health inequality in Calderdale, Kirklees and Wakefield.* Found at https://groundswell.org.uk/wp-content/uploads/2022/03/HealthNow-West-Yorkshire-Report.pdf





How the literature describes changes in patient experience

Understandably, most of the literature discussed in this review focuses on changes to healthcare and patient experience caused by COVID-19 related national lockdowns, social distancing and consequent changes to service delivery.

The pandemic underlined and intensified some of the health inequalities identified in our 2020 literature review but also offered potential for positive change. The Government's 'Everyone In' initiative provided emergency accommodation for many people experiencing homelessness who had not previously been receiving support, putting many people in a better position to access health services. Measures taken in response to the pandemic also encouraged and supported health and housing sectors to work innovatively and collaboratively to meet the needs of people experiencing homelessness.

1 Barriers to accessing healthcare

1.1 Registering for GP services

Our 2020 literature review demonstrated that GP practices often refused to register people who lacked proof of address. Healthwatch findings from the past two years suggest some

improvement; some regions recorded high GP registration rates among people experiencing homelessness,[7] and others reported year-on-year increases in registrations.[8]

Nevertheless, requirements for proof of address and other identification to register with GP practices still present a barrier. Although NHS guidance states that anyone can register with a GP without proof of address or identification, an investigation by the Bureau of Investigative Journalism found that less than a quarter of the practices they surveyed would register someone without proof of address, identification or legal immigration status.[9]

93% of #HealthNow research participants were registered with a GP. This high rate might reflect our methodology; we may not have reached those people most excluded from health services because COVID-19 made it difficult for us to reach a broad range of participants. Research conducted by St Mungo's supports the possibility that GP registration among people who are homeless has often been over-estimated.[10] While 98% of St Mungo's hostel residents were registered with a GP, almost a fifth of their clients accommodated in hotels under Everyone In were not registered with a GP. This suggests that people not accessing homelessness services are also less likely to be accessing health services.

The early stages of the pandemic, when the Everyone In initiative was operating, introduced new challenges and exacerbated existing ones, partly because of the number of people who were relocated under the scheme. Some GP practices temporarily closed their registers to new patients. Others said that they "do not register homeless patients".[11]

Staying registered with a GP is also an issue. In a survey of people experiencing homelessness in Manchester, many respondents reported confusion about why they had been de-registered from a practice. In many cases, they were not advised on how to register with another GP.[12]

I.2 Registering for dental practices

There is ample evidence that access to dentistry is a widespread concern for people experiencing homelessness. All participants in a piece of Healthwatch research in Nottingham were registered with a GP but less than half were registered with a dentist.[13] Findings from research in Derby found that only 29% of participants had seen a dentist in the previous year.[14] People often felt anxious or said that they did not need to see a dentist. As with GP registration, a lack of ID or proof of address were also identified as a barrier.

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[7] Healthwatch Sandwell (2020). *Accessing healthcare in Sandwell: homelessness project report 2020*. Found at https://www.healthwatch.co.uk/reports-library/accessing-healthcare-sandwell-homelessness-project-report-2020

[8] Healthwatch Derby (2022). *Experiences of health and social care services for people who are homeless or living in temporary accommodation*. Found at https://www.healthwatch.co.uk/reports-library/experiences-health-and-social-care-services-people-who-are-homeless-or-living

[9] https://www.thebureauinvestigates.com/stories/2021-07-15/most-gp-surgeries-refuse-to-register-undocumented-migrants

[10] St Mungo's (2021). *Housing and health: working together to respond to rough sleeping during COVID-19*. Found at https://www.mungos.org/publication/housing-and-health-working-together-to-respond-to-rough-sleeping-during-covid-19/

[11] NHS North-West London (2020). *NWL Homelessness Health Project: the NWL Response to the 'Everyone In' Campaign April to July 2020*. Found at https://mcusercontent.com/c4876cb152fa1983ef265ad1b/files/0723c314-3902-4604-9f47-8ccc28008fba/NWL_20Homeless_20Health_20Project_20_20FINAL.pdf?mc_cid=08300de86e&mc_eid=e3c037e9c5

[12] Healthwatch Manchester (2021). *Cut loose: An investigation into the effect of deregistration of homeless people from GP Practices*. Found at https://www.healthwatchmanchester.co.uk/sites/healthwatchmanchester.co.uk/files/HWM%20Dereg%20homeless%20people%20fv%207c.pdf

[13] Healthwatch Nottingham and Nottinghamshire (2020). *Homelessness and barriers to primary healthcare*. Found at https://www.healthwatch.co.uk/reports-library/homelessness-and-barriers-primary-healthcare

[14] Healthwatch Derby (2022).

#HealthNow research insights: lack of access to dentistry is a serious concern

#HealthNow research shed further light on problems with access to dentistry. Only 26% of our participants reported that they had seen a dentist during the previous year. Around half of those who attempted to access a dentist said that they had been unsuccessful.

While problems accessing dental care were documented in our original literature review, we identified new limitations on the availability of dentistry during the pandemic. Some participants believed that dentistry was unavailable at the time they were interviewed. Others said that they were unable find an available dentist when they had moved areas during the pandemic, or because they had not used a surgery for a long time.

> *"I rang five different dentists. No one is taking new patients, but they don't tell you where to go. No help. Really, really frustrating"*
>
> *(Greater Manchester)*

In many cases, inability to register with a dentist led to reliance on emergency hospital treatment. We even heard some stories from people who had removed their own teeth because they were unable to access dental care.

I.3 Digital exclusion

The COVID-19 pandemic led to an acceleration in the digital transformation of health services. Many services quickly adapted by providing access to, and delivery of, care through digital technologies. This intensified the digital exclusion many people experiencing homelessness already faced. A rapid review of evidence on the impact of digital primary care suggested that the movement towards digital delivery created and exacerbated health inequalities through a 'digital inverse care law', whereby those most in need of healthcare risk being 'locked out'.[15] The authors acknowledge the complexity of this issue and recognise the importance of flexibility in primary care to ensuring patients' needs are met. Further research into digital approaches to primary care highlighted an increased reliance on support workers and clinicians working in the community to facilitate appointments in the community for people experiencing homelessness.[16]

[15] Paddison, C. and McGill, I. (2022). *Digital primary care: Improving access for all?* Found at https://www.nuffieldtrust.org.uk/research/digital-primary-care-improving-access-for-all-rapid-evidence-review

[16] Howells et al. (2022). *Remote primary care during the COVID-19 pandemic for people experiencing homelessness: a qualitative study*. Found at https://bjgp.org/content/72/720/e492

Research into access to mental health and substance use support for people experiencing homelessness shows further implications of digital exclusion.[17] Participants described frustration and challenges around not having the required devices, which were often at risk of theft. Those who did have devices often lacked sufficient digital literacy to use them to access services and support. Research by Doctors of the World also identified a lack of access to the health information and online symptom checkers that were increasingly important during the pandemic.[18]

#HealthNow research insights: health inequalities are perpetuated by poverty

Our research highlighted many ways in which poverty causes reduced access to health services. Financial barriers arose as a result of health services increasingly using digital methods to communicate with patients. Mobile phones, sometimes with cameras, were often required, which also necessitated phone credit to return calls and messages, and to access the internet. Some people, such as older participants or those who had spent long periods in prison, felt that assumptions were made about how accessible technology was to patients.

> *"I think it's just – there's lots of things [involving technology] where you're sort of expected to know but if you've been out of the loop for a long time..."*
>
> *(Newcastle)*

> *"It's all online or email… it's frustrating because if you haven't got internet, you can't get access. Or if you are not computer wise… So, it's frustrating for everybody"*
>
> *(Greater Manchester)*

Digital barriers also meant that many participants struggled to attend remote appointments, such as with mental health or drug recovery services, during the pandemic.

In all four areas, transport costs stopped participants from reaching appointments. In West Yorkshire, participants explicitly linked this to

[17] Adams et al. (2022). *A Qualitative Study Exploring Access to Mental Health and Substance Use Support among Individuals Experiencing Homelessness during COVID-19*. Found at https://www.mdpi.com/1660-4601/19/6/3459

[18] Doctors of the World (2020). *A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic*. Found at https://www.doctorsoftheworld.org.uk/wp-content/uploads/2020/06/covid-full-rna-report.pdf

changes in their accommodation during the pandemic. West Yorkshire covers rural and semi-rural locations, so when the only available accommodation was a significant distance from healthcare providers participants could no longer afford to reach them. In Greater Manchester, in-work poverty also contributed to reducing access to appointments:

"Had to work – on a temp contract so have to work longer if they tell you, or they won't give you more hours."

(Greater Manchester)

While it is possible that access to digital healthcare engagement might help to reduce problems with transportation affordability, this was not something we heard often.

Another financial concern reported in all areas was insufficient access to nutritious food. Reliance on daycentres or foodbanks created additional health problems, such as an inability to meet specific dietary needs and concerns about the risk of increased exposure to COVID-19 infection at the height of the pandemic.

I.4 Accessing mental health support

Literature about patient experiences continued to highlight difficulties attempting to access mental health services. Services were often deemed inflexible and unable to meet patients' needs. A Healthwatch report in Blackpool reported familiar barriers; that people faced challenges qualifying for support, that referral pathways were overly complex and that waiting times were long. It also noted the need for quicker responses to mental health crises.[19] Further research emphasised how mental health providers offering support primarily within standard business hours failed to meet the needs of patients who require access to support late at night.[20] Research in Manchester reinforced the need for services to give patients choice and autonomy, emphasising that 'the ideal appointment plan looks different for every person'.[21] A report by the King's Fund and the University of York found that services were often perceived as 'firefighting', stepping in too late and unavailable until people's needs were severe.[22]

[19] Healthwatch Blackpool (2021). *Homelessness and health: Blackpool*. Found at https://www.healthwatch.co.uk/reports-library/homelessness-and-health-blackpool

[20] Adams et al. (2022).

[21] Gallagher, C. (2022). *It's my medication: mental health and homelessness in Manchester*. Found at https://www.fulfillinglivesevaluation.org/wp-admin/admin-ajax.php?juwpfisadmin=false&action=wpfd&task=file.download&wpfd_category_id=333&wpfd_file_id=7242&token=0ac1e6a4370028601f3db4f244872f98&preview=1

[22] Pleace, N. and Bretherton, J. (2020). *Health and Care Services for People Sleeping Rough: the views of people with lived experience The Partnership for Responsive Policy*. Found at https://www.york.ac.uk/media/healthsciences/images/research/prepare/reportsandtheircoverimages/Health&CareServicesforPeopleSleepingRough.pdf

Forthcoming #HealthNow research exploring access to mental health services has identified similar barriers (due autumn 2022). Participants described both systemic and individual barriers to accessing timely and appropriate support for their mental health. They also reported low expectations of mental health services, often informed by past experiences of poor interactions with mental health services and professionals.

#HealthNow research insights: access to mental health services is highly challenging for those with other disadvantages

We heard about difficulties accessing mental health services in all areas. Of the 64% of participants who reported challenges with their mental health, 66% told us that they had not seen mental health services enough to meet their needs. Among the most frequently mentioned issues were long waiting lists and difficulties re-entering services after being discharged or changing circumstances.

> *"I have been offered counselling but because I missed the deadline to apply, they withdrew their referral and now I'm on the waiting list again."*
>
> *(Greater Manchester)*

> *"I have been waiting for about five years now … because I go to prison …. I go to the bottom of the list and then it's like restart."*
>
> *(West Yorkshire)*

Access to mental health services was particularly challenging for those with drug and alcohol dependence.

> *"I want help with my issues, especially when it comes to my addiction and my mental health. There is nothing they will do. It's almost like I've got leprosy and they won't touch us because of my history, when it's exactly because of my history that they should be treating us."*
>
> *(Newcastle)*

Similarly, some participants reported that GPs had refused to refer them for mental health services if they had a history of addiction.

> *"Unfortunately, I have got substance misuse and due to that they look down their nose at me and they just think it's down to that. But they don't realise that my substance misuse is because I have had trauma in my life. I have never had a doctor actually sit and talk to me in a manner where I can look at him and respect him and feel safe with them."*
>
> *(West Yorkshire)*

I.5 Co-occurring mental health and drug and alcohol dependence problems

Besides the #HealthNow reports, evidence continues to mount that access to appropriate mental health services and support is more challenging for people using drugs or alcohol. This occurs despite guidance that people with severe mental illness should not be excluded from mental health services because of their substance use.[23]

A 2022 peer research report describes patients being refused mental health support because of their drug use and experiencing judgement and stigmatisation. This led to reduced trust in services and, consequently, less motivation to seek support.[24]

An evaluation of the Fulfilling Lives programme demonstrated how people fell through the gaps between mental health and drug and alcohol support.[25] Participants described the detrimental impact of not receiving mental health support on their recovery from addiction.

I.6 Women's access to drug and alcohol services

Research carried out in Brighton and Hove and East Sussex exploring the experiences of people who had engaged in substance use support services found distinct implications for women.[26] Women identified concerns that services felt 'male-oriented'. This was particularly challenging for those who had experienced domestic abuse or unhealthy relationships. They also pointed to a lack of childcare provision embedded into recovery services. The report identified the need for assertive outreach, women-specific spaces, peer support and trauma informed support within substance use services.

A Fulfilling Lives paper describing initial learnings from the effects of COVID-19 containment measures found that some of these issues were at least partially addressed as a result of the pandemic.[27] Women who had previously been reluctant to engage in the 'male dominated environments' of drug recovery centres were far more comfortable with the telephone assessments necessitated by lockdown measures.

I.7 Access to COVID-19 vaccines and testing

Groundswell research uncovered a number of barriers to COVID-19 testing and vaccines.[28] While some participants had not been able to access a COVID-19 test, often due to digital barriers or competing health priorities, most reported that vaccines had been relatively easy to access. Though around two thirds of participants had been able to access a COVID-19 test, many had felt coerced into taking them. This most commonly occurred either in prison or as a precondition to accepting accommodation offers. We heard that information made available

[23] NICE Quality Standard QS188 (2019). *Coexisting severe mental illness and substance use.* Found at https://www.nice.org.uk/guidance/qs188/resources/coexisting-severe-mental-illness-and-substance-misuse-pdf-75545728091845

[24] Harland et al. (2022). *Understanding the life experiences of people with multiple complex needs: peer research in a health needs assessment.* Found at https://academic.oup.com/eurpub/article/32/2/176/6357866?login=false

[25] Rieley et al. (2021). *The Perspectives Project-Part II: learning from people with lived experiences through substance misuse treatment and mental health support*. Found at https://www.fulfillinglivesevaluation.org/wpfd_file/learning-from-people-with-lived-experiences-through-substance-misuse-treatment-and-mental-health-support-2021/

[26] Bhonagiri, A. and Senoran-Martin, N. (2021). *Lived Experience Perspectives Fulfilling Lives Southeast submission on 'lived experience perspectives' for the Independent Review of Drugs by Professor Dame Carol Black*. Found at https://www.bht.org.uk/wp-content/uploads/2021/07/Fulfilling-Lives-Lived-experience-Dame-Carol-Black-Independent-Review-of-Drugs.pdf

[27] Fulfilling Lives Lambeth Southwark Lewisham (2020). *Initial findings of the impact of lockdown during COVID-19 for the people supported by Fulfilling Lives Lambeth Southwark and Lewisham*. Found at https://fulfillingliveslsl.london/initial-findings-of-the-impact-of-lockdown-during-covid-19-for-the-people-supported-by-fulfilling-lives-lambeth-southwark-and-lewisham/

[28] Groundswell (2021). *COVID-19 testing and vaccines: what's working for people facing homelessness?* Found at https://groundswell.org.uk/2021/covid19-testing-vaccines-whats-working/

and accessible through means other than digital formats increased vaccine and testing uptake. Professionals who were available to talk through concerns were highly valued.

Research from Birmingham about COVID-19 vaccine uptake amongst people experiencing multiple disadvantage also outlined the importance of trusted information to ensure people were able to access the vaccine. Vaccine uptake was also impacted by digital exclusion and difficulties in travelling to vaccine sites.[29]

#HealthNow research insights: COVID-19 restrictions had a disproportionate impact on people experiencing homelessness

Our #HealthNow COVID-19 monitoring research identified several impacts on health and wellbeing. It illustrated how unmet health needs and delayed treatment had a significant effect on people experiencing homelessness.

> *"[I] experience pain in legs and hips and back. Walk on crutches. In pain constantly. Sometimes the pain is so bad [I] can't get out of bed for days. Had an op [operation] for spine delayed until August"*

Lack of communication and transparency around the changes in support from services or delays to treatment due to the pandemic led to confusion and isolation for many.

> *"I have been on lockdown for 3 weeks. Can't access a GP service and unable to speak with my keyworker as they are unwell" "[I] was unwell a few weeks ago with…a severe chest infection. [I] was ill for about a month and relied on my son to bring food and do washing. [I] tried to see GP but was refused an appointment. [I] still experience trouble breathing"*

This was particularly true for people experiencing mental health difficulties who discussed the challenges in receiving support remotely and the knock-on effect this had on relationships with healthcare professionals.

> *"I was attending group therapy sessions but that has been cancelled for over 2 months now. My counsellor also became unwell with the virus and I was told if I was struggling to call the Samaritans but for me it takes me a while to build up trust with someone so calling a stranger isn't easy for me and I'm not always able to find the courage. I was also being helped by Mind before lockdown, but their facilities also shut down so I've kind of been left to fend for myself for the most part"*

[29] Birmingham Voluntary Service Council (2021). *Vaccine uptake amongst people with personal experience of multiple disadvantage in Birmingham*. Found at https://www.bvsc.org/vaccine-uptake-amongst-people-with-personal-experience-of-multiple-disadvantage-in-birmingham

2 Trust and relationships

The formation and continuation of trusting relationships between healthcare professionals and people experiencing homelessness has emerged as a common theme.

#HealthNow research insights: positive, ongoing relationships make a big difference

In our 2020 literature review, we found evidence that GPs often exhibited paternalistic attitudes towards people experiencing homelessness. Doctors were likely to conflate those patients' health worries with drug and alcohol issues, using this as justification for limiting their involvement with treatment.

In the #HealthNow West Yorkshire report, we explored this further and found that relationships between health professionals and people experiencing homelessness can underpin wider healthcare experiences and outcomes. The theme cut across services, from mental health to pharmacies, but we found that relationships with GPs were spoken about more frequently and passionately.

Some West Yorkshire participants spoke highly of GPs who "listened" and "understood", but this was almost exclusively reported by those who had regularly seen the same doctor over long periods. For others, the COVID-19 pandemic exacerbated existing problems associated with a lack of continuity of care, since people had often had to move areas as a result of Everyone In.

> *"Because I moved, they said I was out of the jurisdiction area for them still to care for me. I got used to that doctor … so then I have got to get used to it again. Going to go through the same process all my life every time I move. My anxiety goes through the roof."*
>
> *(West Yorkshire)*

Feelings of being ignored, sidelined in their own treatment and medication, or stigmatised because of drug and alcohol dependencies were associated with a lack of enduring relationships. This was common across health services.

> *"They just read notes on a computer and they think they know you. It's not about that, is it? It's like reading a book, and I am not a book."*
>
> *(West Yorkshire)*

Often, as a result of this impersonal treatment, participants had been unaware of their own physical or mental health diagnoses, sometimes for many years. A lack of trust in health professionals meant that patients felt unable to seek information.

2.1 Continuity of care

Continuity of care for GP patients is an ongoing concern for the general population. Against a backdrop of increased workloads and staff shortages, the Royal College of General Practitioners (RCGP) have argued that "building trusting relationships between GPs and patients is the most powerful intervention for delivering effective, high-quality care."[30] In a recent RCGP survey, however, only 39% of GPs and GP trainees said that they were able to deliver the 'relational continuity or relationship-based care that their patients need', down from 60% on a similar survey in 2020. GPs felt that their practices' capacity to ensure that patients can see the same doctor on repeat visits has significantly reduced over the last two years, and this is likely to result in fewer positive health outcomes.

The difference made by GP continuity is even more pronounced for people experiencing homelessness. Research investigating the most effective ways to help people experiencing multiple disadvantage to access primary healthcare found that seeing the same GP, nurse and receptionist across repeated visits played an important role in instilling the confidence to attend future appointments.[31]

2.2 Inclusion health and outreach services

In its guidelines for commissioners and service providers, the Faculty for Homeless and Inclusion Health highlights the importance of developing respectful relationships over time between people experiencing homelessness and health practitioners. The Faculty points to such causes as long treatment journeys from health issues such as drug dependencies and a lack of existing trust.[32] There is growing evidence, including from our #HealthNow research, that inclusion health services provide a useful role in establishing positive relationships between health services and patients.[33] In a collaboration between UCL and homelessness charity Pathway, specialist GP services were shown to be better placed than mainstream services to develop trusting relationships with patients living in homeless hostels.[34] This was largely because their experience in working with this client group enabled an increased understanding of, and empathy towards, the effects of early-life trauma on the challenges faced by people who have experienced homelessness in building relationships. GP in-reach services were found to be especially effective in developing such relationships.

Recent research into the effectiveness of outreach primary care models outlined significant benefits for people experiencing homelessness. Patients described outreach care as feeling more comfortable, convenient, and safer, as well as harnessing a sense of belonging.[35] An evaluation of a community dental model in Plymouth identified improved dental hygiene,

[30] Royal College of General Practitioners (2022) *College Chair outlines 5-point plan to reinvigorate continuity of care for patients against a backdrop of GP pressures*. Found at https://www.rcgp.org.uk/about-us/news/2022/june/fit-for-the-future.aspx
[31] Rossman, R., Rieley, I. Harrison, M., and Bishop, G. (2022). *'Bright Spots': what enables people with multiple and complex needs to access primary healthcare?* Found at https://www.bht.org.uk/wp-content/uploads/2022/02/Bright-Spots-Report-2022-V6.pdf
[32] Faculty for Homeless and Inclusion Health (2018) *Homeless and Inclusion Health standards for commissioners and service providers*. Found at https://www.pathway.org.uk/wp-content/uploads/Version-3.1-Standards-2018-Final.pdf
[33] Groundswell (2022)
[34] Armstrong et al. (2021). *Barriers and facilitators to accessing health and social care services for people living in homeless hostels: a qualitative study of the experiences of hostel staff and residents in UK hostels*. Found at http://dx.doi.org/10.1136/bmjopen-2021-053185
[35] Hirst, V. and Cuthill, F. (2021). *Benefits of GP care in outreach settings for people experiencing homelessness: a qualitative study* Found at https://pubmed.ncbi.nlm.nih.gov/33630748/

increased trust of healthcare professionals and wider engagement with health care settings beyond the dental clinic.[36]

Despite this new evidence of the benefits of inclusion health practices, little is known about transitions from inclusion to mainstream health services. Further research is needed to investigate whether the barriers that are mitigated by registering with specialist homeless health services re-emerge when patients no longer meet those services' eligibility criteria. For instance, it is not clear whether the improvements to trust and relationships brought about by specialist services remain long term.

#HealthNow research insights: relationships with pharmacy staff are often positive

Our #HealthNow research found that, in general, experiences with pharmacies were among the most positive across the health services. Differences between pharmacies and GPs were highlighted in Birmingham, Newcastle and West Yorkshire. These tended to revolve around an increased likelihood of feeling listened to and involved in treatment, rather than merely being informed.

> *"They actually listen. They ask questions, rather than assuming and telling you. When you are talking to them, they ask you more questions about the condition, whereas if you go to the doctors they will go, 'right, well, it's this, this and this'. They don't ask that many questions about what's going on with you."*
>
> *(West Yorkshire)*

In each #HealthNow area, we heard about non-discriminatory staff attitudes and helpful, friendly service. Relationships tended to develop over time, resulting in barriers being reduced.

> *"The pharmacy is very attentive. They're patient and compassionate; they always have my prescription ready. They give me the right advice if I have any issues."*
>
> *(Birmingham)*

> *"They're all good people. They treat me the way I treat them, do you know what I mean? I'm happy with that … The people that are in there I've known for two years now and they're nice people."*
>
> *(Newcastle)*

In West Yorkshire, we also heard how pharmacy staff had been diligent and successful in meeting participants' needs during the COVID-19 pandemic. As pharmacies had remained open, with fewer changes in service provision than other healthcare providers, these relationships largely remained intact.

2.3 Impacts of the pandemic on trust

Research in Manchester into the feelings of people experiencing homelessness about mental health medication found further evidence of struggles to trust mainstream GPs.[39] Patients worried that treatment would be withdrawn if they objected to prescriptions and had little faith that GPs would consider alternatives to medication, such as therapy. However, the study also found signs that the COVID-19 pandemic has had some positive effects on relationship-building with mainstream GPs and other healthcare providers. GPs had begun to adopt more trusting, less risk-averse positions. Methadone, for example, was more commonly being prescribed weekly or fortnightly rather than daily. This mirrored research by Fulfilling Lives Lambeth, Southwark and Lewisham.[40] A more trusting attitude to opioid substitution treatment by drug recovery services was beginning to point towards positive results for "hard to reach" clients, who had previously struggled to engage effectively with the services.

3 End-of-life care and mortality

3.1 End-of-life care

Little new evidence has emerged of end-of-life care experiences since our 2020 literature review, in which we referred to a Care Quality Commission report on end-of-life experiences in homeless hostels. This report identified a lack of access to continuous professional palliative care; people in their last days and weeks of life received healthcare provision far inferior to that of the general population and were over-reliant on hostel staff who were untrained and inexperienced in this area.[42] We have since identified one piece of academic research on the subject. While not disputing a lack of access, it found that mainstream NHS end of life support is not valued by people experiencing homelessness as much as authentic relationships with support providers from any background.[43] In particular, the report found that people living in homeless hostels valued peer-led support and recommended increasing this type of provision. In our 2020 review, however, we drew attention to situations in which the only end-of-life care received by people who were homeless came informally through peer groups. We identified a need for further research, which has not yet been conducted.

[39] Gallagher (2022)
[40] Fulfilling Lives (2020). *Initial findings of the impact of lockdown during COVID-19.* Found at https://fulfillingliveslsl.london/initial-findings-of-the-impact-of-lockdown-during-covid-19-for-the-people-supported-by-fulfilling-lives-lambeth-southwark-and-lewisham/
[42] Care Quality Commission (2017) *A second class ending: exploring the barriers and championing outstanding end of life care for people who are homeless.* Found at https://www.cqc.org.uk/publications/themed-work/second-class-ending-exploring-barriers-championing-outstanding-end-life
[43] Webb, W., Mitchell, T., Snelling, P., and Nyatanga, B. (2020). *Life's hard and then you die: the end-of-life priorities of people experiencing homelessness in the UK.* Found at https://doi.org/10.12968/ijpn.2020.26.3.120

3.2 Mortality

Recent research using data from the 1970 British Birth Cohort Study[44] found that participants who had reported having been homeless were more than twice as likely as participants who had not been homeless to have died before the age of 44. This was the case across several types of homelessness, even when other factors such as mental health and socio-economic status were controlled for. Findings from statistical analysis in Scotland looking into premature death for people experiencing multiple disadvantage were similar.[45] Having experience of at least two of homelessness, opioid dependence, justice involvement or psychosis were associated with very high rates of premature mortality, particularly from preventable causes of death.

Focusing on clients who had died while accessing their services, a Fulfilling Lives South East report explores how patient experiences might contribute to premature death.[46] It found that six clients had died in hospital from treatable and preventable causes, or "deaths that can be mainly avoided through effective public health and primary prevention interventions". The report illustrates how each had suffered from restricted access to healthcare through such issues as ineligibility for services, lack of knowledge of treatment or problems accessing transport. Stigmatising experiences in hospitals also meant that clients had delayed seeking treatment until conditions had become severe. The specific complexity of women's health needs was also found to be a contributing factor, and the report suggests that dedicated women's healthcare services might prevent future premature deaths.

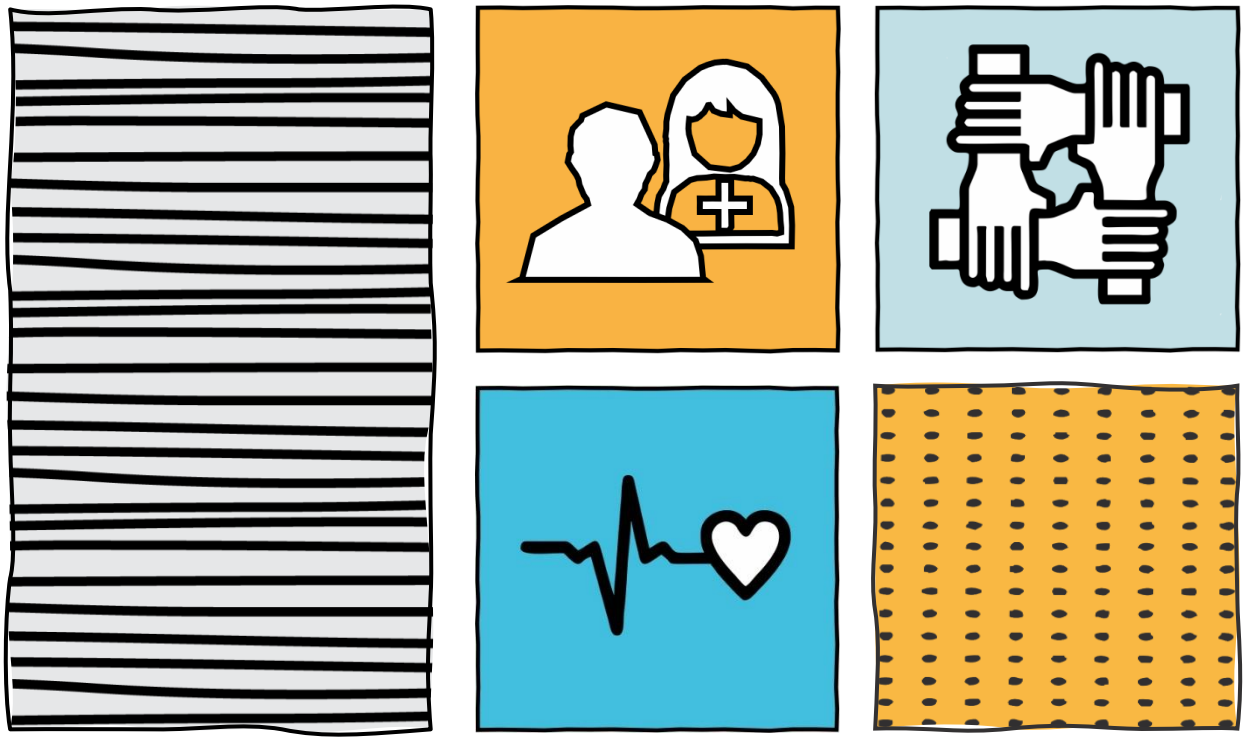
A 2020 report published by Calderdale Safeguarding Adults Board which investigated the causes of five deaths of people who were homeless in Halifax identified similar barriers.[47] Stigmatising experiences with health services, particularly in relation to drug and alcohol use, were again cited, as well as the complexity and inflexibility of health services.

[44] White et al. (2021). *Mortality among rough sleepers, squatters, residents of homeless shelters or hotels and sofa-surfers: a pooled analysis of UK birth cohorts.* Found at https://academic.oup.com/ije/advance-article/doi/10.1093/ije/dyab253/6454072

[45] Tweed, J., Leyland, A., Morrison, D., and Katikireddi, V. (2022). Premature mortality in people affected by co-occurring homelessness, justice involvement, opioid dependence, and psychosis: a retrospective cohort study using linked administrative data. Found at https://doi.org/10.1016/S2468-2667(22)00159-1

[46] Cooke, C., Rossman, R., and O'Brien, J. (2021). *How can we avoid treatable or preventable deaths?* Found at https://fulfilling-lives-se.org/2021/12/22/high-mortality-rates-within-the-multiple-disadvantage-community/

[47] Cullen, N. (2020). *Burnt bridges: a thematic review of the deaths of five men on the streets of Halifax during Winter 2018/19*. Found at https://safeguarding.calderdale.gov.uk/wp-content/uploads/2021/06/burnt-bridges.pdf



Next steps

Key themes from this report have been shared with our #HealthNow peer network, who will discuss potential policy recommendations and solutions based on the findings. We will continue to work closely with our #HealthNow peers to ensure that decision-makers are held to account for their implementation.

This report and any proposed recommendations will be shared through our national homeless health partners meeting to inform national actions aimed at addressing homeless health inequalities as part of our ongoing #HealthNow programme.

Some of the key issues explored in this report are further examined through our thematic peer-led research into access to mental health support which will be published later this year.

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