Research

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Provision and accessibility of primary healthcare services for people who are homeless:

a qualitative study of patient perspectives in the UK

Abstract

Background
Anecdotal reports of people who are homeless being denied access and facing negative experiences of primary health care have often emerged. However, there is a dearth of research exploring this population's views and experiences of such services.

Aim
To explore the perspectives of individuals who are homeless on the provision and accessibility of primary healthcare services.

Design and setting
A qualitative study with individuals who are homeless recruited from three homeless shelters and a specialist primary healthcare centre for the homeless in the West Midlands, England.

Method
Semi-structured interviews were audiorecorded, transcribed verbatim, and analysed using a thematic framework approach. The Theoretical Domains Framework (TDF) was used to map the identified barriers in framework analysis.

Results
A total of 22 people who were homeless were recruited. Although some participants described facing no barriers, accounts of being denied registration at general practices and being discharged from hospital onto the streets with no access or referral to primary care providers were described. Services offering support to those with substance misuse issues and mental health problems were deemed to be excluding those with the greatest need. A participant described committing crimes with the intention of going to prison to access health care. High satisfaction was expressed by participants about their experiences at the specialist primary healthcare centre for people who are homeless (SPHCPH).

Conclusion
Participants perceived inequality in access, and mostly faced negative experiences, in their use of mainstream services. Changes are imperative to facilitate access to primary health care, improve patient experiences of mainstream services, and to share best practices identified by participants at the SPHCPH.

Keywords
health services accessibility; homeless persons; primary care.

INTRODUCTION

Homelessness manifests itself in many forms including rough sleeping, squatting, sofa surfing, and residing in hostels or council housing.[1] Homelessness is a national concern in the UK, with >115 550 homeless applications being submitted to local authorities in England during 2016/2017.[2] The number sleeping rough in some urban areas has doubled in the last 6 years.[3]

Significant healthcare disparities remain for the homeless community; standardised mortality ratios for females and males who are homeless are reported to be 11.9 and 7.9 respectively, compared with the general population.[4] The Inverse Care Law, that is, *'the availability of healthcare is inverse to the health needs of the population'*,[5] is often applicable to the homeless as these individuals face barriers when accessing mainstream primary healthcare services.

Those who are homeless are known to be 40 times less likely to be registered with a mainstream general practice compared with the general population.[6] In an attempt to address such disparities, specialist primary healthcare centres for people who are homeless (SPHCPH) have been established. Such centres provide a multitude of services including GPs, dentists, specialist nurses, and psychotherapy counselling services, usually under one roof.[7] Patients who are homeless are expected to relocate from the centre to mainstream primary care providers once permanently housed.[8]

Barriers to accessing health care can contribute to the worsening of health issues experienced by people who are homeless, due to delayed diagnosis and treatment. It is known that this population is up to 60 times more likely than the general population to attend an accident and emergency (A&E) department,[9] with substance and alcohol misuse commonly linked to such visits. This may indicate points of weakness in the primary healthcare system for people who are homeless.

Exploring reasons for underutilisation or non-access to primary care services, experiences that deter or facilitate such use, and potential reasons for frequent A&E visits by those who are homeless are imperative in order to improve the health of this population. Use of primary care services is particularly important, as seeing a trusted healthcare professional (HCP) is essential to ensure continuity of care.[10] Standards for service providers and commissioners have been published by the Faculty for Homeless Health that focus on the need for cross-sector collaboration, including outreach where facilitated access to the sites are not practical or successful.[11]

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How this fits in

Anecdotal reports of people who are homeless being denied access to general practices and primary healthcare services struggling to fulfil their complex healthcare needs have often come to light. However, there is a dearth of research examining the views and experiences of people who are homeless on such services. By exploring the perspectives of individuals who are homeless on the provision and accessibility of primary healthcare services, this study shows that key barriers exist for people who are homeless in registering with a mainstream general practice and their awareness of services available to them. There is scope for facilitating better access to services, improving patient experiences at mainstream general practices, and replicating best practices experienced by patients at the specialist primary healthcare centre for people who are homeless.

However, implementation remains poorly understood.

This study aimed to explore the perspectives of the population that is homeless around their access to and use of primary healthcare services, including mainstream general practices and an SPHCPH.

METHOD

A qualitative study using face-to-face, semi-structured interviews was conducted that allowed for a naturalistic enquiry of participants' perspectives and experiences.[12] Participants who were homeless, aged ≥18 years with capacity to provide informed consent, and communicate in English (or otherwise who had access to an interpreter on site) were recruited from three diverse homeless shelters and an SPHCPH in the West Midlands region of England; details of the recruitment sites are shown in Box 1. A convenience sampling method was used based on the availability of participants at each site during data collection. Posters were made available in the public areas of the shelters to advertise the researchers' visit. Owing to variable literacy levels among the study population, staff at the study sites also verbally communicated details of the project to potential participants. Individuals were approached by staff at the study sites and referred to the research team if they expressed an interest to participate. At the SPHCPH, participants were referred to the research team following their consultation with a healthcare practitioner. The interviews took place in private rooms to maintain confidentiality, with the exception of two interviews that were conducted in communal areas at the participants' request.

Informed consent, both signed and verbal, was obtained from the participants and interpreter (when used) by researchers operating in pairs. The interpreter was working in a professional capacity and had accompanied the study participants in their medical consultation, hence participants expressed they were happy with their presence. The researchers attended a street banquet for people who are homeless and accompanied a street outreach team for several hours to familiarise and build rapport with the study population before data collection. However, the research team had no links with the study sites or participants.

An interview schedule was developed based on the limited existing literature, discussion among the research team, input from HCPs at the SPHCPH, and use of the Theoretical Domains Framework (TDF). The interview schedule was piloted with a participant at each site. The TDF outlines 14 domains of behavioural determinants, each embodying individual constructs and representing a synthesis of 33 behaviour change theories.[13] These include knowledge, skills, resources, social influences, and intentions. TDF enables the identification of appropriate components of planned behavioural interventions, the barriers and enablers that need to be addressed, and the way behaviour changes brought

Box 1. Recruitment sites

Study recruitment sites	Details
Shelter A	Shelter provided to single males who are homeless and aged ≥21 years, for a maximum of 3 months. Access is available to support workers, educational and health support.
Shelter B	Shared accommodation for individuals legally classed as homeless, including single females, males as part of a family, single mothers and children; no single males are accepted. The background of those at the centre varies from immigrants to victims of abuse. Support workers are available and registration at a local general practice is facilitated.
Shelter C	Housing-related support in the form of self-contained flats, helping individuals prepare for independent living.
Specialist primary healthcare centre for people who are homeless (SPHCPH)	Offering primary care services specifically to the population that is homeless and vulnerably housed, if >16 years of age and not pregnant. Services include access to GP appointments, mental health triage, substance misuse services, bereavement counselling, prescribing nurse clinics, outreach programmes, and drop-in services.

Table 1. Demographics of participants, *N* = 22[a]

Demographic	*n*
Recruitment site	
Shelter A	5
Shelter B	5
Shelter C	2
SPHCPH	8
Sex	
Female	5
Male	15
Length of time homeless	
<6 months	8
6 months–1 year	5
1–2 years	4
3–4 years	1
≥5 years	2
Self-reported general health status	
Very good	5
Good	5
Fair	5
Bad	5
Very bad	0
GP access	
Yes	18
No	2
Sleeping arrangements	
Hostel	16
Council, housing association	2
Other, such as with friends or relatives, B&B, caravan	2
Sleeping rough	0
Privately rented or owned accommodation	0
Ethnicity	
White	14
Asian	2
Black	2
Mixed	1
Prefer not to say	1
Other	0
A&E visit in last 12 months	
Yes	10
No	10

[a] *Two participants (n = 2) who did not consent for audiorecording were excluded from their direct quotes being represented in the manuscript; however, data were used to draw recommendations and conclusions. B&B = bed and breakfast. A&E = accident and emergency department. SPHCPH = specialist primary healthcare centre for people who are homeless.*

Box 2. Key themes and subthemes from data

Organisation and delivery of services
- Patient registration at general practices
- Integration of services
  - Signposting to services
  - Integration of services for mental health and substance misuse
- Continuity of care
  - Transition of care across services
  - Sharing of patient medical records
- Waiting times and appointment lengths

Patient-related factors
- Patient's knowledge and awareness of primary healthcare services
- Patient's skills and health literacy
- Patient's resources
- Patient's feelings and emotions

Social exclusion and stigma

GP awareness of the complex healthcare needs of people who are homeless

through the interventions can be measured and understood.[14] The researchers had utilised TDF previously in research involving participants who were homeless.[9,15] Interviews were audiorecorded, transcribed verbatim, and analysed through a thematic framework approach[16] by two researchers and checked by a third researcher before discussion in the team. The first four transcripts were analysed initially to develop a pool of subthemes in addition to those identified from the topic guides. Interrelated subthemes were then categorised into main themes through inductive coding. This provided a working framework. Each transcript was manually annotated after line-by-line reading. Facilitators and barriers to access and use of services were mapped onto the domains relevant to the TDF.

Anonymity was established by coding the setting and participant so that both were unidentifiable. Audiorecordings of the interviews were uploaded onto encrypted files before being deleted from the recording device. Consent forms were stored in a locked filing cabinet at the university and were accessed only by the lead researcher.

RESULTS

Demographic characteristics
A total of 22 interviews were conducted by two researchers across the four sites (Table 1). Participant ages ranged from 24 to 70 years. Participants had experienced homelessness for <6 months to ≥5 years. A range of routes to homelessness were described by the participants including immigration issues preventing access to public funds and social housing support, loss and bereavement, substance misuse, and violence. Most suffered from chronic health conditions and comorbidities, such as epilepsy and diabetes, and infectious diseases, including HIV and hepatitis C (summarised from the qualitative data as mentioned by the participants). In relation to participant views, key themes that arose around their access and experiences of the use of primary care and community services are presented here and summarised in Box 2. The facilitators and barriers identified across these themes from the data are mapped in Box 3 against the TDF domains.

Organisation and delivery of services
Patient registration at general practices. Most participants identified the absence of a 'fixed abode' as the largest barrier to registering at a mainstream general practice where both proof of address and photo identification were often requested by the frontline staff. Those using mainstream practices were either registered before becoming homeless or through a mutual agreement between the shelter and the local general practice. Some participants relied on help from friends or relatives to assist with supplying proof of address by allowing utility bills to be addressed in their names.

Some mentioned that there was 'no way' of getting a general practice registration when sleeping rough:

Box 3. Facilitators and barriers of access to primary healthcare services mapped against the Theoretical Domains Framework

TDF domain	TDF descriptor	Subtheme	Facilitator	Barrier
Beliefs about capabilities	Acceptance of the truth, reality, or validity about an ability, talent, or facility that a person can put to constructive use	Patients' perceived ability (or lack of) to find a healthcare provider	✓	✓
		Patients' perceived ability (or lack of) to integrate with the norms and rules within mainstream services	✓	✓
Beliefs about consequences	Acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation	Patients' beliefs about the consequences of not receiving health care	✓	✓
		Consequences of continuity of care (or lack of)	✓	✓
		Consequences of being discharged onto the streets with no primary care providers		✓
		Consequences of fragmented services on health		✓
Emotions	A complex reaction pattern, involving experiential, behavioural, and physiological elements by which the individual attempts to deal with a personally significant matter or event	Feelings of embarrassment when seeking health care		✓
Environmental context and resources	Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behaviour	Lack of patient 'fixed abode' and photographic ID	✓	✓
		Signposting (or lack of) to appropriate services		✓
		Patients' lack of resources to pay for public transport or make calls for appointments		✓
		Patients' lack of resources to search services in their local areas		✓
		Availability (or lack of) facilities to promote medication adherence	✓	✓
		Discharged from hospitals onto the streets		✓
		Unfavourable eligibility criteria for access to substance misuse and mental health services	✓	
		Facilitated registration for primary care services through temporary shelters	✓	
Goals and intentions	Mental representations of outcomes or end states that an individual wants to achieve	Patients' intentions to seek health care	✓	✓
Knowledge	An awareness of the existence of something	Patients' knowledge/lack of knowledge of mainstream services available in their area	✓	✓
		Patients' knowledge/lack of knowledge of SPHCPH for people who are homeless available in their areas	✓	✓
		Patients' lack of knowledge of the rules and policies of mainstream practices	✓	✓
		Lack of knowledge among mainstream frontline staff about eligibility for registration of patients who are homeless		✓
		GPs' knowledge/lack of knowledge of the complexity of patients' health conditions	✓	✓
Memory, attention, and decision processes	The ability to retain information, focus selectively on aspects of the environment, and choose between ≥2 alternatives	Committing crime to go to prison to access health care		✓
Reinforcement	Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus	Proactive follow-up of patients at the SPHCHP	✓	
Skills	An ability or proficiency acquired through practice	Patients' lack of skills in completing paperwork and navigating through the system		✓
Social influences	Those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours	Support from friends and families in registration process	✓	
		Social network to facilitate appointments and engagement	✓	
		Perceived stigma and discrimination from other patients		✓
		Perceived stigma and discrimination from healthcare staff		✓
Social/professional role and identity	A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting	Trust (or lack of) between healthcare staff and patients	✓	✓
		Self-identity as a person who is homeless		✓
		Poor handover of patient information across healthcare professionals and settings		✓

✓ TDF = Theoretical Domains Framework; TDF domains for optimism and behavioural regulations were not identified in the data. The domains for goals and intentions are presented together in the data, meaning that 12 TDF domains are presented in 11 rows. SPHCPH = Specialist Primary Healthcare Centre for People who are Homeless.

'Getting proof of address when you're on the streets you don't have an address so it does get quite difficult and like I managed to get erm my uncle to let me stay with him for a while, get some bills sent there er like my bank statements stuff like that so I could actually get a GP … I know several people who have been coughing up blood and all that kinda stuff but they can't get in to see a GP coz they can't register.' (male [M], aged 24 years, shelter A [SA])

'Since we've come [here], I'm not registered, she's [daughter] not registered [because] I can't find [a] GP.' (female [F], aged 32 years, shelter B [SB])

Integration of services. This was described in the context of signposting, and patient use of mental health and substance misuse services in the community.

Participants described a lack of signposting to appropriate services. Despite participants being refused registration at local mainstream practices, they mentioned that they were not signposted to alternative services such as SPHCPH. This resulted in a patient having no access to a general practice for several months. Instead, participants at the SPHCPH recalled being signposted to such services by police officers or charity staff:

'I found out about this [SPHCPH] *from a street warden, err like a police officer, not the doctors that I first went to, the other GPs when I tried to sign up to go to them. I went to about four or five in my postcode. Err all of them says that I couldn't sign up because I had no fixed abode, but none of them give me the details about this* [SPHCPH].' (M, aged 43 years, SPHCPH)

The lack of service integration was also described in the context of mental health and substance misuse services, which were deemed to exclude those with the greatest need. Entry thresholds to such services were said to actively obstruct those patients who were self-harming, including those with recent suicide attempts, despite these incidents often being precipitated by poor mental health.

One participant described such practice policy as being responsible for many suicide attempts and illicit drug use:

'… I self-harm a lot right I've had a lot of suicide attempts but what [the mental health services] … *if you've self-harmed within the last 6 months they won't touch you as well as if you're on the alcohol or*

drugs as well they won't touch you because they think you're too high of a risk … you shouldn't be using [recreational drugs] *to self-medicate but when you don't have access to the services what else are you meant to do?'* (M, aged 24 years, SA)

Some participants with mental health conditions and concomitant substance misuse mentioned not being able to receive mental health support until they addressed their substance misuse issue despite their perception that these were interrelated, thus placing them in a vicious cycle. A participant described committing crimes with the intention of going to prison in order to access health care:

'I wanted to come off alcohol that bad they said it was killing me — but they couldn't have no funding until April … I got self-sent to prison for 3 weeks so they could help detox me.' (M, aged 34 years, SA)

Continuity of care. Themes around continuity of care were identified in the context of transition of care across services and sharing of patient medical records.

Transition of care between secondary and primary health care and onto social services were often deemed to be suboptimal in practice. Variation in hospital discharge pathways for patients who were homeless was reported by those who had been admitted to hospital while homeless. One hospital was aware of the participant's homeless status and discharged them only once accommodation had been arranged. However, the accommodation was unsuitable as it had no fridge to store their insulin. Alternatively, another participant was discharged onto the streets despite making staff aware of their living circumstances:

'They knew full well I didn't have anywhere to go once they discharged me but they discharged me anyways.' (M, aged 24 years, SA)

Participants also gave accounts of how poor transition of care between health and social services can perpetuate the cycle of homelessness.

Failure of hospital staff to notify the city council regarding a participant's need for housing on discharge led to a participant being refused accommodation on arrival at the council despite their assumption of eligibility. Though the health of the participant had improved, they were forced to return to rough sleeping:

'I went over to that council and they said that they had no information at all about me coming there so the hospital didn't communicate with them to say that I was going there, which then left me on the streets.' (M, aged 24 years, SA)

Some participants moved out of the catchment area of their practice and therefore needed to re-register at a new practice, whereas others described not 'bothering' to re-register because of feeling unsure about the stability of their new accommodation.

Participants recounted negative experiences of having to re-tell their medical and social history owing to the perceived absence of a good system of handover between different services and sharing of patient medical records. They deemed this frustrating given their complex life circumstances.

The participants mentioned that they could not trust HCPs with their health unless they saw them on a regular basis:

'... you make a relationship with the doctor then the next week you come and it's a totally different doctor and you have to re-tell them your whole life's story ...' (M, aged 43 years, SPHCPH)

However, users of the SPHCPH described continuity of care in this setting. Staff at the centre also undertook outreach services on the streets and at a local homeless shelter, used a patient's social network in order to contact them, provided opportunistic interventions, and initiated follow-up. The sense of reliance on the staff at the practice, however, posed a barrier to the patients relocating to a mainstream general practice.

'... if you go to a normal surgery, you'd have to see the doctor then you'd have to see that nurse then you'd have to see the thingy nurse where you could just see the one person they could just do the whole job there' (M, aged 33 years, SPHCPH)

Waiting times and appointment lengths. Given the multitude of healthcare problems they were facing, several participants described the long waiting lists for an appointment as a barrier to accessing care. Participants explained that they often experienced a rushed appointment in mainstream practices that limited their opportunity to fully discuss the multiple health issues they faced.

Participants alluded to the disservice the 'one appointment, one problem' policy was causing them:

'... it seems like they just like have you in for 5 minutes ... they have a quick chat with you, ask how you feel then like kick you out ... like they spend less time with you.' (M, aged 43 years, SA)

On the contrary, participants at the SPHCPH praised the flexibility of appointments that enabled multiple issues to be addressed in one consultation. Provision of drop-in sessions at the centre was identified as a facilitator of primary care access:

'Most days at 1 o'clock it's a drop-in, ask for a nurse or a doctor [inaudible] other surgeries you've got to wait 2 to 3 weeks to get an appointment, that doesn't happen [at the SPHCPH].' (M, aged 64 years, SPHCPH)

Half of participants reported attending A&E in the 12 months preceding interviews. Participants described long waiting times and difficulty travelling to the general practice as reasons for presentation at A&E.

Long waiting times at A&E itself were also a barrier and led to non-use of 'any' healthcare services by some participants:

'Like I say I got mugged, beaten up right, broken nose, broken toe but I couldn't be bothered to go into A&E and just sit there for 8 hours ya know not to mention the fact I would have had to walk all the way from Paignton to Torquay and that's about 6 miles ... I haven't seen any healthcare person since that happened.' (M, aged 24 years, SA)

Patient-related factors
Patient's knowledge and awareness of primary healthcare services. Some participants mentioned that they were aware of the mainstream general practices that existed in their local area. A few, however, explained that finding a local practice was not easy given their lack of access to the internet and their unstable living arrangements. Most had attempted to register with a mainstream practice in the recent past, with varying degrees of success. The SPHCPH was known only to those participants who were staying in a nearby hostel, or who had been referred by personnel such as charity workers and police officers:

'No I don't know anything [about the SPHCPH].' (F, aged 32 years, SB)

Patient's skills and health literacy. Some participants felt confident in registering at a mainstream practice as they were able to complete application forms and understand the processes involved.

However, others mentioned that they had struggled because of learning difficulties or being unable to comprehend the system:

'People have dyslexia ... learning difficulties, people that maybe are on drugs or addictions will not be able to maybe erm get through so easy in signing up to a GP because of their mental state, personality disorder, erm also not understanding the waiting times and procedures, they get frustrated.' (M, aged 30 years, SA)

Patient's resources. Some participants described having to walk to services, which was restricted by existing health issues and disabilities. After becoming homeless, one participant was forced to stop attending counselling sessions for depression and anxiety as they could not afford to pay for transport.

One participant explained how severe pain further restricted service access as, on arrival at the practice, the participant no longer felt well enough to interact with staff:

'I can't afford fares ... by the time I get there and I'm walking, I'm in such a bad mood that I don't talk to nobody.' (M, aged 50 years, shelter C [SC])

Resources were also described in the context of managing prescribed medicines. Participants reported having a large pill burden. A former rough sleeper explained that shelter and food were prioritised above medication when living on the streets. Medicines were often distributed or stolen within social circles.

One participant described the difficulty they faced in storing insulin as there was no fridge in the temporary accommodation:

'They had no err fridge for my insulin right so I was putting my insulin in cold water in the sink and they was coming in, cleaning my room and leaving my insulin out of the water, so my insulin's going warm.' (M, aged 50 years, SC)

Patient's feelings and emotions. A person's emotional state was identified as a barrier to accessing primary health care.

Feelings of embarrassment and depression were examples of emotions that deterred people who are homeless from seeking health care:

'The pain I'm going through I just can't tell anyone about it coz I'm embarrassed.' (M, aged 50 years, SC)

'I've not said anything I don't — I don't know if they [GP] *could* [help] *... so I do blame myself ... for not mentioning it* [homelessness] *but I think it's just better that way.'* (F, aged 29 years, SB)

Social exclusion and stigma
While accounts of good relationships between participants and healthcare providers were described by some, others perceived themselves as being victims of discrimination and stigmatisation by HCPs due to their living circumstances, immigration status, and health issues. Some participants recounted mistrust between themselves and the HCPs:

'When you go back in and you say [to a GP] *something like ya know* [the medication has] *been stolen, for example, half the time the GP's not going to believe you ... they're just gonna think you want another script early because you're using it recreationally ....'* (M, aged 24 years, SA)

'When we go GP or like er healthcare, no matter dentist or anything, it's different. Some it's very good at treat[ing] *like same* (equally) *but some we feel like racist. We got problem*[s], *ill*[ness], *but you treat us like this. We're humans, we are human*[s].'* (F, aged 35 years, SB)

The influence of staff attitude on a patient's health-seeking behaviour was emphasised by several participants and said to be a 'decider between life and death' for some patients who are homeless:

'That could be the decision between him, you, finding him alive with a smile on his face tomorrow or dead because of him just choosing to walk in that door because it was a nice nurse on or it was the horrible b*tch that's in on a Wednesday ... especially with having HIV ya know, going to speak to somebody about it and not speaking to somebody could be the difference between living and dying.' (M, aged 33 years, SPHCPH)

There was a general perception that good rapport and trust between patients and staff existed at the SPHCPH, which was found to motivate participants to seek care; the practice was described as *'a little close-knit family.'* (M, aged 33 years, SPHCPH) Staff members were also commended for

their tolerance towards patients behaving in an 'aggressive' way and competency in managing comorbidities. Some participants also described the experience of facing stigma and exclusion from other service users at mainstream practices, which led them to exhibit poor behaviour and be de-registered from services:

'When I've gone through certain circumstances erm I've felt a certain way, everyone's against you, the world's against you, so naturally you're gonna have this mentality and personality that you don't care and you're gonna come across quite abrupt so then ... that person automatically knows or thinks that you're from a certain segmentation.' (M, aged 30 years, SA)

GP awareness of the complex healthcare needs of people who are homeless
While some GPs would provide additional support to patients who are homeless, other GPs were perceived to have failed to tackle their complex healthcare needs.

For example, a patient who was registered at a mainstream practice received delayed support when GPs failed to signpost him to mental health services for 6 months after his diagnosis of depression and anxiety:

'When I was in the GP they didn't really tell me about a lot of the services initially ... it took them a good 6 months after diagnosing my depression and anxiety for them to even know about the drugs and alcohol service ... know it took a long while for that.' (M, aged 24 years, SA)

Some mainstream GPs were also reported to lack awareness of the impact of homelessness on health. Further training for mainstream HCPs to raise awareness of such issues was suggested by several participants in order to improve primary care provision:

'I think they probably need to be made more aware of [homelessness] *because there's a lot of erm things that you can face on the streets, you can face a lot of illness more than you would do in like a house.'* (M, aged 24 years, SA)

DISCUSSION
Summary
This study has reported the perspectives of people who are homeless on their access to and use of primary healthcare services. Homeless people perceived inequality in access and faced mostly negative experiences in their use of mainstream primary healthcare services. Changes are imperative to facilitate access and improve patient experiences of mainstream services. The service delivery model at the SPHCPH was perceived by participants to be best practice and so implementing such practice in mainstream settings could help to bring about positive change.

Key barriers to the access and use of primary healthcare services related to being denied registration at the mainstream general practices, lack of continuity of care because of having unstable accommodation, fragmented services, lack of awareness by primary HCPs on the complexity of the healthcare needs of those who are homeless, inadequate signposting, and perceived stigma and discrimination from other patients and HCPs.

A total of 12 TDF domains were identified in the data including: beliefs about capabilities; beliefs about consequences; emotions; environmental context and resources; goals; intentions; knowledge; memory, attention, and decision processes; reinforcement; skills; social influences; and social/professional role and identity. These domains can be targeted in future interventions. The barriers to primary healthcare services identified in this study have the potential to widen existing health inequalities. Participants highly valued the provision of the SPHCPH.

Strengths and limitations
In exploring the in-depth perspectives of those who are homeless on their access to and use of primary healthcare services, the authors recruited participants from multiple sites, which provided a variety of experiences associated with homelessness and primary healthcare utilisation. The validation and piloting of the research materials, use of theory, and subjection of data to rigorous framework analysis increased the trustworthiness of the findings.

This study has some limitations: findings may not be representative of the views and experiences of all people who are homeless given the use of a small study sample. Some participants relayed experiences of their family and friends rather than personal accounts, which may reduce reliability of the findings. However, social influences were deemed important in health-seeking behaviour by participants of this study and in the authors' previous work with those who are homeless.[9,14] Given the diverse nature of homelessness and participant experiences, data saturation was not achieved. Lastly, there is a potential risk of response bias as participants may have provided desirable

answers for fear of repercussions on the care or treatment they receive. Researchers attempted to address this limitation in advance through information leaflets and verbal reassurances.

The participants of this study were mostly male and comprised people living in hostels, who were registered with a primary healthcare provider and therefore the present results need to be interpreted with caution. However, this compares well with the local demography of those who are homeless in the West Midlands.[17]

Comparison with existing literature

NHS England states that individuals can register with a general practice regardless of residential status;[18] however, there continues to be confusion at practice level, as this study identified people who were homeless and who had been denied registration with a mainstream practice. This study's finding corroborates limited existing research and, in addition, provides in-depth patient experiences.[19]

Previous published research found that mainstream GPs reported a perceived lack of competence when treating patients who were homeless, owing to the lack of its coverage in the curriculum.[20] This was reflected in the responses of participants that suggested the skill set possessed by mainstream practitioners did not meet the complex needs of this particular population, contrary to the care provided at the SPHCPH. Positive experiences at the SPHCPH have been reported as a barrier to relocating to mainstream practices when patients move to permanent accommodation.[8] Outreach services were found to overcome multiple barriers experienced at mainstream settings.[21] Previous literature suggests that provision of housing, regardless of the quality, could improve a patient's access to primary care and subsequently their health.[22]

The findings of this study show that the current service delivery model could be a potential barrier to accessing mainstream primary healthcare services by the homeless population. This finding corroborates published literature,[23] which indicates that the rigid appointment systems may be difficult to adhere to for patients who are homeless due to their chaotic lifestyles.

Implications for research and practice

This study has highlighted the complex interplay of barriers to access and experiences of primary healthcare services by those who are homeless. The model of service delivery at the SPHCPH was regarded by the study participants as best practice in overcoming many barriers. While commissioning more specialist primary healthcare centres would be an idealistic solution to improve their access to primary health care, the study findings also suggest that mainstream services need to be adapted to be inclusive of this population. The following recommendations are grounded in the study findings and aim to address key points of weakness in the system in order to improve access and experiences of primary healthcare services by those who are homeless.

Short-term recommendations:
- Training and education of frontline staff at mainstream general practices to reinforce the registration guidelines; emphasising that being of no fixed abode is not a barrier to registering, so as to avoid any confusion at practice level.
- National distribution of 'My right to access health care' cards to provide guidance to individuals who are homeless about registering at mainstream providers and facilitate self-advocacy. This scheme is currently limited to London.[24]
- Provision of information to staff at mainstream practices to facilitate signposting to additional health and homeless services; aiming to reduce fragmentation of services and improve continuity of care.
- Review of entry criteria to primary care mental health services for people who are homeless in order to increase accessibility. People who are homeless face additional stresses and risk factors compared with the housed population and should have a lower entry threshold to mental health services to improve timely access.
- Compliance with the Homelessness Reduction Act 2017,[25] which mandates that local housing authorities and health service providers provide anticipatory and corrective measures for the reduction of homelessness, and which came into force for health service providers in October 2018. Compliance would ensure healthcare settings proactively identify vulnerable people and work collaboratively with social services to offer support, so that patients are no longer discharged onto the streets, and are referred to primary care services for more seamless care.[26]

Long-term recommendations:
- Provision of a health-needs assessment tool for use by primary care practitioners.

This will support practitioners to feel more confident when addressing complex issues and ensure a holistic approach to the care of patients who are homeless.

- Incorporation of health care for patients who are homeless into the standards for education of HCPs to increase understanding, improve quality of care, and reduce perceived discrimination towards this marginalised community.
- Training of designated staff to deliver specialist care in those mainstream practices with a high homeless population as well as facilitating access to multiple services under the same roof within these practices, thus sharing good practice identified at the SPHCPH.

An inventory list of specialist services available for those who are homeless has recently been developed[8] that can help commissioners undertake a local-needs assessment of services. However, facilitating access to mainstream services also requires addressing wider barriers identified in this study. For example, anti-stigma intervention for HCPs, such as the 'targeting the roots of healthcare provider stigma',[27] can be useful. This model requires improving: the ability of healthcare professionals to manage and cope with their emotions when working with patients in challenging situations; improving competence and confidence of staff; and addressing the lack of awareness of one's own prejudices. The lack of understanding of homelessness by HCPs may be partly responsible for the discrimination experienced by the participants of this study. Previous research conducted with healthcare professionals *has* linked perceived discrimination arising from patients' low self-esteem and subsequent paranoia,[23] but those suggestions are not consistent with the findings of this study.

Obtaining the views of wider stakeholders, such as mainstream primary care providers, would provide further insight into the barriers and facilitators to accessing primary healthcare services. Evaluation research of various service delivery models, such as outreach programmes and non-medical prescribing, including their impact on health and quality-of-life outcomes of people who are homeless, is warranted.

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REFERENCES

1. Shelter. What is homelessness? 2019. https://england.shelter.org.uk/housing_advice/homelessness/rules/what_is_homelessness (accessed 21 Jun 2019).

2. Fitzpatrick S, Pawson H, Bramley G, *et al.* The homelessness monitor: England 2018. Table 1.0 — summary of homelessness statistics. London: Crisis, 2018. https://www.crisis.org.uk/media/238700/homelessness_monitor_england_2018.pdf (accessed 21 Jun 2019).

3. Ministry of Housing, Communities and Local Government. *Rough sleeping statistics autumn 2017, England (revised)*. 2018. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/682001/Rough_Sleeping_Autumn_2017_Statistical_Release_-_revised.pdf (accessed 21 Jun 2019).

4. Aldridge RW, Story A, Hwang SW, *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. *Lancet* 2017; **391(10117):** 241–250.

5. Hart JT. The inverse care law. *Lancet* 1971; **297(7696):** 405–412.

6. Elwell-Sutton T, Fok J, Albanese F, *et al.* Factors associated with access to care and healthcare utilization in the homeless population of England. *J Public Health (Oxf.)* 2016; **39(1):** 26–33.

7. NHS England. *Improving access for all: reducing inequalities in access to general practice services*. 2018. https://www.england.nhs.uk/wp-content/uploads/2017/07/inequalities-resource-sep-2018.pdf (accessed 17 Jun 2019).

8. Crane M, Cetrano G, Joly L, *et al. Inventory of specialist primary health care services in England for people who are homeless*. London: Social Care Workforce Research Unit, King's College London, 2018. https://www.kcl.ac.uk/scwru/res/hrp/hrp-studies/hearth/hearth-study-inventory2018.pdf (accessed 20 Jun 2019).

9. Smith KG, Paudyal V, MacLure K, *et al.* Relocating patients from a specialist homeless healthcare centre to general practices: a multi-perspective study. *Br J Gen Pract* 2018; DOI: https://doi.org/10.3399/bjgp18X694577.

10. Freeman G, Hughes J. *Continuity of care and the patient experience*. London: King's Fund, 2010. https://www.kingsfund.org.uk/sites/default/files/field/field_document/continuity-care-patient-experience-gp-inquiry-research-paper-mar11.pdf. (accessed 17 Jun 2019).

11. Hewett N, ed. *Standards for commissioners and service providers*. Faculty for Homeless Health, 2011. https://www.pathway.org.uk/wp-content/uploads/2013/02/Homeless-Health-Standards.pdf (accessed 17 Jun 2019).

12. Ritchie J, Lewis J, Nicholls CM, eds. *Qualitative research practice: a guide for social science students and researchers*. London: Sage, 2014.

13. Cane J, O'Connor D, Michie S. Validation of the theoretical domains framework for use in behaviour change and implementation research. *Implement Sci* 2012; **7:** 37.

14. Paudyal V, MacLure K, Buchanan C, *et al.* 'When you are homeless, you are not thinking about your medication, but your food, shelter or heat for the night': behavioural determinants of homeless patients' adherence to prescribed medicines. *Public Health* 2017; **148:** 1–8.

15. French SD, Green SE, O'Connor DA, *et al.* Developing theory-informed behaviour change interventions to implement evidence into practice: a systematic approach using the Theoretical Domains Framework. *Implement Sci* 2012; **7:** 38.

16. Pope C, Ziebland S, Mays N. Analysing qualitative data. *BMJ* 2000; **320:** 114.

17. Bowen M, Marwick S, Marshall T, *et al.* Multimorbidity and emergency department visits by a homeless population: a database study in specialist general practice *Br J Gen Pract* 2019; DOI: https://doi.org/10.3399/bjgp19X704609.

18. NHS England. *Patient registration. Standard operating principles for primary medical care (general practice)*. 2015. https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2018/01/patient-registrations.pdf (accessed 17 Jun 2019).

19. Rae BE, Rees S. The perceptions of homeless people regarding their healthcare needs and experiences of receiving health care. *J Adv Nurs* 2015; **71(9):** 2096–2107.

20. Lester H, Bradley CP. Barriers to primary healthcare for the homeless: the general practitioner's perspective. *Eur J Gen Pract* 2001; **7(1):** 6–12.

21. Elissen AM, Van Raak AJ, Derckx EW, Vrijhoef HJ. Improving homeless persons' utilisation of primary care: lessons to be learned from an outreach programme in the Netherlands. *Int J Soc Welfare* 2013; **22(1):** 80–89.

22. Schanzer B, Dominguez B, Shrout PE, Caton CL. Homelessness, health status, and health care use. *Am J Pub Health* 2007; **97(3):** 464–469.

23. Mills ED, Burton CD, Matheson C. Engaging the citizenship of the homeless — a qualitative study of specialist primary care providers. *Fam Pract* 2015; **32(4):** 462–467.

24. Healthy London Partnership. 'My right to access healthcare' cards. 2019. https://www.healthylondon.org/our-work/homeless-health/healthcare-cards/ (accessed 17 Jun 2019).

25. GOV.UK. Homelessness Reduction Act 2017. http://www.legislation.gov.uk/ukpga/2017/13/contents/enacted (accessed 21 Jun 2019).

26. Paudyal V, Saunders K. Homeless reduction act in England: impact on health services. *Lancet* 2018; **392(10143):** 195–197.

27. Knaak S, Patten S. A grounded theory model for reducing stigma in health professionals in Canada. *Acta Psych Scan* 2016; **134(Suppl 446):** 53–62.