The Journal of
The Royal College of General Practitioners
The British Journal of General Practice

Editor
E. G. Buckley, FRCPE, FRCGP
Livingston

Assistant Editors
A. R. Bichard, DPhil
J. M. Bumstead, BSc

Honorary News Editor
E. E. J. Martin, FRCGP
Bedford

News Editor
J. E. Fricker, BA

Editorial Board
R. C. Froggatt, FRCGP
Cheltenham

D. R. Hannay, MD, PhD, MRCGP, FFCM
Sheffield

M. D. Jewell, MRCGP
Bristol

R. H. Jones, MRCP, MRCGP
Southampton

J. S. McCormick, FRCPI, FRCGP, FFCM
Dublin

D. J. Pereira Gray, OBE, MA, FRCGP
Exeter

N. C. Stott, FRCPE, MRCGP
Cardiff

C. Waine, FRCGP
Bishop Auckland

Statistical Adviser
I. T. Russell, PhD, FSS
Aberdeen

Published by The Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.
Editorial Office: 8 Queen Street, Edinburgh EH2 1JE.
Printed in Great Britain by Thomas Hill Print (1985) Ltd., Bishop Auckland, Co. Durham DL14 6JQ.

The health needs of homeless families

HOMELESSNESS is increasing, partly because of the decline in privately rented accommodation resulting from legislation which has made renting property less attractive to landlords. In addition, the reduction in public expenditure on housing, the closure of large hospitals for the mentally ill and handicapped and the increase in the number of single parent families[1] have increased the demand for the dwindling supply of rented accommodation. In 1986, Shelter estimated that 100 000 families in Britain were homeless, double the 1979 figure. In London many of the boroughs have dealt with this increase by placing families in temporary bed and breakfast accommodation and the numbers of homeless families in bed and breakfast accommodation in Greater London has increased steadily from 1270 in June 1979 to 4382 in June 1986 and 7792 in June 1987 (Shelter figures). This is not a cheap or humane policy; £63 million was spent in 1986/7 in Greater London; £17.3 million in Tower Hamlets alone. The cost to the public sector of bed and breakfast accommodation for a couple with two children was £13 074 per year in 1985 whereas the cost of new council accommodation would have been £7601 per year.[2]

Access to a general practitioner can be difficult for homeless families if they are placed in temporary accommodation far from their original doctor. The family may register with a general practitioner as temporary residents, but this is unsatisfactory because their medical records are not available. It would clearly be an advantage in areas with large numbers of homeless families to identify local general practitioners with a particular interest in these families. In some areas a salaried general practitioner has been appointed[3] but this should not normally be necessary.

The government's junior health minister has asked family practitioner committees to pay special attention to patients who have difficulty in obtaining general medical services.[4] General practitioners should impress upon patients moving from their area the importance of registering with a new doctor promptly, using their current medical card (FP4). General practitioners should also instruct their receptionists to ask for patient's medical cards when they register. If the patient does not have a medical card, the receptionist should complete form FP1, obtaining as much identification detail from the patient as possible and in particular the patient's National Health Service number.

Many homeless families are from ethnic minorities and some speak little English Interpreters with a knowledge of health problems are needed to facilitate communication between health workers and families and each family practitioner committee should ensure that suitable interpreters are available. Representatives of the family practitioner committee, health authority and local authority can use the joint care planning team and joint consultative committee to discuss the particular problems of homeless families from ethnic minorities.

Environmental health problems and overcrowding are common among homeless families. Young children need room to crawl and play and many homeless children are understimulated and undermotivated.[5] Children should not be placed in bed and breakfast accommodation unless there is space for them to play and day nurseries should be available for preschool children. Accidents are common among young children living in bed and breakfast accommodation.[6] Up to 12 families sometimes share one kitchen with the consequent risk of infection and the danger of scalding

© *Journal of the Royal College of General Practitioners,* 1987, **37**, 433-436.

when boiling water is carried to the rooms.[7] It is hardly surprising that children living in such conditions frequently require hospital admission. Difficulties can also arise when teenage children have to share a bedroom with siblings of the opposite sex or with their parents.

In some instances families are not allowed to remain in their accommodation during the day and they may be forced to walk the streets. All bed and breakfast accommodation for homeless families should be available to the family all day.

The health visitor and social worker must be able to interview the families in their own accommodation and not be restricted to the main reception areas. Environmental health officers have statutory powers of entry and should always be called in when reasonable access has been refused. Where liaison between the health visitor and environmental health officer is unsatisfactory, the medical officer for environmental health should be asked to help. Further problems can arise if the housing department gives the health visitor the name of the husband only with no indication of family composition while the family is registered in the wife's name.[8] Some landlords will then refuse access to health visitors. Housing departments must notify health visitors of the names of both parents, if known.

It is the children of homeless families that are particularly at risk; they have low levels of immunization and irregular developmental checks.[9] The families need education in life skills, child care, family planning and other aspects of health promotion in an environment which is supportive and unhurried. There are two solutions. A local general practitioner could take responsibility for homeless children and run a child health clinic or such a clinic could be run by the district health authority. In either case the health visitor should be present at the clinic sessions. District health authorities and family practitioner committees must ensure that appropriate provision is made for these families.

A.M.B. Golding
Senior Consultant in Community Medicine, Camberwell Health Authority

References

1. Greater London Council. *Temporary accommodation: counting the cost. GLC housing research and policy report no. 4.* London: GLC, 1986.
2. Greve J. *Investigation into homelessness — interim report.* London: GLC, 1985.
3. Pay GPs more for their work with homeless. *Pulse* 1987; **47:** 19.
4. *Hansard* No. 1508, pp. 23-27, 25 February 1987, Columns 319-320.
5. Thompson J. Homelessness: a priority for political action. *Health Visitor* 1986; **59:** 325.
6. Drennan V, Stearn J. Health visitors and homeless families. *Health Visitor* 1986; **59:** 340.
7. Stearn J. An expensive way of making children ill. *Roof* 1986; September/October: 11.
8. Lovell B. Health visiting homeless families. *Health Visitor* 1986; **59:** 334.
9. Boyer J. Homelessness from a health visitor's viewpoint. *Health Visitor* 1986; **59:** 332-333.

Future trends in general practice computing

A SURVEY carried out at the end of 1986 by the NHS Information Technology Branch[1] gives the latest figures on 'computerized' general practices. This unfortunate term refers of course to the computerization of certain administrative tasks in the practice. The 514 replies to the survey provide interesting information about the present use of computers and future plans for this sample of practices. Ninety per cent used their computer for repeat prescribing but only 73% reported its use for patient registration, 72% for cervical cytology auditing, 61% for immunization recall and 52% for morbidity recording. The features which practices most desired to be developed further for computing were: practice accounts, use during consultations, standard problem classifications, a standard drug dictionary, word processing, morbidity recording and user definable search reports. 'Wider' developments which the practices would like to see included electronic mail and data links to hospitals and family practitioner committees and computer readable medical cards.

Experience in the first 10 years of microcomputing in general practice suggests that within the next decade most practices will be using computers for administrative tasks. We will see the widespread use of computers for practice accounts and wages and for preparing practice documents and reports. Most practices will be using remote data bases to receive up-to-date information on drugs, waiting lists, recommendations and regulations, helping organizations, standard procedures, diagnostic information and so on. Electronic mailing can be expected to replace telephone conversations and paper as the principal method of communication on administrative matters between surgeries, hospitals, family practitioner committees and district health authorities. Such communication requires only the necessary equipment. More difficult will be to agree on the format of common sets of data, such as a standard way of identifying patients so that information can pass directly between data bases without further keyboard entering.

It is likely, however, that in the next decade electronic records will remain supplementary to the manual records which will continue to be the complete patient documentation ('the computer assisted record'). Although many more computer terminals will be sited in the consulting room their use will be restricted until general practitioners become skilled at incorporating computer use into their normal consultation style.

General practitioners have shown interest in a large range of computer applications[2] and not only in the administrative area. It has long been shown that repeat prescribing[3] can be more easily monitored with a computer but even this application may be superseded by pharmacists dispensing repeat prescriptions directly from Smart card technology.[4] In their clinical work, doctors have already shown how computers can facilitate many aspects of anticipatory care[5] and this may be the main thrust of general practice computing in the future. Computers will increasingly be used to obtain information from patients before the consultation or to provide health education. However, computer supported decision making in the diagnosis and management of acute problems[6] is a more problematic area. It holds out the possibility of reducing medical error and the value of such expert systems has been proved in limited areas such as patients presenting with abdominal pain at a hospital.[7] However, in the domain of general practice, it is more difficult to see how artificial intelligence can help in eliciting symptoms and signs and assessing priorities in management. In this century we can expect only limited applications in well defined areas, with the computer helping prevent mistakes, for example, by alerting doctors to possible adverse drug interactions in their prescribing.