healthwatch
Nottingham & Nottinghamshire

Homelessness and Barriers to Primary Healthcare

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'They need to listen to me, they don't understand me.'

Comment from respondent

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Who are Healthwatch Nottingham & Nottinghamshire?

Healthwatch Nottingham & Nottinghamshire is an independent organisation that helps people get the best from local health and social care services. We want to hear about your experiences, whether they are good or bad.

We use this information to bring about changes in how services are designed and delivered, to make them better for everyone.

Why is it important?

You are the expert on the services you use, so you know what is done well and what could be improved.

Your comments allow us to create an overall picture of the quality of local services. We then work with the people who design and deliver health and social care services to help improve them.

How do I get involved?

We want to hear your comments about services such as GPs, home care, hospitals, children and young people's services, pharmacies and care homes.

You can have your say by:

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Executive summary

Over the last decade, homelessness has increased both nationally and in Nottingham and Nottinghamshire. People who experience homelessness often have worse health outcomes. Existing research suggests that people who are homeless experience barriers to accessing healthcare at three different but related levels (Campbell et al., 2015).

Individual-level barriers can include things like mental health (e.g. anxiety and/or depression), emotional barriers (e.g. fear or embarrassment) and different day-to-day priorities. Provider-level barriers can include difficulties registering, negative attitudes of staff (e.g. lack of empathy or understanding), time to address mental health concerns, and geographical barriers (e.g. proximity to other services and transport). System-level barriers can include the how healthcare services are or aren't integrated with other support services, and financial factors.

In line with wider research, existing intelligence by Healthwatch Nottingham and Nottinghamshire suggests that people who are homeless have had negative experiences related to their circumstances. The aim of this report is to build on existing intelligence at Healthwatch Nottingham and Nottinghamshire and in the wider literature about access to and experiences of primary care services (GPs and dentists). We had responses from 29 service users and 1 service provider across the county in Nottingham City, Bassetlaw and Mansfield.

Our results showed that 100% (n=29) of the people said they were registered with a GP. Some people had difficulties registering but these were overcome with support. The registration rate with respect to dentists was much lower at 44% (n=11), but it is not necessary to register to receive treatment at NHS dentists. Whilst all the people who responded had seen a doctor in the last year, seven people had not seen a dentist in the last two years.

We found similar barriers to accessing healthcare at doctors and dentists. The most common barrier to seeing a GP was anxiety and/or depression (62.1%, n=18) followed by feeling judged or stereotyped by healthcare practitioners, and fear of diagnosis (27.6%, n=8). These were also the three most common responses with respect to the dentist.

With regard to experiences, the responses were both positive and negative. Some experiences may be unique to homeless people or more likely to affect them. This is reflected in the 28% (n=8) and 17% (n=4) of the people who responded who highlighted feeling judged or stereotyped by healthcare practitioners as a barrier in accessing their doctor or dentist, respectively. Several people told us that they did not feel listened to, and only about two-thirds agreed that they feel listened to at the GP. Further, of particular importance is that only 32% (n=9) agreed that they have enough time to discuss their health with their doctor, particularly mental health.

In summary, this report highlights the positive results that all the homeless people who responded were registered with a GP and had accessed their GP in the last year. However, it also draws attention to the lower rate of homeless people accessing their dentist. We found a mixture of positive and negative experiences, some of which may affect homeless people more than those who are not. In particular, we note that approximately one-third of the homeless people who responded felt judged or stereotyped by the healthcare practitioner and that more than half did not agree that they had time to discuss their health concerns, particularly mental health.

Introduction

Purpose

People who are homeless often face additional challenges in accessing healthcare. Much has been written on this topic; however, it has not yet been explored in depth in Nottingham and Nottinghamshire (HWNN). In order to address this, through this project HWNN sought the knowledge and perspectives of the homeless population regarding their access to, and experiences of, primary healthcare settings, specifically at GP and dental surgeries. In doing so, we aimed to identify any challenges and propose solutions and recommendations to influence the planning and delivery of local healthcare services.

Before we contacted homeless people, we reviewed the context and existing research on homelessness and healthcare. You can read a brief summary of this below—a longer and more detailed version can be found in the Appendix at the end of this document.

The context

Homelessness has worsened locally and nationally since 2010 (Fitzpatrick et al., 2018). People can become homeless for a number of reasons and—like rates of homelessness—these vary from place to place (MHCLG, 2019). Nottingham City Council (2017) reviewed the evidence for the causes of homelessness and concluded that 'local people might be at a heightened risk of homelessness than elsewhere nationally'. The number of rough sleepers per 1000 households in Nottingham is 2.6 compared to the national average of 2 (Nottingham City Council, 2019). [1] In Nottinghamshire, the picture is slightly different. The average number of rough sleepers per 1000 households across the county is 1.4, which is less than the national average. But there is variation between areas within the county, as shown in Table 1 below. The number of rough sleepers in Nottingham and Nottinghamshire from 2010 to 2018 (the most recent data) is shown in Figure 1 below. Despite a decrease of 21% between 2017 and 2018, the number of rough sleepers is over 10 times greater than it was in 2010. Whilst the increase is less dramatic for Nottinghamshire, it has still more than doubled.

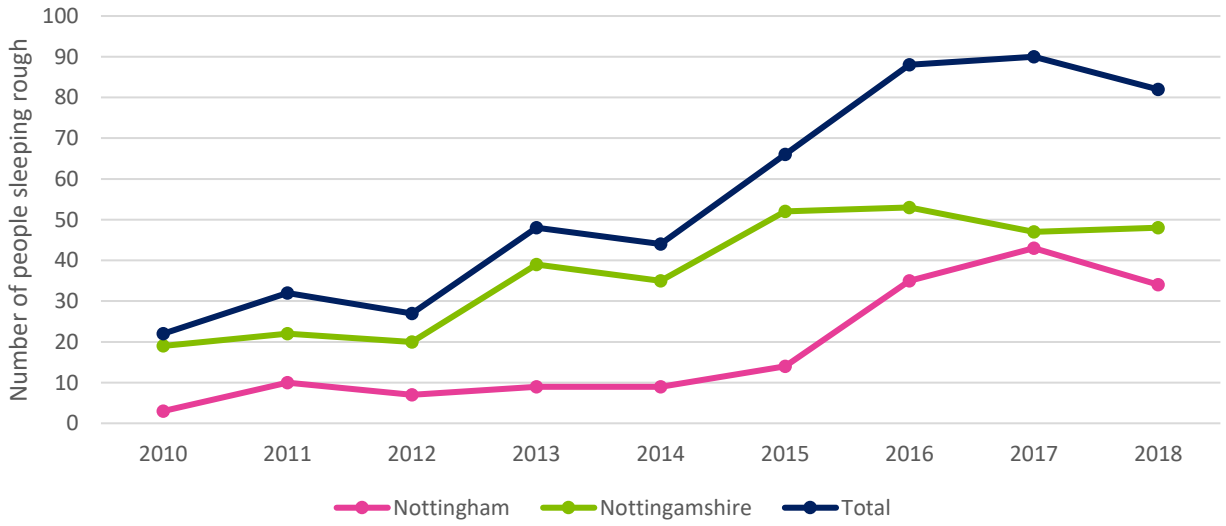
[1] In comparison with other 'core' cities, Nottingham has a lower rate of rough sleepers than Bristol and Manchester, but a higher rate than Birmingham, Leeds, Liverpool, Newcastle and Sheffield. It might also be noted that these figures are from before the full roll-out of Universal Credit in Nottingham, which was predicted to increase risk of homelessness.

Table 1. Rooflessness in Nottingham and Nottinghamshire.

Local Council	Number of rough sleepers per 1000 households (2018)
Nottingham City	2.6
Ashfield	0.9
Bassetlaw	3.2
Broxtowe	0.6
Gedling	0
Mansfield	3.6
Newark and Sherwood	1
Rushcliffe	0.4

(Nottingham City Council, 2019) *Local statistics and headlines from the annual MHCLG rough sleeper estimates, Autumn 2018.* [Available at: https://www.nottinghaminsight.org.uk/d/aKr681H]. Nottingham: Nottingham City Council.

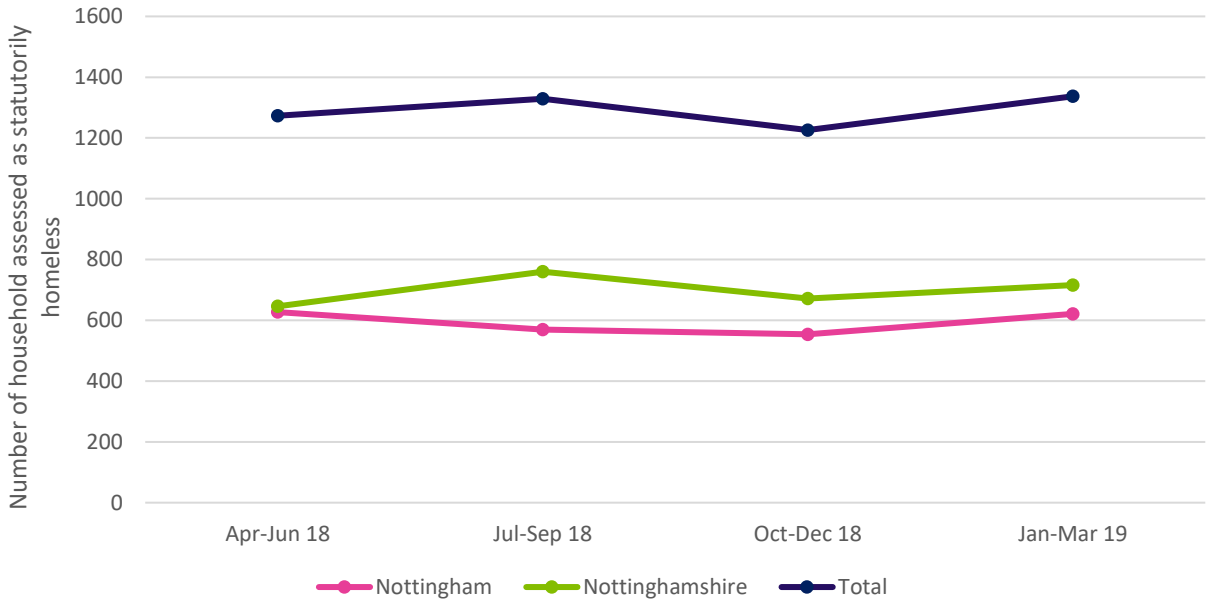
Figure 1. Rooflessness in Nottingham and Nottinghamshire.[2]



Rough sleeping is only one form of homelessness (FEANTSA, 2017). The figures for statutory homelessness in Nottingham and Nottinghamshire are illustrated in Figure 2 below (MHCLG, 2018). This refers to people who have been assessed by the local authority as meeting the legal definition of homelessness: that is, they don't have somewhere to live or are not 'reasonably able to stay' (Crisis, 2020). The trend below shows that over the last year, the number of statutory homeless people in Nottingham and Nottinghamshire has remained fairly constant, but there is a lack of trend data to show this over a longer time period. The proportion of the population who fall into this category is lower than the national average (PHE, 2018).

[2] *Note: Authors' own calculations for Nottinghamshire comprise sum of Ashfield District Council, Bassetlaw District Council, Broxtowe District Council, Gedling Borough Council, Mansfield District Council, Newark and Sherwood District Council and Rushcliffe Borough Council.*

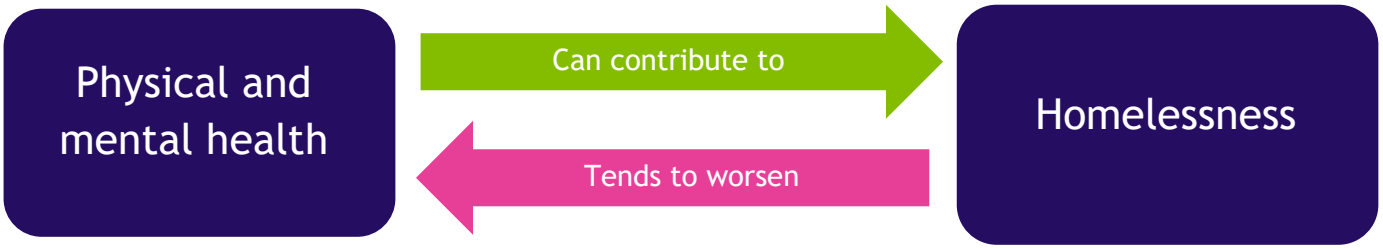
Figure 2. Statutory homelessness in Nottingham and Nottinghamshire.[3]



Homelessness and healthcare

Evidence suggests that the relationship between homelessness and health goes two ways (see Figure 3). In other words, physical and mental health can be one of a range of factors which can lead to homelessness; whilst homelessness tends to lead to worsening health. This is the case for all different types of homelessness mentioned above, but the effects are greater for rough sleepers (Elwell-Sutton, 2016).

Figure 3. Two-way relationship between homelessness and health.



Our focus in this report is on primary care, which includes GPs and dentists, also known as the 'front door' of the NHS. The literature is summarised in Table 2 below according to a holistic approach. This means approaching the complex issues at the level of patients, providers, and the system (Campbell et al., 2015).

[3] *Note: see Footnote 7.*

Table 2. Summary of the literature review.

	Barriers
Individual	Mental health: anxiety, depression Emotional barriers: fear, embarrassment Priorities and lifestyle
Provider	Registration: requiring identification or proof of address Attitudes of staff: stigma, empathy and understanding Time: being able to address mental health concerns Geography: transport and proximity to other services
System	Co-ordination of care: mental health and other support services Financial: affording transport and treatment

It is important to keep in mind that there are interactions between these different levels. For instance, system-level financial barriers which prevent people from accessing dental care, for example at the early stages of the problem, can worsen individual-level barriers of anxiety or embarrassment. We might also consider how the appointments systems at the provider level can be incompatible with the priorities or circumstances at the individual level.

Many of the experiences and barriers highlighted in the preceding literature review echo Healthwatch Nottingham and Nottinghamshire's existing intelligence. For example, we have previously heard from homeless people that they feel they are stereotyped and treated differently by clinicians. For instance, feeling that a stereotypical view of homeless people as being associated with substance misuse can prevent the 'real' underlying mental health problems from being dealt with. Our existing evidence suggests that homeless people's mental health needs are not being met, possibly due to a combination of a lack of awareness and a lack of provision. An empathetic understanding of homeless people's situations and history has been emphasised as important. Previous experiences have also highlighted the importance of a close relationship and rapport with their GP, especially when having conversations which are personally challenging, such as about mental health. In the absence of an established or trusting relationship it can be difficult to speak up, ask questions or challenge the things that homeless patients do not feel are right for them. These are important in encouraging shared decision making, which the literature and our existing evidence found to be limited.

Methodology

Based on the literature review, we developed a survey to find out about homeless people's access to and experiences at the GP and at the dental surgery:

- When people last saw a GP and dentist;
- If people are registered with a GP and dentist;
- If anything might prevent people visiting a GP and dentist;
- How visiting the GP and dentist makes people feel and what their experiences are like;
- And finally, if there is anything that they would like to change.

The questionnaire contained both tick-box and open-ended questions, providing both quantitative and qualitative data for analysis.

First, the questionnaire was piloted at a homeless centre in Nottingham City and it was then arranged to undertake the questionnaire at three homeless centres in Nottingham and Nottinghamshire in the areas with a relatively high proportion of homeless people with respect to the population: Nottingham City, Bassetlaw and Mansfield. In total, we spent three half-days at these centres respectively, and collected responses from a total of 29 service users and one service provider. All of the people were given verbal and written information outlining the research project and consent for interview was sought prior to any interview.

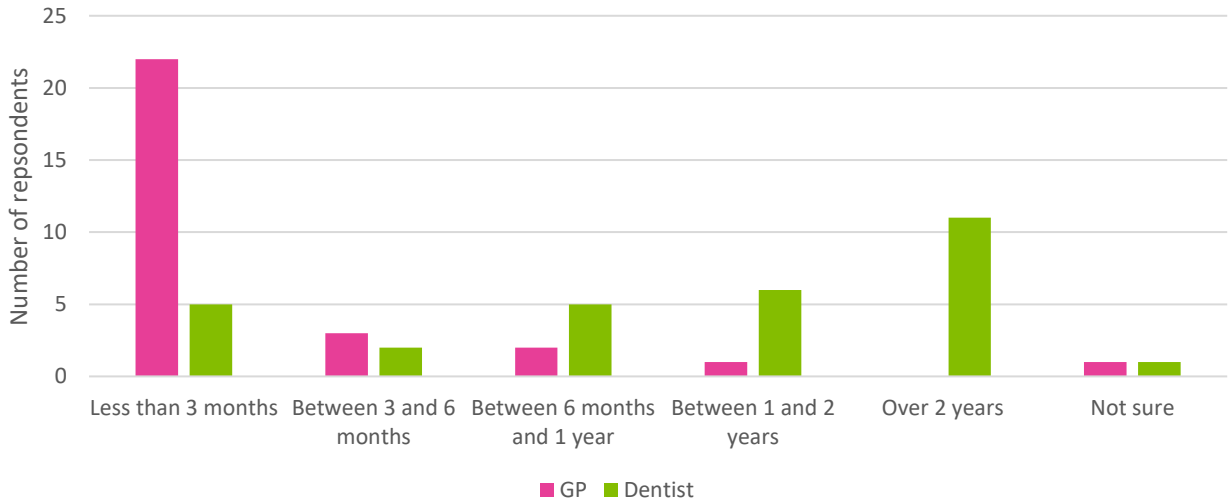
Part 1: Access

Regarding access, the clearest finding from our research was that all the service users who responded at the homeless centres we visited were registered with a GP. That is, the registration rate was 100% (n=29). Many people spoke positively of their experience of registering, describing the process as '*easy*', '*very easy*' and '*no problem*'. However, whilst all managed to register, it was not a process without difficulties for all of the people who responded. The qualitative responses highlighted the importance of having support in place to help those who had difficulties with, for example, filling out forms or speaking English. Seven people said they received help, most commonly from a support worker but also from reception staff at the GP surgeries and from friends. Only one person told us about a negative experience with registration arising from a request for ID from a GP surgery they previously attempted to register with.

In contrast, fewer than half of the people who responded were registered with a dentist, with a registration rate of 44% (n=11). Four people told us that this was because they didn't need to go, suggesting that some homeless people register only when the need to access dental treatment arises; one person said they weren't registered because they were too anxious and another because they had only recently moved to the area. One person told us that they couldn't register with a dentist because they didn't have a passport or an address. It is important to note that you can access and receive treatment at an NHS dentist without registering (NHS, 2019).

The differences in the registration rates were reflected also in the frequency of access. Figure 4 below shows the number of people who had seen their GP and dentist over various time periods. Most (n=22) of the people who responded had seen their GP within the last three months; for only one person had it been longer than a year since they saw their GP. In contrast, many of the people who responded did not undertake the second part of the interview because they had not seen their dentist in the last two years. For those who had seen their dentist in the last two years, the most common response was between one and two years, though four people had seen a dentist in the last three months.

Figure 4. Frequency of responses to the question(s): 'Thinking about in the last two years, when did you last see a GP/dentist?'



The factors that prevented the people who responded from seeing their doctor are presented in Table 3 below. The reasons are ordered according to the percentage of people who told us that this was an issue for them. The most common response was anxiety or depression. This was reiterated as a barrier in the qualitative responses, and one person told us that this can be a problem because it's difficult being around other people when feeling anxious. The second and third most common response was feeling judged or stereotyped by health practitioners, and being unable to make phone call, respectively; again, this came through in the some of the open-ended responses for the experiences discussed below. Nevertheless, putting aside anxiety and depression, for these and all other reasons we put forward as suggestions from the literature review, less than a third identified these as a barrier. We cannot generalise from our small sample, but whilst these barriers affected some homeless people, many more do not experience these barriers. Very few people identified affording transport and prescriptions as a barrier. For transport, this could be due to the proximity of doctors' surgeries to the support centres we visited to conduct this research.

Table 3. Number and percentage of responses to the question: 'Is there anything that prevents you seeing your GP?'

Reason given	Number of people responded	Percentage
Anxiety/depression	18	62.1%
Feeling judged or stereotyped by health practitioners	8	27.6%
Fear of diagnosis	8	27.6%
Embarrassment of health issue	7	24.1%
Unable to make phone call	6	20.7%
Difficulty in keeping appointments once made	6	20.7%
Embarrassment of substance abuse	4	13.8%
No address	3	10.3%
Unable to afford transport	3	10.3%
Cost of hold times on telephone	2	6.9%
Unable to afford prescriptions	1	3.4%
Other	6	20.7%

Some people gave more detail about why they might not visit the GP surgery. Eleven people expanded on issues arising when making appointments. This included difficulties in making phone calls due to long hold times: for some people this can exacerbate anxious or uncomfortable feelings. For two people not having enough phone credit was a barrier. Another person noted that it can be difficult to ring at the required time before 8am and others told us that they need support to make an appointment and this prevented them accessing the doctors. Five people made reference to anxiety and/or depression as a reason again.

The reasons the people who responded did not visit the dentist are shown in Table 5 below. A similar pattern to the responses regarding GPs can be observed in these responses. However, it should be noted that there were fewer responses to this question (n=23). Again, the most common response was anxiety or depression, followed by feeling judged or stereotyped by health practitioners; but the

percentages are lower in each case at 61% (n=11) and 17% (n=3), respectively. For 17% (n=3) of the people who responded, fear of diagnosis, embarrassment about their teeth or oral health, and fear of the dentist were a barrier to accessing care. However, the discussions we had with those who didn't answer this part of the questionnaire because they hadn't accessed dental care in over two years suggested that many more homeless people don't visit the dentist out of fear about diagnosis or treatment. Sometimes, this was due to past experiences: one person told us that *'previous treatment made condition of teeth worse'* and another said that they had *'a poor experience that has made me anxious'*. Indeed, anxiety was mentioned in five of the qualitative responses. For example, 'anxiety about the process and what the dentist may say to me'. Other qualitative responses revealed a general dislike for visiting the dental practise but many different experiences revealed no clear pattern in the data.

Table 5. Number and percentage of responses to the question: 'Is there anything that prevents you seeing your dentist?

Reason given	Number of people responded	Percentage
Anxiety/depression	14	61%
Embarrassment of teeth / oral health	6	26.1%
Fear of diagnosis	5	21.7%
Feeling judged or stereotyped by health practitioners	4	17.4%
Fear of the dentist / being told off by the dentist	3	13%
Unable to afford transport	3	13%
Embarrassment of substance abuse	3	13%
Unable to make phone call	1	4.3%
No address	1	4.3%
Unable to find a dentist that will accept me as a patient	1	4.3%
Unable to afford prescriptions	1	4.3%
Difficulty keeping appointments once made	1	4.3%
Waiting times for an appointment are too long	1	4.3%
Other	4	17.4%

Part 2: Experiences

We asked the people who responded how they feel at different points during their visit to their GP and dentist: in reception, in the waiting room, and in the appointment.

At the GP surgery

Turning first to the experiences in the GP surgery. In reception, nine people responded positively that they feel 'fine' or '*okay*' or that they feel '*alright*'. Others noted the positive experiences they have had with staff, highlighting that they are '*helpful*', '*polite*', '*friendly*' and '*welcoming*'. One person said that the reception staff were '*brilliant*' and another recalled that they sometimes '*make me a cuppa*'. Whilst the responses were mostly positive, a couple of people did however tell us that reception staff can be '*judgemental*' or '*rude*' or make someone feel invisible. In the waiting room, many people told us that they '*fine*', '*okay*', '*very good*' or that it's '*no problem*'. One person told us that they feel judged in the waiting room due to perceptions about stereotypes of people who are homeless and three people told us they feel anxious here. In the appointment, the responses were on the whole positive. Nine people said that they feel '*okay*' or '*alright*' in the appointment and one person said '*very good*'. Other people told us that their doctor was '*sympathetic*' and '*there to help*' and that '*they do not rush you*'. However, others said that their doctor '*undermines*' them, '*picks and chooses what they listen to*' and that they '*struggled*' to get their doctor to listen to them. Others explicitly said that they do not feel their doctor cares about or understands them. One person noted that they '*get embarrassed*' if they have not been able to keep up their personal hygiene routine.

We asked further questions specifically about people's experiences during their appointments. The results are displayed for both doctors and dentists in Table 6 below. Fewer people responded to these questions (n=19). Positively, 71% (n=20) of the people who responded felt that everything was explained clearly by their GP. However, this means 9 people did not. In line with the open-ended responses above, some people told us they did not feel listened to: 43% (n=13) said they did not feel listened to, compared to 57% (n=16) who did. The same proportions hold for responses to the question about feeling cared for. Next, only half (n=14) of the homeless people said they felt listened to and that their situation is understood and only 43% (n=12) said they felt involved in the decisions that affect them. This also came through in the open answer questions: '*Not involved in the decision making, I should be*' and '*They need to listen to me, don't understand me. Don't care about me*'.

Importantly, at 32% (n=9), less than a third of the people felt like they had enough time to discuss their concerns, especially mental health. Indeed, this was the most common recommendation given by the people for making visiting the GP easier or nicer. For example, one person said there is '*not enough time for consultation—feeling rushed*' and another suggested doctors should '*explain everything clearly to me and have more time for appointments so that I can fully understand what is being said*'. Given the prevalence of mental health support needs amongst the homeless population discussed in the above literature review, this is of particular importance. Whilst not highlighted explicitly in these results, a previous Shared Decision Making Project suggests that homeless people are not always taken seriously—or are treated stereotypically—regarding their mental health concerns.

At the dental surgery

Turning now to how people told us they feel at the dentist surgery, four people said they felt '*fine*' or '*okay*' in reception, and three people said they felt '*scared*' or in a '*panic*'. Three people made positive comments about the reception staff: '*lovely*', '*nice*', '*polite*' and '*friendly*'. In the waiting room, more people said that they felt '*anxious*', '*nervous*' or '*scared*' but the same number also said they felt '*okay*' or '*fine*'. In the appointment, several people made positive comments about the dentist, describing them as '*good*' and '*nice*' and that they were welcoming and explained what they would be doing. In these qualitative responses, there were no comments that made specific reference to experiences encountered by people who have been homeless.

The additional questions regarding experiences of appointments are displayed in Table 6 below. Positively, two-thirds (n=12) reported that they feel everything is clearly explained at the dentist and slightly fewer, but still greater than half, 55% (n=10), feel listened to. Similar to the responses to the questions regarding experiences at the GP, half (n=9) of the people we felt their situation is understood

and feel cared about. However, less than half of the people we felt involved in the decisions that affect them and have enough time to discuss their concerns; again this is low in comparison to the other responses.

Table 6. How people who responded feel about aspects of their appointments at the GP and dentist.

During my appointment, I …	GP		Dentist	
	Number	Percentage	Number	Percentage
Feel everything is clearly explained	20	71.4%	12	66.7%
Feel listened to	16	57.1%	10	55.5%
Feel cared about	16	57.1%	9	50%
Feel my situation is understood	14	50%	9	50%
Feel involved in the decisions that affect me	12	42.9%	7	38.9%
Feel I have enough time to discuss my concerns, especially mental health	9	32.1%	8	44.4%

Conclusions

This project aimed to find out what the barriers are to accessing healthcare services for someone who is homeless in Nottingham and Nottinghamshire. We also sought experiences of using healthcare services. We interviewed or received responses from 29 service users who were homeless and one service provider, in three homeless support centres in different areas of Nottingham and Nottinghamshire: Nottingham City, Bassetlaw and Mansfield.

The existing research shows that there are large variations in the number of homeless people registered with GPs across the UK. However, our results showed that 100% (n=29) of the people who responded were registered with a GP. Some people had difficulties registering but these were overcome with support from staff at homeless support centres, reception staff at GP surgeries themselves, and sometimes family or friends. Hence, whilst registration was high, the results point to the importance of support being in place to enable those who require it to be able to register. For the people who responded at homeless support centres, this support was readily available; but for others, this might not be the case. The registration rate with respect to dentists was much lower at 45% (n=9), but it is not necessary to register to receive treatment at NHS dentists. Nevertheless, there were marked differences between the last time the people who responded had seen a doctor and a dentist. Whilst all the people had seen a doctor in the last year, seven people had not seen a dentist in the last two years.

The reasons given as barriers to access to GPs and dentists were broadly similar. For both, the first and second most common responses were anxiety and/or depression and feeling judged or stereotyped by healthcare practitioners. These two factors were also the only ones selected in the one response we received from the service provider professional. However, anxiety and/or depression was by far the most common response. Whilst other factors prevented the people who responded from accessing healthcare, all responses other than anxiety and/or depression were highlighted as an issue for less than a third of the respondents. The additional qualitative responses regarding access reflected the quantitative results. Many people spoke of difficulties when attempting to make appointments to see the GP in this section.

With regard to experiences, the responses were mixed. This reflects our previous report on the general public's experiences at GP surgeries (HWNN, 2019) and hence does not suggest a systematic difference for homeless people. However, some experience may be unique to homeless people or more likely to affect them. As was clear in that previous report, the way people are treated is an important aspect of how they experience healthcare services. People highlighted the positive attributes of health practitioners and reception staff; but others felt that they were not treated well. As noted above, this is reflected in the 28% (n=8) and 17% (n=4) of the people who responded who highlighted feeling judged or stereotyped by healthcare practitioners as a barrier in accessing their doctor or dentist, respectively. Whilst many responses did not explicitly draw on experiences unique to homeless people, the results for this question suggest that this particular aspect may be a problem particularly for homeless people. Several people told us that they did not feel listened to, and only about two-thirds agreed that they feel listened to by the GP. Further, of particular importance, is that only 32% (n=9) agreed that they have enough time to discuss their health with their doctor, particularly mental health. This is an important concern given the needs of the homeless population.

In this research we spoke largely to people who were either rough sleeping or living in temporary accommodation, such as a hostel. It was beyond the scope of this project to seek to speak to people who were experiencing other forms of homelessness—another seldom-heard group. Access and experiences for this particular group of homeless people might be different. For example, our research highlighted that support services were important for the homeless people who responded in terms of accessing healthcare. These same support services might not be available or of the same use to people experiencing other forms of homelessness, as they may not, for example, access support through homeless support centres. Relatedly, an important finding for future survey research was the use of a yes/no response question for identifying homeless people: some people responded that they were not homeless even though, for example, they were currently residing in a homeless support service. It is possible that survey questions attempting to uncover demographics of this kind may not capture many people who would be classified as homeless, as they do not identify themselves as such. Hence, future research should consider including categories and definitions to capture rooflessness, houselessness, insecure housing and inadequate housing (Patient and Client Council, 2015).

Recommendations

- Ensure that support is in place or can be signposted to for people who are homeless to register at the GP and/or dentist. This support may be provided by key workers or receptionists: for example, help with filling out forms.

- Ensure that staff take into consideration that homeless people may feel anxious or depressed when visiting their GP and/or dentist. For example, by providing a supportive and welcoming atmosphere, and waiting times in reception not being too long.

- Ensure that there is sufficient time for homeless patients to discuss their physical and mental health concerns at GP appointments by booking a longer appointment time.

- Ensure that homeless patients are listened to and involved in the decisions that affect them. This again may take more time and hence services should consider booking longer appointments so patients do not feel rushed.

- Ensure that homeless patients are treated by all staff at the practice with the same respect and dignity as other patients. Homeless patients must feel reassured that they are not stigmatised for their status as homeless.

Appendix: Extended literature review

Homelessness in a national and local context

Since 2010 there has been a 169% increase in homelessness in England (Fitzpatrick et al., 2018). However, this headline figure hides variation between the two main types of homelessness recorded in national statistics; there has been a much greater increase in rough sleeping than statutory homelessness (Fitzpatrick et al., 2018). Rough sleeping, or 'rooflessness', is a form of homelessness whereby people are sleeping 'without a shelter' (FEANTSA, 2017). Those who are statutorily homeless are households accepted as requiring 'housing assistance from local authorities on grounds of being currently or imminently without accommodation' (Fitzpatrick et al., 2018).[4] These people might be described as 'houseless' or 'insecure' (FEANTSA, 2017).

People can become homeless for a number of reasons. Any number of factors relating to external factors (such as government policies), 'changing circumstances' or 'personal factors' can be involved, but the main factor is the availability and affordability of housing (Nottingham City Council, 2017).

As well as between different types of homelessness, there is also much variation between different places (see MHCLG, 2019). It is therefore important to look at specific areas in greater detail. Locally, Nottingham City Council (2017) reviewed the evidence for the causes of homelessness and concluded that 'local people might be at a heightened risk of homelessness than elsewhere nationally'. Indeed, the number of rough sleepers per 1000 households in Nottingham is 2.6 compared to the national average of 2 (Nottingham City Council, 2019).[5] In Nottinghamshire, the picture is slightly different. The average number of rough sleepers per 1000 households across the county is 1.4, which is less than the national average. But there is significant variation between areas within the county, as shown in Table 1.

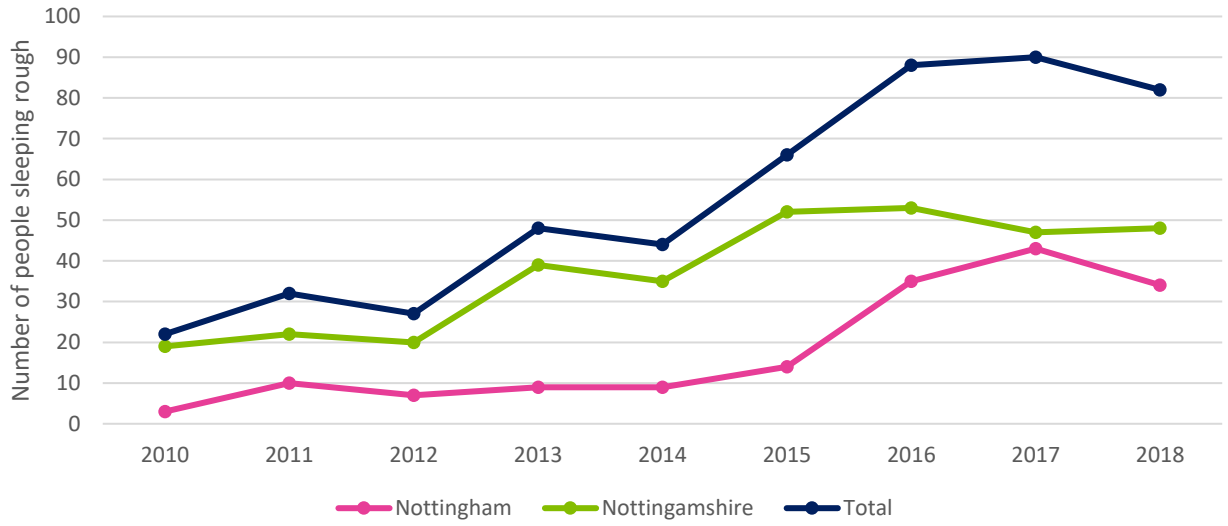
Figure 1 illustrates the number of rough sleepers in Nottingham and Nottinghamshire from 2010 to 2018, the most recent data. Despite a decrease of 21% between 2017 and 2018, the number of rough sleepers is over 10 times greater than it was in 2010. Whilst the increase is less dramatic for Nottinghamshire, it has still more than doubled. As with the previous data, it is important to note that some local areas have much greater numbers than others; in particular, Bassetlaw and Mansfield.

[4] Not all people can be legally registered as statutorily homeless, requiring priority need means '[m]any single homeless people […] are not recognised as statutory homeless and are not referred to in statistics' (Eavis 2018).
[5] In comparison with other 'core' cities, Nottingham has a lower rate of rough sleepers than Bristol and Manchester, but a higher rate than Birmingham, Leeds, Liverpool, Newcastle and Sheffield. It might also be noted that these figures are from before the full roll-out of Universal Credit in Nottingham, which was predicted to increase risk of homelessness.

Table 1. Rooflessness in Nottingham and Nottinghamshire.

Local Council	Number of rough sleepers per 100 households (2018)
Nottingham City	2.6
Ashfield	0.9
Bassetlaw	3.2
Broxtowe	0.6
Gedling	0
Mansfield	3.6
Newark and Sherwood	1
Rushcliffe	0.4

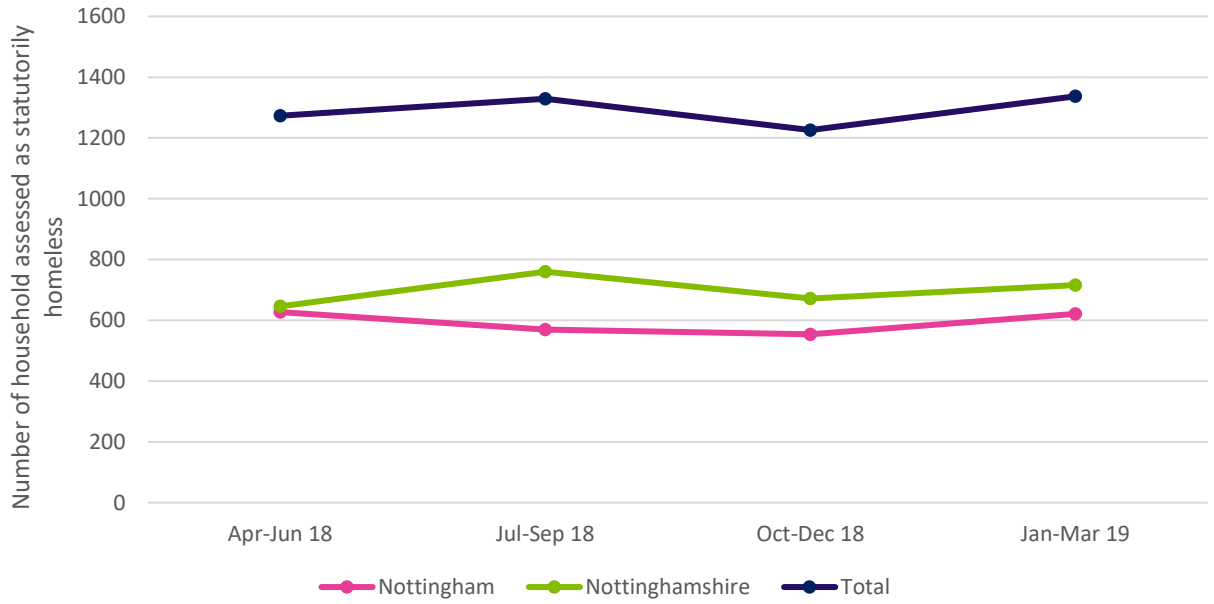
Figure 1. Rooflessness in Nottingham and Nottinghamshire.[6]



As noted above, rough sleeping is only one form of homelessness. The figures for statutory homelessness in Nottingham and Nottinghamshire are illustrated in Figure 2 below (MHCLG, 2018). The trend below shows that over the last year, the number of statutory homeless people in Nottingham and Nottinghamshire has remained fairly constant, but there is a lack of trend data to show this over a longer time period. Whilst the absolute numbers of statutory homelessness are higher in Nottinghamshire, the proportion of the population who fall into this category is lower than the national average (PHE, 2018).

[6] *Note: Authors' own calculations for Nottinghamshire comprise sum of Ashfield District Council, Bassetlaw District Council, Broxtowe District Council, Gedling Borough Council, Mansfield District Council, Newark and Sherwood District Council and Rushcliffe Borough Council.*

Figure 2. Statutory homelessness in Nottingham and Nottinghamshire.[7]

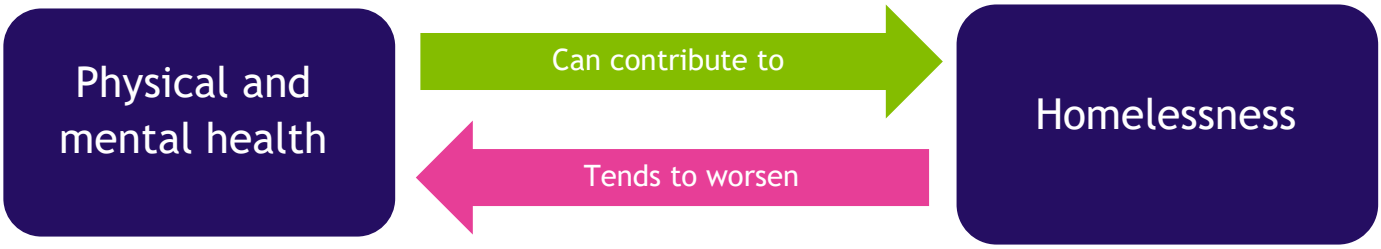


In sum, from a national and local perspective, homelessness has worsened recently. There is variation across the UK but the local situation is similar to the national picture. The increase in the number of rough sleepers is large and 'concern over rough sleeping has reached levels that are unprecedented in recent years' (Fitzpatrick, 2018). Nevertheless, the number of statutorily homeless people has also increased and is much higher. We will now move on to explore how homelessness and health are related.

Homelessness and health

Evidence suggests that the relationship between homelessness and health goes two ways (see Figure 2). In other words, physical and mental health can be one of a range of factors which can lead to homelessness; whilst homelessness tends to lead to worsening health. This is the case for all different types of homelessness mentioned above, but the effects are greater for rough sleepers (Elwell-Sutton, 2016).

Figure 3. Two-way relationship between homelessness and health.



[7] *Note: Authors' own calculations for Nottinghamshire comprise sum of Ashfield District Council, Bassetlaw District Council, Broxtowe District Council, Gedling Borough Council, Mansfield District Council, Newark and Sherwood District Council and Rushcliffe Borough Council.*

Whilst poor health is not a *direct* cause of homelessness, it can create circumstances which put someone at greater risk of homelessness due to 'limited employment and income, unsuitable accommodation, [or] families unable to cope with additional carer responsibilities' (Nottingham City Council, 2017). Indeed, following having dependent children, mental and physical health or disability are the second and third most common priority needs; this indicates that poor health heightens vulnerability to homelessness (MHCLG, 2018a). In light of this, Nottingham City Council's *Nottingham Homelessness Prevention Strategy 2019-2024* seeks to address mental health and wellbeing as a 'priority area of focus' (Nottingham City Council, 2019a).

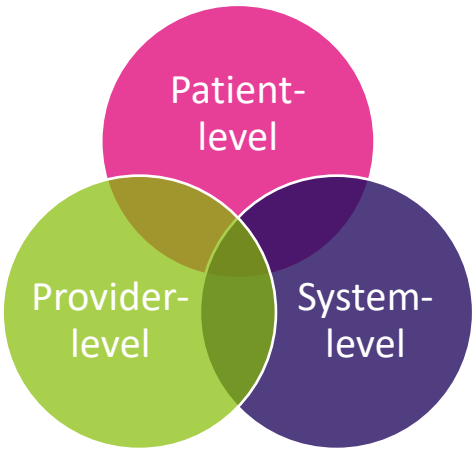
The implications of homelessness for an individual's health are beyond doubt. Homelessness can be thought of as an 'extreme health inequality' (Geddes and Fazel, 2011). Life expectancy has been found to be just 47 years and 43 years for men and women respectively – and early deaths are largely due to treatable conditions (Thomas, 2012; Elwell-Sutton et al., 2016). Meanwhile, a range of physical and mental health problems and suicide are many times more prevalent compared to the general population (QNI, 2018; Homeless Link, 2014). However, it is important not to 'over-medicalise' homelessness; in other words, 'access to healthcare is of secondary importance to access to housing' (Lester and Bradley, 2001). Therefore, the most effective solution is 'the elimination or mitigation of most health problems of the homeless through safe, affordable housing' (Daiski, 2007).

Homelessness and healthcare

Closely related to the health outcomes for people who have experienced homelessness is access to and experience of healthcare. Due to the research methods generally undertaken, as reflected in this report, this tends to focus on rough sleepers or people in alternative types of accommodation rather than people who might be described as 'insecure' or 'houseless'. However, research which has been able to compare different categories of homelessness suggests that barriers are greatest for this group (Elwell-Sutton et al. 2016). Some research has suggested that 60% of rough sleepers had not seen a GP in more than five years (Crane and Warnes, 2001) and almost half would not consider the GP as their first point of call for support (HW Croyden, 2018). In the following review, we will not differentiate between different types of homelessness but a majority of the research has been with people who would be described as 'roofless'.

There is a vast literature exploring the experiences of homeless people in a range of healthcare settings. Our focus in this report is on primary care, also known as the 'front door' of the NHS. This means we will look at secondary care (e.g. hospital) access only in so far as it is related to access to primary care. In this section we will look at the experiences and barriers to healthcare for homeless people. We will explore primary care as a whole but it should be noted at the start that dental care often featured as a greater unmet need throughout the literature (e.g. HW Leeds, 2014; HW Reading 2017). Following Campbell et al. (2015) we will take a holistic approach: this means approaching the complex issues at the level of patients, providers, and the system, whilst keeping in mind that there may be interactions between all three levels (see Figure 4).

Figure 4. A holistic approach to barriers to healthcare.



Patient-level barriers

A number of personal reasons can make visiting the GP or the dentist difficult. Anxiety and depression can play a part in this; but fear of receiving a diagnosis and embarrassment of presenting particular health problems are important too (HW Norfolk, 2013; HW Waltham Forest, 2015). In particular, health concerns relating to substance misuse can be particularly stigmatising and therefore difficult to talk about – and it has been found that negative attitudes towards people who abuse substances are more prevalent amongst primary (rather than secondary) care professionals (Lloyd, 2010). In addition, it has been found that being unable to afford dental care means patients may not present until their problem has progressed (HW West Berkshire, 2018) which may further add to emotional barriers such as embarrassment when accessing dental services (HW Waltham Forest, 2015). Alongside these concerns, self-esteem has been raised as a barrier by surveyed healthcare professionals (Patient and Client Council, 2015).

Due to their circumstances, homeless people can sometimes have different priorities with regards to their health (Rae and Rees, 2015). More specifically, 'day-to-day basic needs are often a priority ahead of the larger underlying mental and physical issues' (HW West Berkshire, 2018). Further, priorities can be different for people experiencing rooflessness compared to houselessness (Power et al., 1999). This means homeless people do not always access services until health conditions have worsened. Relatedly, it has been argued that healthcare professionals and agencies are often equipped to address acute or 'crisis' issues rather than dealing with longer-term problems (Power et al., 1999). Moreover, 'chaotic lifestyles' can contribute to difficulties in making, keeping or attending appointments (HW Norfolk, 2013; HW West Berkshire, 2018; Elwell-Sutton, 2016).

Provider-level barriers

Registration processes have been consistently raised as a 'significant barrier' to healthcare for homeless people (Eavis, 2018). Whilst it is legal to be asked for proof of identity and/or address when registering with a GP, it is against NHS guidelines to refuse to register someone who cannot provide these (NHS, n.d.). Nevertheless, the largest survey to date shows that registration rates are lower for people who are homeless than the general population, especially for rough sleepers (Elwell-Sutton et al., 2016).

However, local context appears to matter: registration rates between surveys and geographical areas vary significantly (Lester and Bradley, 2001). Several Healthwatch reports highlight registration as a barrier to access for homeless people.[8] These reports highlight that homeless people may have been refused registration due to not having documentation or the process may have been made more difficult as a result. A number of Healthwatch bodies have now launched campaigns, workshops and cards detailing the right to register (e.g. HW Warwickshire, n.d.). It has also been found that having to register in a different area – due to patient lists being full – is a barrier for some homeless people (HW Northamptonshire, 2017). On the other hand, research by Healthwatch has found that registration does not feature as an important barrier in some places (HW Reading, 2017; HW Northamptonshire, 2017; HW Norfolk, 2013). Nevertheless, even where homeless patients are able to register with their GP, a large body of research suggests that there are further barriers to access.

A barrier consistently found in the literature can be the way homeless people are treated by healthcare professionals and other staff. Indeed, we have previously found that homeless people feel differently treated: 'I think it's because I'm homeless that they don't care' (HWNN, 2019). Similar findings have emerged elsewhere detailing stigmatising attitudes of staff (HW Norfolk, 2013; HW Leeds, 2014; HW Waltham Forest, 2015; HW Reading, 2017; Hewett et al., 2012). Homeless people have emphasised the importance of non-judgemental and empathetic attitudes contributing to a good relationship with GPs (HW Essex, 2017). Notably, Lester and Bradley's (2001) research found that GPs themselves raised this as a 'major' issue, highlighting 'their training, perceptions of homeless people, and consultation

[8] See HW Essex (2017), HW East Riding of Yorkshire (2018), HW Leeds (2014), HW Leeds (n.d.), HW Waltham Forest (2015), HW Hounslow (2018), HW West Berkshire (2018), HW Croydon (2018), HW Croydon (2018a), HW Blackburn and Darwen (2019).

style' (see also Riley et al., 2003; QNI, 2018). It has also been found that waiting rooms can feel like stigmatising and 'uncomfortable' places for homeless people (HW West Berkshire, 2018; see also Riley et al., 2003).

Similarly, it has also been found that homeless people feel their healthcare practitioners do not understand their situation, listen to them fully or allow sufficient input from homeless people themselves regarding their care (HW Northamptonshire, 2017; HW West Berkshire, 2018; HW Croydon, 2018).

Geographical considerations are important to consider. This can be because of the cost of transport to get to primary care services, which can result in missed appointments and long, time-consuming journeys on foot (HW Waltham Forest, 2015). It can also be in terms of proximity to other frequently accessed services such as homeless centres (Patient and Client Council, 2015).

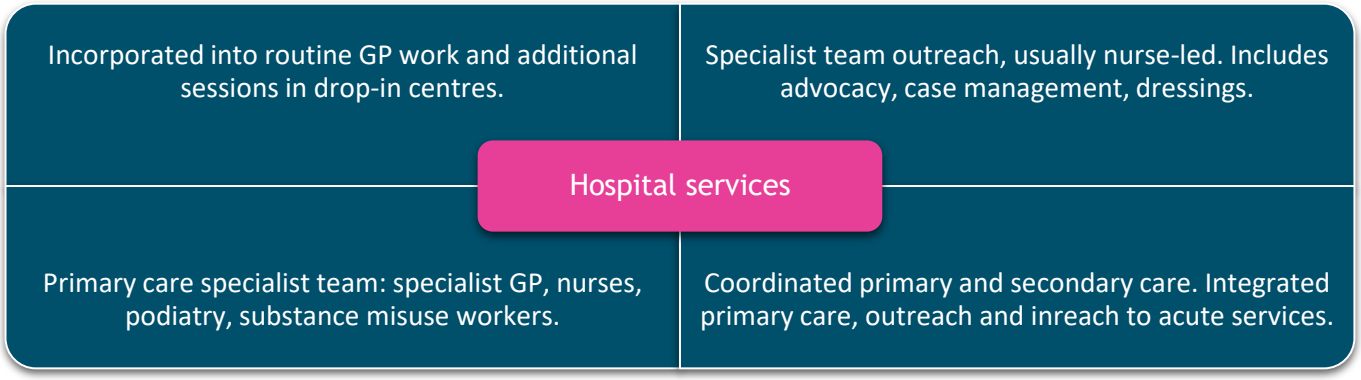
As previously mentioned, the appointments system has also been raised as a potential barrier. From their research with health professionals, the Patient and Client Council (2015) found that 'appointments issued weeks in advance' and 'strict attendance and compliance rules' can be barriers 'for the very vulnerable homeless who have urgent needs but chaotic lifestyles'.

System-level barriers

These barriers relate to issues such as the types of services available and how different services are co-ordinated, as well as wider constraints on services in terms of funding. Because most people's income depends upon employment, which is affected by the access to and the changing structure of the labour market, we also consider here the implications of financial situations on access to healthcare.

There are a range of different services and 'pathways' provided across England, rather than a single approach (Medcalf and Russell, 2014). Where specialist services are available, homeless people – and potentially other people who could signpost to them – do not always know they exist (HW Blackburn and Darwen, 2019). Relatedly, 'not getting the type of help, support or treatment that is wanted or expected, or being offered something which doesn't meet your needs' can contribute to negative experiences (HW Norfolk, 2013). As noted in the policy context, new specialist outreach services have recently been established in Sherwood and Newark alongside the existing Homeless Health Team in Nottingham City.

Figure 5. Models of healthcare for homeless people.



Source: Adapted from Medcalf and Russell (2014).

A particularly important issue due to the prevalence of mental health problems within the homeless population is access to appropriate mental health services. This has been raised as problematic in a number of research projects. HW Essex (2017) found this to be a more significant issue than access to services for physical health; in particular, homeless people said there was not enough time to talk about mental health concerns. Elsewhere, it has been found that 28% of homeless people do not feel they are getting the mental health support they need (HW Croydon, 2018). Research also highlights the need for integrated mental and physical health to provide 'holistic care' for homeless people (Eavis, 2018; Patient and Client Council, 2015). Locally, Nottingham City Council (2017) has highlighted the following as a service gap and/or unmet need:

"There is a significant over representation of people with mental health support needs in homeless support and accommodation services. Homelessness services have become services for people with health and wellbeing support needs who happen to be homeless. There should be appropriate, sufficient and accessible support arrangements in place to prevent people with mental health needs from becoming homelessness or effectively respond to the needs of those who do become homeless."

Alongside issues more specific to the experiences of homeless people, many experiences resonated with the findings of the general public. However, these problems can be made worse given the circumstances of homeless people. For example, a focus group participant of HW Waltham Forest (2015) noted that being turned away and asked to return the following day is much more problematic when walking long distances due to lack of access to private or public transport. Other case studies have highlighted calling on a mobile phone to make appointments can lead to quickly running out of credit when on hold (HW Reading, 2017).

Due to barriers to primary care, some studies have reported that homeless people are more likely to attend and be admitted in A&E (Hewett et al. 2012; Homeless Link 2014; Nottingham City Council, 2017). However, Elwell-Sutton et al. (2016) find evidence of an 'inverse care law'. This means that those most in need of services are getting the least care: they showed that rough sleepers 'who have especially low rates of registration with GPs were least likely to be admitted to hospital for treatment' compared to other presentations of homelessness (see also HW Norfolk, 2013).

Summary

To sum up, a number of barriers to healthcare arise from being homeless. This section has highlighted these through a holistic lens: taking account of the barriers at the individual-, provider- and system-level. The main themes covered in this literature review are summarised below.

Table 3. Summary of the literature review.

	Barriers
Individual	**Mental health:** anxiety, depression **Emotional barriers:** fear, embarrassment Priorities and lifestyle
Provider	**Registration:** requiring identification or proof of address **Attitudes of staff:** stigma, empathy and understanding **Time:** being able to address mental health concerns **Geography:** transport and proximity to other services
System	**Co-ordination of care:** mental health and other support services **Financial:** affording transport and treatment

It is important to stress the interaction between these barriers. For instance, system-level financial barriers which prevent people from accessing dental care for example at the early stages of the problem can worsen individual-level barriers of anxiety or embarrassment. We might also consider how the appointments systems at the provider level can be incompatible with the priorities or circumstances at the individual level.

Many of the experiences and barriers highlighted in the preceding literature review resonate with HWNN's existing intelligence. For example, we have previously heard from homeless people that they feel they are stereotyped and treated differently by clinicians. For instance, feeling that a stereotypical view of homeless people as associated with substance misuse can prevent the 'real' underlying mental health problems from being dealt with. Our existing evidence suggests that homeless people's mental health needs are not being met, possibly due to a combination of a lack of awareness and a lack of provision. An empathetic understanding of homeless people's situations and history has been emphasised as important. Previous experiences have also highlighted the importance of a close relationship and rapport with their GP, especially when having conversations which are personally challenging, such as around mental health. In the absence of an established or trusting relationship it can be difficult to speak up, ask questions or challenge things that homeless patients do not feel are right for them. These are important in encouraging shared decision making, which the literature and our existing evidence found to be limited.

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