More than a statistic

A peer-led consultation with people experiencing homelessness for the London Homeless Health Programme

By Martin Burrows, Rob Edgar and Théa Fitch

Groundswell – October 2016

Groundswell

Groundswell is a registered charity that exists to enable homeless people to take more control of their lives, have a greater influence on services and play a fuller role in our community. Our core beliefs are that effectively tackling homelessness benefits the whole community, and using the knowledge and experience of people affected by these issues is the only way to tackle them. Groundswell's work includes the Homeless Health Peer Advocacy service which supports homeless people to address their health needs and our Insight and Action Programme which takes a radical grassroots approach to uncovering the issues faced by homeless people and crucially, develops achievable solutions.

Contents

Foreword

The London Homeless Health Programme was developed in response to the large and growing issues associated with homelessness and rough sleeping in our city.

The numbers of people sleeping rough in London have been increasing steadily over recent years. Wellbeing and health are seriously compromised when you are affected by homelessness. The average age of death for someone who is sleeping rough is just 47, half that of the general population. Rates of drug and alcohol dependence are very high. Mental health, dental health and foot health are often poor. Respiratory disease is common. Important indicators for health outcomes are significantly worse than for the general population.

Many people who are affected by homelessness are very high users of NHS hospital services. They attend Accident and Emergency departments five times as often as the general population. When they are admitted to hospital, they stay three times as long and when they are ready to leave they are often discharged on to the streets without their underlying issues being addressed.

The voice of people experiencing homelessness is rarely heard in public consultation. The London Homeless Health Programme commissioned Groundswell to undertake a peer-led consultation project. More than a statistic is Groundswell's report of this important work.

We have also published Commissioning Guidance which outlines 10 commitments for improving health outcomes for people who experience homelessness in London. Each commitment includes ideas and practical tips.

The views and experiences set out in More than a statistic have played a significant role in shaping the Commissioning Guidance so that it responds to the lived experience of people who are or have been homeless.

We want to thank the people who so generously told Groundswell their stories and the authors of this report who have summarised these stories very eloquently.

The scale of change we are aiming for needs strong commitment and clear purpose from commissioners. As the governance leads for the London Homeless Health Programme we are very pleased to be able to publish this report so that its insights can be used widely.

Kenny Gibson

Head of Public Health Commissioning

NHS England

Adrian McLachlan

Chair

NHS Lambeth Clinical Commissioning Group

Paula H Swann

Paula Swann

Chief Officer

NHS Croydon Clinical Commissioning Group

Executive summary

Groundswell was commissioned to undertake a peer-led consultation and evaluation project that would enable people with lived experience of homelessness to meaningfully contribute to the London Homeless Health Programme. Groundswell recruited and trained two co-researchers, both with personal experience of homelessness, who were involved in this consultation. Through employing a qualitative methodology, utilising focus groups and one-to-one interviews, 91 Participants from 24 London boroughs were engaged. This report tells the stories and experiences of healthcare from the perspective of people who are currently homeless across London. The findings of the report are presented in chapters relating to different areas of healthcare delivery. Many of the topics highlighted, and stories told, do however have cross cutting themes that can apply to other areas of healthcare.

Primary Care

- **Need for flexibility and easy access.** Rigid systems in Primary Care; strict access regulations, appointment slots and short windows for consultations, were a key barrier to using primary care.
- **Value of specialist homelessness GP Practices.** Specialist GP practices were seen to offer a high quality service that met the needs of people experiencing homelessness. Key to this were flexible appointments, services beyond just physical health, and an acceptance of patients based on an understanding among staff of the needs of homeless people.
- **Competing priorities.** Health needs are often overtaken by immediate survival needs and/or substance dependency. It is not that people experiencing homelessness do not want good health – they may have more pressing needs to address on a daily basis.
- **Meeting people where they are.** Mobile services and health 'in-reach' into homelessness services were seen to meet people where they are and can overcome competing priorities that may prevent people from addressing a health need.
- **Consistency is crucial.** Consistency in staff and service access is a key factor that can mean people experiencing homelessness build trust and experience effective interventions.
- **Migrants face increased barriers.** People who are not originally from the UK face increased personal and structural barriers to making the most of healthcare. A lack of knowledge about how healthcare works in London was also a barrier.
- **Free primary care not enough to meet health needs.** Migrants, for whom access to secondary care was restricted, felt that primary care was not sufficient – as serious conditions could go untreated, resulting in an increased usage of emergency care.

Mental Health

- **Dual diagnosis restricting access.** Access to mental health support is made significantly more difficult by substance dependency. Difficulties and delay in securing funding frequently resulting in people not getting support or relapsing.
- **Mental health support for all.** The high levels of mental ill health among people experiencing homelessness means that participants felt that support should be offered to all, and not just those with a diagnosed mental health issue.
- **Earlier and more effective interventions needed.** For many participants an earlier intervention would have avoided a further decline in mental health, and would have prevented further development of substance misuse issues.
- **Training for staff on homelessness.** There is a need for clinical and non-clinical staff to have training around the causes and consequences of homelessness, as well as training about the available provision of support for people experiencing homelessness. It was felt that this would best be delivered by people with experience of homelessness themselves.

Planned Care

- **Hospitals not felt to be user friendly.** A key barrier identified by participants when using hospitals was the 'intimidating' environment which resulted in missed appointments.
- **Waiting times & communication styles compounding stigma.** While frustrations with waiting times and methods of communication may be common among the general population, they can further compound homeless people's feelings of exclusion.
- **Independent peer support highly valued.** Having well trained, independent support from people with experience of homelessness is an effective way to address health needs and overcome inequalities.
- **Involving patients in decision making is essential.** Participants often felt that their opinions were not valued and they were not in control of their own care.

Emergency & Unplanned Care

- **Reliance on emergency care.** The open access nature and the opportunity to have multiple health needs attended to in an immediate fashion meant that many participants relied on emergency care to address health needs.
- **Respite care welcomed for some groups.** Respite care was welcomed as an option for people who are 'entrenched' in the street homeless population, or who live chaotic lifestyles and cannot sustain accommodation. For the wider homeless population, it was felt that it was only a temporary solution. Long-term, stable accommodation was the only solution to improve people's health.
- **Hospital discharge crucial to breaking the cycle of homelessness.** Negative experiences of hospital discharge processes were all too common. For some participants, however, a decisive intervention at the point of discharge allowed them to change their lives in a positive way.
- **Healthcare as an effective route to accommodation.** Healthcare staff can play an important role in supporting individuals experiencing homelessness to access secure and appropriate accommodation.
- **Data recording and sharing needed.** Data recording and consented sharing with agencies outside the NHS was generally seen as a positive, and likely to result in increased service quality.
- **Recording accommodation status.** Accommodation status recorded on their NHS records was seen as a way to plan appropriate treatment, trigger discharge procedures earlier, and increase accountability.

Public Health

- **Effectively tackling substance misuse.** Participants widely felt that by better tackling substance misuse issues, homelessness, and the health inequalities that relate to it, would be reduced. Delays, and long waiting times to access detox, were the key issues that participants wanted addressed.
- **More smoking cessation options, and better information needed.** Many participants wanted to, and had attempted to, quit smoking. However, it was felt that options for living smoke free were not effective for them. There is a great need for smoking cessation tailored to the needs of homeless people.
- **Lack of readily available information.** Information on health and healthcare was not meeting the needs of participants. Better information, both printed and online, and delivered by healthcare and support staff is necessary. Particular focus on patients' rights to healthcare, access, and the types of service.
- **On-going participation a must.** Continued participation and engagement from people experiencing homelessness with the London Homeless Health Programme was welcomed.

End of Life Care

- **Specialist palliative care to overcome isolation.** The isolation that homeless people can face means that extra support for people in their final days (as well as those around them) is needed.
- **Choice in final decisions.**Participants strongly felt that there was an important need to facilitate choices for people in order to enable them to make their own decisions on how and where they want to die.

Introduction

While the routes into homelessness can be diverse, and people's experiences unique, it has been well demonstrated that one of the results of homelessness is significantly poorer health than the general population, as well as restricted access to support required to address these health needs. Facing significant health inequalities, people experiencing homelessness have a life expectancy 30 years lower than the general population, and as a group are also some of the most expensive patients to treat. While poor health is the key driver in this increased cost, the homeless population has a disproportionately high reliance on unplanned health care services and A&E, a high level of missed outpatient appointments, and individuals rarely seeking early stage or preventative treatment.

Underlying this, substance misuse and mental health issues are all too common among the homeless population, and compound in an interlinking and complex fashion that can spiral without treatment. Poor physical and mental health can also undermine the other interventions employed to stabilise the lives of people experiencing homelessness.

This consultation study, delivered by Groundswell researchers who have personal experience of homelessness themselves, explores the experiences of people who are affected by homelessness in relation to health and in using healthcare. While participants were not recruited on the basis that they had experience of using healthcare, but more broadly that they were experiencing homelessness, health problems and experiences of using healthcare, both positive and negative, were widespread.

It is important to highlight that people experiencing homelessness, by definition, have ended up in their situation because the safety net offered by support services has not worked for them. This often leads to a distrust of the services that are there to support people, and can mean that individuals may be less motivated to engage with them. This is no different for healthcare, where an unsuccessful intervention may result in a crucial health need not being addressed at all. As one participant explains:

> "So I used a service when I was in [Homelessness service], a couple of weeks ago. And there was a doctor and a dietitian coming round. And I had got a bad ankle so I put my name down. And they just got to my appointment and they decided to quit for the day, which was really annoying. Because I had waited for most of the day for it. So they then referred me to somewhere […] But having had the experience, I didn't want to go there and wait for hours to be told I couldn't… so you kind of… just… didn't bother."
>
> **Focus Group Participant**

This report tells the stories and shares the experiences of healthcare of people who are currently homeless across London. While the chapters of this report are organised into different areas of healthcare, many of the topics highlighted and stories told have cross cutting themes that apply to all areas of healthcare.

Methodology

Groundswell designed a peer-led systematic consultation project that would involve people with lived experience of homelessness throughout the project. True peer research and evaluation works when people from a community are engaged as co-researchers during the entirety of the data collection process, rather than simply as passive enquiry subjects. All data collection was undertaken by people who had personal experience of homelessness and had been trained in the enquiry and structured consultation methods. The key advantage of taking this approach is that peer researchers can reduce problematic power relationships that can exist when interviewing people who are experiencing social exclusion. Richer data tends to result. A focus group approach was employed, allowing researchers to explore in depth the experiences and opinions of participants on how healthcare services could be improved.

Two co-researchers were recruited and trained. Training took place over two days and focused on developing a theoretical understanding of research and evaluation processes, as well as practical approaches to interviewing. Learning took place through hands-on activities, which were used as an opportunity for drafting focus group guides, covering the topics identified from the London Homeless Health Programme's commissioning intentions. Piloting and refining the topic guides, use of language, and structure for the focus groups took place in follow-up sessions.

Participants were engaged through homelessness and community based services across London. Focus Groups were arranged through staff in these services, recruitment aided by advertising ahead of the groups. In total, 13 Focus Groups and 2 one-to-one Interviews were held – which engaged 91 participants from 24 London boroughs.

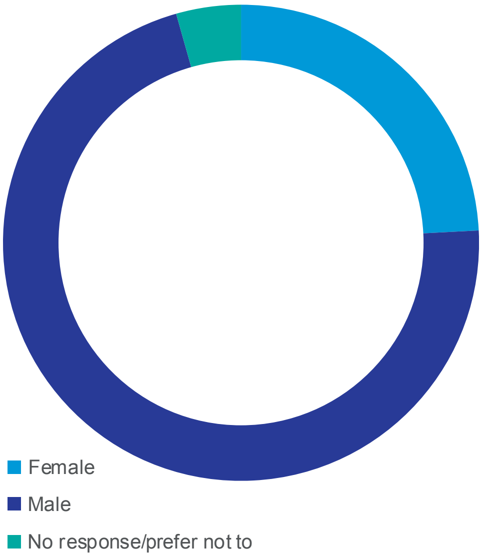
Audio recordings were transcribed, coded and analysed through NVivo[1] data analysis software. Co-researchers fed into the analysis of the data and the report writing on an on-going basis.

Sample

Groundswell designed a sampling framework that looked to engage an equal number of participants from inner and outer London boroughs. Participants recruited were living in a range of different accommodation situations; including rough sleeping, hostels, people who were sofa surfing, and the 'chronically insecurely housed'. We aimed to engage a representative sample of people experiencing homelessness. Due to limited data available on the latter of these groups, however, our comparator for the population are drawn from CHAIN[2] and SNAP[3].

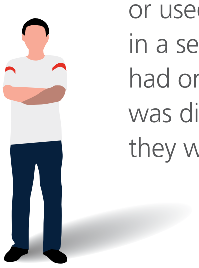
72% of the people who took part in the consultation were recorded as male and 24% female. This is broadly similar to the gender breakdown found in homeless accommodation services, where 70% are male and 30% female[4], as amongst London's street homeless population which is 85% male and 15% female[5].

Gender of Participants



The most common age groups of participants correspond to those found in CHAIN data on rough sleeping in London with the bulk of participants in the 26-36; 36-45 and 46-55 year age brackets, (24, 23% and 23% respectively of participants compared to 28%; 30% and 21% of CHAIN records). However, young people are somewhat under sampled. This is more stark when compared to those using homeless accommodation services; 49% of whom are 16 – 24, and only 12% of whom are over 50. However, these differences are likely to reflect a client group that is significantly different to those who were the principal target of this consultation and evaluation.

Participants predominantly lived or used services in central London boroughs, although a third of participants were from outer London boroughs. 12% of participants did not report which borough they lived in or used services in. Interestingly, this was predominantly in a service we accessed that supported people who had or were applying for refugee status. When this was discussed, participants explained that they felt they were too mobile to give a specific borough.



Outer or Inner London Borough	Count	%
Inner London Borough	48	53%
Outer London Borough	32	35%
No response	11	12%
Grand Total	91	

Compared to the wider homeless population, 71% of rough sleepers in 2015-16 were recorded in inner London boroughs and 29% in outer boroughs.[6] However, accommodation services are much more evenly spread. 53% of participants recorded living or predominantly using services in and inner London boroughs while 35% were in outer boroughs.

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1 NVivo is a qualitative data analysis computer software package produced by QSR International.

2 CHAIN is the Combined Homelessness and Information Network, a multi-agency database recording information about rough sleepers and the wider street population in London. The system, which is commissioned and funded by the Mayor of London and managed by St Mungo's Broadway, represents the UK's most detailed and comprehensive source of information about rough sleeping.

3 Homeless Link's SNAP is an annual review of single homelessness support in England that looks at the capacity, support and services available to people who become homeless in England, as well as funding and changes to provision. It includes demographic information for service users.

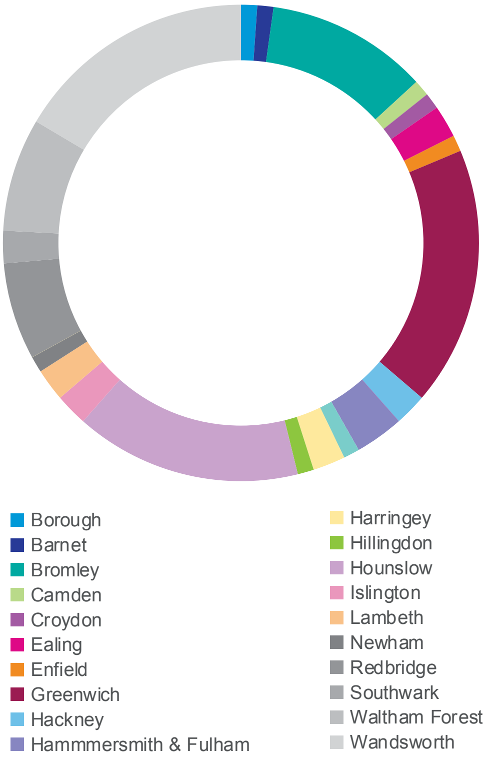
4 Homeless Link Support For Single Homeless People in England Annual Review 2015.

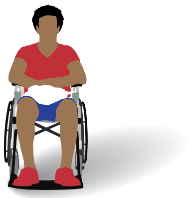
5 CHAIN annual report, Greater London April 2015 – March 2016, GLA 2015.

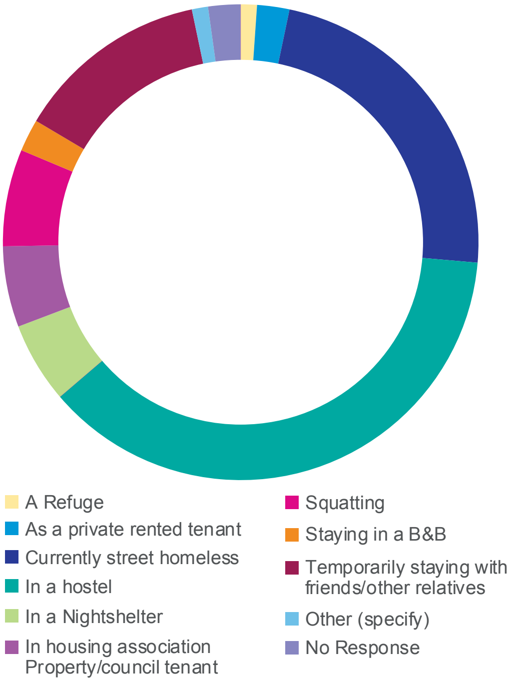
6 CHAIN annual report, Greater London April 2015 – March 2016, GLA 2015.

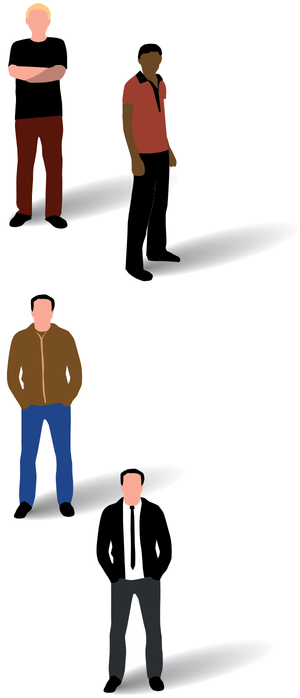
Participants reported living in a range of different types of accommodation, with just over a third living in hostels, 23% currently street homeless, and 13% staying with friends or other relatives.

Further information on participants' demographics is available in the appendix of this report.


Borough where participants live or mainly use support services




Current Accomodation Status of Participants



Primary Care

Primary Care: Case Study

Victor[7] is in his mid-40s and is currently applying for refugee status. He is living in NASS accommodation in an outer London Borough. He has recently moved here after a period rough sleeping. He is unsure of how long it will be before he has to leave this accommodation. Victor uses a specialist homeless GP in central London, which he used while he was rough sleeping, as he can access a variety of services, and he feels he knows and trusts the staff there.

Victor has no income and feeds himself through food vouchers and donations from supermarkets. He also does voluntary work for a charitable organisation at a soup kitchen in order to get additional food. Being a diabetic, there are certain foods he cannot eat, and he reports that his diet is particularly unhealthy. His various health appointments, support meetings, and all the paperwork he needs for his immigration case, are spread across London. He has no funds to pay for public transport so he moves around the city by foot. Despite the vast amount of walking he does each day he is still putting on weight.

Victor has severe issues with his feet that are linked to his diabetes and he has been seeing a podiatrist at his specialist homelessness GP practice in central London. He is a big man, carrying around a heavy bag with all his papers. He finds it difficult to walk and meet the appointments he has to get to. He has been told by a medical professional that this is a factor in his poor foot health. He has also been attending appointments with an eye specialist as his eye-sight is beginning to fail, which is also likely to be linked to his diabetes.

Victor has begun to face a decline in his mental health. He reports that his situation is causing extensive stress and he has expressed suicidal thoughts. Victor explains that while his biggest barrier to accessing healthcare is practical (getting to and from appointments) he is beginning to feel less motivated to seek help.

Access and Flexibility

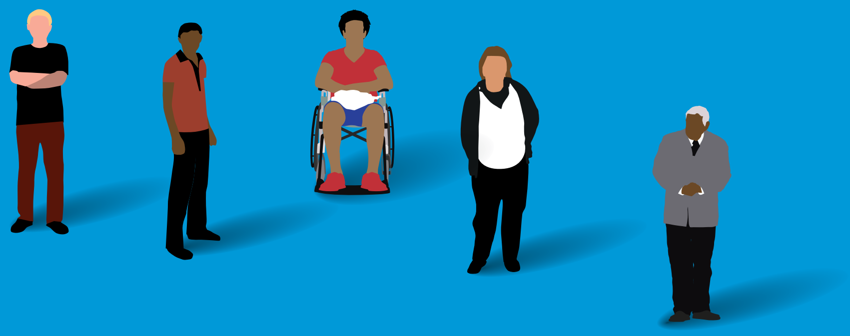
Flexibility in service delivery was a key topic explored throughout the focus groups. Rigid systemic approaches in health services, related to access regulations, appointment slots and short windows for consultations, can act as a barrier for many people experiencing homelessness. The access issues extend beyond GP practices – barriers to making use of other areas of primary care were evident. As one participant explained:

> “When it comes to other issues like the dentist I think you need to make an extra effort for that. And if you don’t have a certificate of NHS then you find it more difficult to access an ophthalmologist or a dentist. In which case I have to use glasses… Even though I was issued the glasses but because of my situation, it got misplaced so I now have to see an ophthalmologist because I can’t live without glasses. I see natural but I am always reading but I am always on internet so I have to have those glasses and those facilities.”

A common example involved the systems employed to make bookings with GPs. As one participant explains:

> “I have to ring at 7 am in the morning. And if you miss that time – it’s only 7 till 8. Maybe no one is going to pick up the phone for the rest of the day, at my GP. So you are only going to be to make a regular appointment. Then you will have to wait a few weeks for an appointment.”
>
> **Focus Group Participant**

Another common issue was GP referrals to specialists, for further tests or prescriptions. Some justified their preference for using hospital A&E departments by explaining that A&E offered access to more diverse treatment. This participant explained his experiences:



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[7] No case study names are real names; they are all pseudonyms.

> “The problem with the GP – I used to have a GP before the issue of my hypertension and things like that many years ago. And at one time, you go to the GP and say you have cold or something like that – oh yes, without getting out of the chair, they write you a prescription. And then I got.. I nearly reported him to the authorities… and when I visit him the next time, he got off his chair, took a blood pressure. I said to him.. you didn’t even check my chest. You just needed to give me.. I mean for two minutes and I was waiting for an hour for you. So some GPs you know they are taking the piss like. That’s in the past like I say. I feel like the hospital when you visit accident and emergency, they really check you. The nurses, they take blood pressure, your pulse. Even blood test they do sometimes if necessary. X-ray if you have got very bad cough, they can send you for x-ray. But like I said GP – my experience with GP at that time I didn’t really want to go to register. Because I thought this GP, What do you want? Ok, I want some tablet… methadone. Ok, starts prescription. And they just give you this kind of medication or something. Without really… proper check which is.. I feel like, some of them probably abuse the system.”

Focus Group Participant

Specialist Homelessness GPs

For those participants who had accessed specialist homelessness GP services there was a general feeling that the service offered by these practices was of high quality and met the needs of people experiencing homelessness. While these conversations were predominantly held in focus groups in central London boroughs, there were also examples of participants who were willing to travel long distances to use these practices. A key factor in this was that many participants who had been of no fixed abode had difficulty signing up with general GPs, and specialist homelessness GPs were more willing to take on patients in these circumstances. For some participants ease of access was most fundamental:

> “You are homeless, you don’t have proof of address, [so] to get a GP you cannot get this done. So when you come to [specialist homeless GP] they must work with you, so they count you as a human. Then you can have a place you can use as an address there as well.”

Focus Group Participant

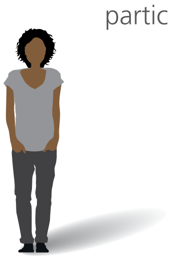
Specialist homelessness services offer people a range of support beyond physical health needs. It was noted that focus group participants particularly valued the drop in appointments offered at specialist homelessness GP services. This more flexible approach enabled participants to get to an appointment when issues were identified, and when motivation to attend appointments was still strong.

Specialist GP services were also seen to offer more time to individuals in consultation and follow-up. While there was a general acceptance that GPs were under pressure, and this led to all patients not being given sufficient one-to-one time, for individuals with existing feeling of being undervalued, this could further embed this sense of self:

> “A GP should be like a friend. You should be able to go to his office and say I have got this problem. And you should be able to verbalise anything that you want to him and have the time to do it. So many GPs are so snowed under that they can only give you a five minute window.”

Focus Group participant.

Furthermore, participants highlighted the expert knowledge specialist homelessness GP services have, and how they enable access to a range of physical and psychological support tailored to the prominent needs of people experiencing homelessness.



"That's why I go to [Specialist Homelessness GP Service] for 20 years because she knows what homeless people need and you know you are going to get sorted. Rather than go to a doctor who just refers you on. Every single person in that building that I am aware of is actually trained around homelessness. And they have experience. And it kind of gels and it works. […] I mean I know a lot of people that go just to talk to some of the staff or whatever."
Focus Group Participant

For other participants specialist GP practices offered an environment of acceptance, due it was felt to the well-informed staff and non-judgmental environment:

"Yeah I think er… because I have used both the homeless GP –which is what I am using now – and a regular GP, I can safely compare that the homeless GPs – like you said – have much more people to deal with it. And most of the time the assumption is that some of these people are street homeless because they have got some addiction. But then they have so many people that don't. And these GPs [at specialist surgery] will usually spend a bit more time… And then they may have that time to actually interview and find out."
Focus Group Participant

Health Outreach & Mobile Services

Often for people experiencing homelessness basic survival needs like food or managing a dependency take priority over addressing health needs. Mobile and outreach services are popular. In addition to addressing immediate needs, such as preventing conditions getting worse or contagious conditions spreading, they effectively signpost individuals to building based NHS services. Participants also spoke of the value of services that come to 'where they are' in particular day-centres, hostels and community centres. Participants reported that if a nurse is present at one of these services on a regular basis, then they are more likely to see them:

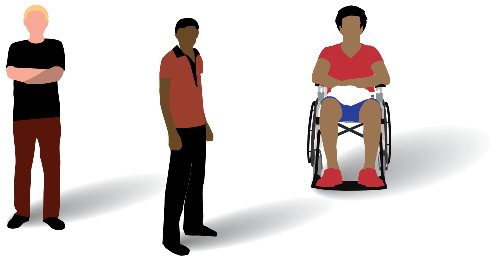
"Well this [community centre] is a place where people – whether you are homeless or you have mental health issues or are suffering from some isolation, any crisis – people can come here and they can have fairly cheap food here, eat…have meals. Can speak to each other and watch some TV. It gives them reason to go out, do something rather than just be stuck at home, not doing anything. So it is quite good here. So when they offer to see a nurse you have a captive audience."
Focus Group Participant

For others there were psychological barriers to accessing support that were overcome by the medical personnel meeting people in the support services they use:

"I am just talking personally – there are some mornings you wake up and you don't feel you want to get out of bed, you don't want to get up and get dressed. You don't want to even face anyone in the hostel, you don't even want to step outside. And by having somebody come in, park up there, it would be great."
Focus Group Participants

Mobile services were universally seen as a key tool in screening and treating people. Many participants reported to have used a mobile tuberculosis (TB) screening unit, and some had used the mobile dental unit. While it was felt that mobile screening was not an answer to improving health, it was felt they were an important aid in supporting people to make the first steps towards positive change, and to signpost people towards using building based NHS services.

"The idea was mentioned earlier about mobile support. A van arrives with this big white van with either your dentist in there or your GP in there or… what other services can we ask for. They come to us as opposed to us going to them"
Focus Group Participant



People experiencing homelessness frequently get stuck in the "revolving door", perpetually falling through the safety net of health and social care, and accessing one specialist service after another. Timely treatment of conditions can support the efficacy of other interventions in stabilising an individual's progress out of homelessness, and into accessing mainstream services. The individual in the following excerpt, after a period in a hostel where he relapsed, was evicted and returned to sleeping rough. Once he was able to return to an assessment centre, he experienced successful treatment and is now in stable accommodation.

> "I ended up at an assessment centre in [London Borough] where they had onsite doctors and nurses. So I didn't see my GP for some time. There was an onsite doctor and nurse, did my bloods and checked on, you know… did all the various checks and stuff. So by the time I had actually moved into a property in St Mungo's, after the assessment centre, that's – I sorted sort of started going back to my doctor again."
>
> **Focus Group Participant**

Consistency in Services

A key topic throughout all focus groups was how participants valued consistency in service delivery. Specifically: staffing and routine visits to homelessness services. The opportunity to see the same GP, who an individual already had a relationship with and with whom they had begun to build trust, made successful engagements more achievable. It also avoided the need for participants to have to 'explain themselves' repeatedly. As these participants put it:

> "It's hard to trust when you have been homeless. Because you are on your own on the street… You have to have them barriers when you are on the street. You are protecting yourself constantly, you know what I mean? Every way."
>
> **Focus Group Participant**

> "I think what is good about it is that you are… your GP, you go with one GP. Although the very first GP now doesn't work there anymore, but people who work there knew him and they know me that I have been with this surgery right from the beginning. And the doctors know you, and some – if your GP is nice, they know you, they know your condition. They know everything about you. There are no doubts and… You know, kind of any suspicions."
>
> **Focus Group Participant**

Consistency was a topic that spanned all NHS services including specialist homelessness services, where despite the benefits offered by having expertise and tailored services to homelessness people it can be undermined by irregular service provision. For example, some participants who had used a specialist homelessness GP found that the high rate of locum staff that worked in the service meant that they did not feel they were receiving a consistent service. One participant explains his experience at a specialist homelessness GP:

> "There is no communication between the person that you go to because you have no constant doctor. You have a locum who reads and it's his perception of what is written on the computer. You have got 12 minutes with somebody that you have never seen before. Over on-going stuff that you have to have continuity with. And that is my be all and end all."
>
> **Focus Group Participant**

Migration & Healthcare

While participants' nationality was not recorded in this study, we can be sure that a large proportion of participants were not originally from the UK – due to the topics discussed and the way that some participants were engaged through specific services for people with no recourse to public funds. Migrants, refugees and asylum seekers are more vulnerable to homelessness than people with long-standing residency in the UK. This is partly due to structural issues like a lack of familiarity with the British social system and not being entitled to benefits and services. It can also be due to personal reasons, such as limited social support networks and difficulties with language. It is clear from the discussions in the focus groups that this brings a further set of difficulties when trying to access and make use of healthcare.

Generally in focus groups non-UK origin participants expressed a lack of knowledge around how and where to access healthcare. Language barriers and a distrust of healthcare were also highlighted as a key barrier:

"But service-wise they are very bad. What they are providing is a language barrier and everything, what they are giving to people. They don't provide good service for them. Even though looking people, they don't care about that. They want the money and everything, they don't care about the people you know? The service provider provisions have to think about that one."

Focus Group Participant

For participants who had refugee status, or who were in the process of applying, there was a mixed response around access to healthcare. For some they were relatively happy about primary care that was free at the point of access and were aware of how to use this system:

"The time I came to this country I was happy with GP and he provided for me. […] And they provided GP. At that time, GP was free, the service free. When I apply for asylum as a refugee, they provide free dentist for treatment and also free eye glasses or check-up eyes. So I am happy with healthcare because I have HC1 or HC2. It is a certification of asylum. So right now I don't have problems."

Focus Group Participant

However, the complex cases that some refugees are currently involved in can make it very difficult to understand how and where to access services, or to make sense of the entitlements that people had. For some this resulted in a fear of using healthcare, as it was believed that this might have a negative impact on their immigration cases. For one participant, some information had been provided but it was either misleading or was not delivered in a way that was clearly understood:

"One of the conversations I had with the Home Office official, he said to me I am not allowed to use the hospital. I said what do you mean, I am not allowed? He said you are not allowed. If you are sick you go to the pharmacy. I said I don't have the money to go to the pharmacy. He said to me you are not allowed to use our NHS, if you are sick you go to the pharmacy and get access there. I don't have the money. I mean I have been living rough for eight weeks and you expect me to have money."

Focus Group Participant

Wider concerns were raised around healthcare moving beyond primary care and including secondary care and mental health support. Here it was felt that it was counter-intuitive to only provide primary and emergency care, as underlying issues would eventually develop into more serious conditions and the ensuing increased usage of emergency care.

"The gentleman that raised the issue of mental health has something that most of us here are dealing with. People do not have papers, they have no status to work, they have no house, no shelter. They cannot access the facilities in this country. They are living on the fringes of society and I have been coming here since December and I have run into so many people that I suspect need help. Nobody is coming here to offer any kind of help. So many people here – sorry – so many people have serious issues, I know that."

Focus Group Participant

Mental Health

Mental Health: Case Study

"I guess my initial contact in this context with the health care system is with my alcohol abuse. And my alcohol abuse turned out to be… well… not a similar story to many other people. I was freelance working from home and I had the time to be able to drink more. But I wasn't coping very well with certain emotional things and I was drinking more and more and more.

I was presenting with my GP primarily. And I get on with my GP surgery really well. But… . Given the nature of the ten minute consultation that you get, there was never enough time to be able to get into the issues. You know, it's always well you are an intelligent guy, why don't you just cut down?

OK, thanks genius. Any more creative ideas? And then you know the only thing that I could do was go to the alcohol services, which were places like [alcohol service] in this borough until April this year. I tried. I didn't like them. I didn't get on with the sort of whole group mentality.

What the doctor couldn't do but would have been good for me to have was more time. And more understanding. That has to be a big issue for me. You know, the GP would always say you've got to go – the only thing I can do is refer you. That is just calling him a gatekeeper. That's all they do, they just open the key. And point you in the right direction. I needed something more than that. I needed a conversation, a proper sitting down and talking to. With an empathic ear.

I wasn't really engaging with the services, my GP wasn't helping. Everything went to the point where eventually I became homeless. And lost the lot. Now, I am angry with my GP surgery because they really had a chance to be able to try and do something about that with different kind of interventions. But they didn't. I don't have the same kind of issues that I think I know you are going to get from other people, like finding it hard to register and stuff – I don't have that. I have different issues.

So with not getting any help I was crying out all over the place. I was calling Samaritans all the time. Obviously it was good to talk but they couldn't help. And I was – I didn't know I had kind of potential mental health issues and stuff. Like all sorts of stuff going on and it was chaotic. So when I do, I drink. And then as soon as I went into an assessment centre…. That was chaos really. That was a very, very different world. So I drank even more. No point carrying on. And ended up in hospital in March last year with severe jaundice and chronic liver disease. And I had the worst blood test I think they had seen for a long time.

However, the journey to get there could have also prevented it. Because in the time since before – just at the time when I was becoming homeless and when I became homeless, I was presenting at A&E all the time. And getting regularly kicked out at 3 o'clock in the morning, and told to walk home. And I just couldn't understand it at all. You know, they would just say right you have just got to stop drinking. They could have just grabbed me, took me in. Wired me up and detoxed me properly. With a view to trusting me that I was wanting desperately to give up. And I was. But they said to me, and so did my GP, that statistically that's not the way it works. Well I am not a statistic. You know? And it needs an individual piece of attention. I am not a statistic. Judging by my situation and all that sort of thing, you can tell that I am not living in the statistical mean average society. So I was trying to cry for that in a not so coherent way as I am doing now. So there wasn't that understanding ear to talk to. There were doctors that were really quite rude... they would take bloods. But it wasn't enough to admit me. And there would always be that recurring argument – we don't detox people. Well, who does?

It was so… discombobulated. It was disparate. It was everywhere. I wasn't capable of putting my bloomin' socks on in the morning never mind figuring my way out to navigate my way through all the various different people and services. Even worse, I didn't have the motivation.

"I wanted to be locked up. That's the way I put it – I wanted to be locked up. I tried getting admitted to a mental health place by threatening to harm myself. But they kicked me out in the morning, they said you are just drunk. And you know… Eventually I did get a diagnosis, a psychiatric diagnosis of personality disorder but it was more related to when I was drinking to be honest than now. But you know I could have done with knowing about that. I have got the where withal to be able to fight for my little self and fight my corner. I feel for people that don't you know? Or are less motivated to do that. And that's why I think kind of different in the sense that you know… I am able to fight for my own stuff. But the sad thing is that you have to fight for your own stuff."

Access to Mental Health Services

Mental ill health is significantly over represented in the homeless population as compared with the general public; with 80% of people experiencing homelessness reporting to have a mental health issues, and 45% having a clinical diagnosis[8]. Despite this, most participants believed that mental health support does not meet the needs of people experiencing homelessness. Many participants spoke of the issues that they had personally faced when trying to access support.

"I have been waiting for cognitive behavioral therapy for 11 months. And like it's… it's almost impossible to even get an actually answer from your doctor. So what's happening with that? When is that happening? I don't know, I will follow it up. Ok next time – I don't know, I will follow it up. It's like… I still suffer from anxiety and panic attacks near enough every day. So it's just like I want to crack on with trying to get myself help. You want to get better, you asked for help and you ask so many times for help and you don't get it, it's kind of frustrating. And you feel like you are hitting your head on a brick wall and in the end you just stop."

Focus Group Participant

Many of the issues that participants had faced in accessing mental health support related to concurrent substance misuse issues. The result of this often being that people in need are bounced between services, unable to fulfill the access criteria for a service due to a competing support need. The dilemma of dual diagnosis is that substance misuse is often a catalyst for mental ill health and vice versa. Often an individual's access to most therapeutic interventions, while dependent on substances, is restricted until the individual can demonstrate a period of stability and henceforth access therapy. A key and common problem, as highlighted throughout the focus groups, is that people reach stability, but then have to wait until funding is put in place – the result often being that people return to the chaos of addiction and mental distress while waiting for support. This is not only damaging to the individuals involved, but results in them using expensive services without long term benefit to the patients' health. Waiting times were a common topic of discussion and, a significant frustration for participants in the focus groups.

"Again, my story – mental health and substance misuse went hand in hand. I don't think I was alone in that one. And the frustration for me was I couldn't talk to the psychiatrist and stuff until I was sober for at least a year almost. That's ridiculous. […] But… but I could have had other interventions that could have helped me. Like CBT or something. Or just awareness training or basic interventions that could have tried to convince me to build my own motivation up to do something about my situation. When I say situation, I mean housing, homeless, drinking, everything. And self-esteem, confidence the lot."

Focus Group Participant

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[8] Homeless Link (2014) The unhealthy state of homelessness. Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf

Some participants indicated that, frustrated by difficulty in accessing mental health provision to address long standing issues, they increased their use of drugs and alcohol to mask the distress they experienced from underlying mental health needs. For some participants this had resulted in greater use of alcohol or illicit substances as a means of 'coping' with mental health issues, leading to a further decline. Participants highlighted that an earlier intervention would have avoided a mental health decline and subsequent increased substance misuse. However, it was felt by participants that as they stood, they were left with little support.

Mental Health Support for all

Poignant discussions occurred in three of the focus groups indicating a need for mental health support to be available to everyone experiencing homelessness, not just those with a diagnosed condition. Participants recognised both the generally high occurrence of mental ill health in the lead up to homelessness, and the negative impact of homelessness on an individual's mental health. It was felt that a blanket approach to mental health support would mean that people don't 'fall through the net' and that issues were dealt with early, thus preventing issues becoming very serious and more complex to treat.

> "That would be helpful yes [to offer Mental Health Support more widely]. It definitely is going to be helpful for anyone. Because people… who become homeless or face mental health issues, they disconnect from the world outside. And it's not just only this issue. There is also, you know, loneliness. And… finding someone to talk to. Finding someone who you can relate to or understand where you are coming from."
>
> **Focus Group Participant**

For some participants they felt they were receiving any support in terms of their mental wellbeing. Some even indicated that they felt that they were forced to over play their mental health issues in order to access support:

> "But I feel like some people here… most of us –even myself – as if like they want to push me towards that…say I have got mental issue. So I will be… better classified, better help with that. Which is a bit sometimes wrong. I mean like the gentleman here said – anxiety. I've got anxiety, I have got depression. I have been through this kind of issue; stress. But they want you to be… say that you have got mental issue because if you don't have mental issue you will be not helped. Because this is what happen. […] So people be pushed towards this side saying I have got mental issue, so they could get [support] – and I have seen it in places where I have been.

> "You know if there is a service provided…before it becomes too late… you know like the system… they want us to say you know like… there is no hope or something, you are mad or… and then you become depressed, you know like. They put you to dark stage, understand. But before you get to that stage there should be some kind of counseling or… before people go into that stage. But you know when you go to that stage there is a price to pay, man, you understand?"

Training for staff: Information and Understanding

Participants universally believe that NHS staff are, in the main, not equipped with sufficient knowledge of homelessness and the associated health needs in order to effectively work with this population.

"I think they have got to really start scratching below the surface of people that present [at health services]. People might well present looking a little bit rough and all that sort of thing and a bit incoherent or a bit aggressive or something. There are some issues there. You can't just take them at surface value. There is reasons why people are in this sort of situation and they need time, empathy, understanding. And actually sometimes just someone to just listen. Let it all out. And it takes time, you know? With me it took time to get through to me to understand what the hell was going on in my life. And then come to my own decision that I wanted to keep it going. Because that was a 50/50 at one point. So, you don't just look at the guy or the girl that turns up. And make a judgment. There's a hell of a lot of stuff going on underneath there. An incredibly valuable and sometimes horribly traumatic experience."

Focus Group Participant

It was felt that it would be advantageous for both clinical and non-clinical staff to participate in training on homelessness, as many participants had negative experiences of unhelpful attitudes expressed by frontline staff, which had deterred them from accessing services.

"I believe that most people that we come across in the front line. It's not their fault, they haven't had the training. They haven't had anything to arm themselves with knowledge about us. We are different to the rest of the world. We have different ideologies, we have different outlooks on life. Some people are emotionally damaged, mentally damaged. There are so many aspects. And you can't just put somebody in a chair and say right you are the new receptionist, get on with it. It doesn't work like that."

Focus Group Participant

There was enthusiastic discussion amongst many groups in terms of the potential content and delivery of training. For many, the breach in understanding could be bridged by creating opportunities for staff to meet, or at least hear the stories of, people who have experienced homelessness and the issues they face. One participant highlighted a scheme that was currently taking place in his hostel:

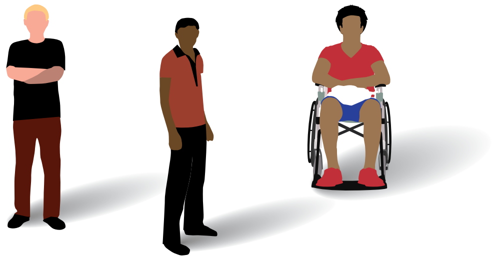
"The hostel I am in, they take student nurses on a six week job training programme. Where the idea is that they come in on a daily basis, mix with the residents, and get to… understand the problems more… that we – not as a group – but as individuals also have. So they go out and take their bedside manner with them. And with this bit of expertise they go back to the college. Or hospital that they come from. And I think that's a brilliant idea. I don't know if they do it in other hostels, but they do it where I am.."

Focus Group Participant

Another key training need highlighted was the need for improved knowledge of existing provision available to people experiencing homelessness, so that NHS staff can better signpost to available support. In particular, knowing who to contact and having an established connection will aid this process.

"They should know… how they can help… or… better know the right place. Where to send the person, the person in crisis. They should know where to send this person. I mean I meant the right place or the right contact. Things should be more efficient than taking long time."

Focus Group Participant



Planned Care

Planned Care: Case Study

April is in her 50s and lives in an outer London borough in temporary, privately run accommodation. She has a history of sleeping rough and living in hostels. Along with drug addiction, April suffers from mental ill health and has considerable issues around her self-care. While she has a complex set of health issues, her most immediate need concerning her leg ulcers, the result of injecting into open wounds.

April's ulcers are severe and effect both her legs. They cause her significant mobility issues, and as they have worsened, she has moved from using crutches to being dependent on using a wheelchair. April needs to attend a local healthcare centre three times a week to have her dressings removed, her legs washed and her dressings changed. April has been told that without these dressing changes it is likely that she will need to have her legs amputated.

April faces a set of overlapping barriers that make it difficult for her to attend her appointments. April's addiction and physical health issues make it difficult for her to remember her appointments, or to stay motivated to attend them. This has been compounded by the way she uses drugs to cope with the pain from her ulcers. As her health has declined, her accommodation has become increasingly unsuitable. In particular, the building she is staying in has a step that she cannot manage in her wheelchair without assistance. She also has real difficulty wheeling herself to the health centre. She is not mobile enough to take public transport, and cannot afford to take a taxi to her appointments. April relies on other residents in the temporary accommodation to push her to appointments for which she 'lends' them money in return.

April has been refused support from the district nurse to undertake the dressing changes in her accommodation. The grounds for this has been that April is not 'house-bound' as she can use a wheelchair.

April has expressed that she would prefer to have her legs amputated rather than have to face continued pain from her ulcers.

Engaging in a hospital setting

For many participants in this study the hospital setting was reported to be an intimidating place to engage with. This was identified as a key barrier and an explanation as to why hospital appointments are often missed.

> "I would suggest that most homeless people really have a massive mental and emotional build up to that [hospital] appointment as well. And it takes a long time – well for me personally – it takes an awful lot of time and energy to get into the mood to actually get there. And then when you get there it's knowing that you have got to go and sit there for three and four hours anyway. You think oh I can't be arsed, should I go? Shouldn't I go? And all the rest of it. Well I will go, I will keep my appointment. So you go and then you get there. […] And that's that build up, because there is an expectation of… . You know you are going to get messed about. And you have that internally, kind of that expectation. Around health care generally wherever you go when you are homeless. Well I wouldn't say second class citizen… but it feels like that."
>
> **Focus Group Participant**

Waiting times & methods of communication

Many participants found the time spent waiting to be seen in health settings problematic. Some experienced this as evidence of being judged, overlooked and misunderstood. While others recognised this as common experience for all patients, waiting is especially troubling for people experiencing homelessness. As one participant explains:

"I have been waiting for an operation for two years on my leg. And every single time… exactly the same… come back in three months. Yeah. Last time it was six months, come back in six months. […] Just a waste of a day… I know I have got nothing better to do, but that is the last thing I want to do, sat in hospital for half a day. Well you get a time, you might get 10.30, but you don't get seen until 12 o'clock, and 12.30. Because they are always running behind. I appreciate they are busy but…I don't think of many people that are homeless that would sit there."

Focus Group Participant

Another common experience was a lack of awareness around when appointments were likely to be. One participant who was currently 'sofa surfing' reported how, due to his movement between different friends' places, he had not received any letters informing him of appointments. He explains how it would better work:

"They have got all your details, they can email you or phone you. Everyone has a phone these days. Everyone, so it's nothing for them to look on computer… and yet it's very rare because they have their number anyway. It doesn't take long to get on the phone and phone us up… It takes a couple of minutes…"

Independent Peer Support

Across all focus groups there was recognition that support to access health care from someone who had shared lived experience of homelessness is valuable.

"Yeah. So I have done groups and things. I found them really, really useful. Got to find the right group that you sort of connect with. I think peer – the power of peer is phenomenal. It really is. As experience goes, it's just… It's the most enlightening and…. wonderful experience that sort of takes the burden of shoulders… Makes you recognise that you are not alone. And you can relate to other people. And oh what a relief that is, you know? You can even have a laugh about it sometimes. And then that helps build strength and confidence. And it's nice to help other people as well and share experience. The power of the peer is phenomenal. It really is. It's very, very important. And there is also a massive trust issue as well I think. A lot of people I have met won't talk to a key worker but they will talk to me. And then when they realise that I am not a key worker [laughing] and it's just sort of like perception as well, isn't it. So I think peer advocacy is fantastic. So yeah."

Focus Group Participants

All of the participants who had been supported by a peer advocate or care navigator reported having a positive experience, indicating that it had helped them to gain a sense of control over their health needs.

"I can only talk about myself – I had a rotten life when I was homeless. That's how my leg is like this. So I know because I have got a busted leg. And I have got one thing to say about [Organisation] here, because I am so far from the last place I was at. And one of their colleagues come out and I didn't know about this until the day before – it was [Name] from your office – and I had to go through a consultation on my leg which was very important appointment yeah. And he literally… they paid for it, for they paid for it to get you to your appointment safe. They stay with you, they go in the room with you so if you are not that good at like… taking in what the doctor says so you haven't go to through that much crap. Sorry about the language. He can then go back to the staff which he did with me and told them exactly what's going on, when you have got an appointment and everything. So I say thumbs up to [Organisation] yeah."

Focus Group Participant

A discussion in one focus group highlighted the need for peers to be well trained and well supported in their work, as well as maintaining independence from homelessness and health services. The discussion touched on the complexity of the role, the 'not professional, professional'. As this participant explains:

"It's good because the guy has got a little experience, he knows how to talk to clients or patients or whatever you want to call them. Empathy, understanding, agreement, shared experience; again because they are not professional professionals if you like. I think that peers can deliver information but they are sort of limited in powers in signposting and referrals. But I would be very wary of giving the peer more authority because you know…. Because before I had somebody who was professionally trained, or somebody who has… like being a doctor for seven years, still learning, still learning, still learning. And so by the same token you want to be talking to somebody who has actually come out of the other end, of that dark tunnel. You don't really want to be – because I am surrounded by people because it is a wet house, by people who – some just don't want to bother. They are just happy to die in that place. But others of us are trying to do something to get out of it."

Focus Group Participant

Decision Making & Accountability

Participants were asked to explore whether they felt that they were in control of their healthcare, whether they felt fully informed and could make choices about their care. Commonly participants felt that they were not given their options or opportunities to shape their own care

"Yeah choice. That would be nice. If you can – because you know yourself much better what is your condition and what affects you, what… where your pains are. So choice is sometime helps yeah. It's a good idea. But I think you feel that you don't really get asked, you get told."

Focus Group Participant

A common discussion around this related to participants feeling that if they were feeling undervalued generally, and as a result were less likely to feel that 'figures of authority' like doctors and nurses listened to their opinions. As one participant explains:

"First impressions count. So if someone will come into a place and they are treated like something that has just been scraped off the pavement, if they go in and get that attitude inside as well, they are going to think well it's going to be like that all over so they won't feel like the doctor will listen."

Focus Group Participant

A proactive approach is needed to involve people experiencing homelessness in shaping their own care. This is particularly so in terms of providing feedback on the care process. Participants felt that feedback processes were not always accessible. Despite many negative experiences of healthcare, few participants had any experience feeding back on their care. For some participants, not having an outlet for their frustration had resulted in negative consequences:

Interviewer: "So have either of you ever fed back about your experiences?"

Focus Group Participant: "Yeah I have stood there and shouted and screamed. That's happened a few times. And I have certainly had bad [experiences]…. And then you just get yourself kicked out. Yeah and you get banned from the place."

When well informed and supported, individuals (whether homeless or not) can have more control over their care. If they can feel confident to feedback on their care, the level of service is ultimately improved. For this participant they had a positive experience of feeding back on their care.

> “I had them [rights and feedback] explained to me at hospital because I am having more treatment – rheumatology and everything. And I went to see them to make a complaint about one of the doctors at my surgery. And then she explained to me if you have any problem you can call this number. She gave me a phone number and an email address. I think it was NHS. And she told me as well if I am not happy with that GP I can ask to see any GP I want. I don’t have to explain. Which is good. Because when I went to see them and I went to the receptionist I don’t want to see that doctor again, because she messed everything up for me. She said well why not? And she looked through all my medical notes and said the doctor told you to do this – did you do it? I didn’t need to do it [tell her], because it’s irrelevant and it’s none of your damned business! I got to see another doctor and things got better from there.”
>
> **Focus Group Participant**

Emergency & Unplanned Care

Emergency & Unplanned Care: Case Study

"I was going through the motions of drug addiction with all the chaos and madness that comes along with that. As a stimulant user I could stay awake for some times seven days in a row. The main thing that stopped me from accessing health care was my mental health: paranoia, anxiety attacks, low self-esteem and not feeling a part of the main stream population. So I would first find it hard to talk about what was really going on for me. Not just in case they judged me but also so I did not have to honestly deal with the extent of the problem myself. I had absolved myself from as many responsibilities as I could. I was happy in my downward spiral and as long as you were not going to give me a reality check I was ok.

The combination of substance misuse, alcohol and self-neglect took its toll on my physical body. This was partly due to the trips, falls and black outs and in the end I was drinking nail vanish remover. Being out in the elements in the cold rain or snow for extended periods of time because of smoking crystal meth and no sleep. I was losing all body fat and muscle and when I reached only 6 ½ stone it developed into heart problems. This was where it started for me; having to get help quickly and go to A&E. I would be going to A&E not for the purpose for health but so I could continue to use substances.

I was starting to be recognised at the local A&E department on a first name basis, even the consultant knew who I was because of the number of times I would present myself. With trips in the ambulance or by the police this felt like my own private cab company at times. But the main reason was that I knew I would get all the help I needed at one place and fast.

On one visit I was lying in bed hooked up to the ECG machine because of my heart palpitations. The consultant, let's call her Tina, came and had a chat with me. Tina took time out of her busy schedule and made a connection on a personal level with me. She came and shared some of her own life story and told me of times when things weren't going too well for her. She also helped me to believe that my life was far from over. At the age of 36 I just need to get the help that a hospital can't deliver or provide. She talked me through some steps I could take to keep myself safe, and sign posted me to the local drug prescriber to get myself stabilised. It was this that allowed me to begin to tackle the underlying mental health issues and the substance misuse problem that I had that was affecting every aspect of my life.

I know how busy the A&E is but the fact that I felt that I was receiving truly personal care was life changing for me. I felt valued and important for the first time in ages' and I am not entirely sure where the motivation came from but that was the catalyst to changing my life. Maybe I wanted to go back one day and show to Tina that I had changed. Or it was just the right information at the right time. I may never know but being able to do more than just health is the best way to help with health. It sounds mad but it has to be joined up thinking to win the war on homelessness health."

Aaron, a person who was formerly homeless

Reliance on Emergency Care

Use of emergency care was a key topic explored through focus groups. People experiencing homelessness are well documented to be high frequency users of Accident & Emergency wards and participants were asked to discuss their own personal experiences and motivations for using emergency care. A key issue raised was that individuals who live chaotic lifestyles experience increased risk and greater likelihood of needing emergency care when compared with the general population:

> “I usually would end up there because of my drinking. […] When I have gone to A&E I wasn’t really aware of where I was or what I was doing there anyway. It is usually third parties letting me know what’s happened. Or the police.”
>
> **Focus Group Participant**

However, as previously discussed, a lack of access to primary care, or a feeling that primary care was not meeting the needs of homeless individuals, was also an influencing factor. In this sense, emergency care was seen as a way to have multiple needs addressed in one visit in a streamlined and immediate fashion. One participant reverted to extreme measures to access support, as they explain:

> “The last time I was in hospital – well, the only time I would go to hospital is in the back of ambulance. Because I wouldn’t go and sit in a waiting room. I would rather get knocked down. Which is what happened to me the last time.”
>
> **Focus Group Participant**

For others the key element was that it was an open-access service where care could be provided for physical health issues as well as other needs, including shelter and respite. Emergency care can often be depended on by people experiencing homelessness, but an effective intervention will reduce this dependency in the long run. As this participant discusses:

> “I know most homeless people go from borough to borough, different hospitals. And there is also the experience of floating around hospitals in waiting rooms until next day. I have physically done that before now. But that particular time that was just a route through help that homeless people will use. And I have certainly used that. As somewhere to stay. Absolutely. Go in on a Friday, you are there for the weekend and you go out Monday. And that is… obviously you need to be there or you wouldn’t be admitted. But there is a constant flow in, out, in, out. And you kind of go underneath the radar doing that as well. Because it isn’t centralised. Because people don’t know one hospital to the other. It takes them a while to find out. And that could be nipped in the bud right at the beginning.”
>
> **Focus Group Participant**

When an individual accesses emergency care it offers an opportunity to tackle issues beyond just the immediate health needs, a chance for a more holistic intervention. While the individual accessing emergency care might be presenting with a specific ailment – it could be the route towards a life changing intervention.

Respite care

The idea of respite care was welcomed as an opportunity to stabilise and recuperate. It was felt that this was particularly the case with people who were ‘entrenched’ and unwilling to move off of the street, or people who lived chaotic lives and were unable to sustain accommodation.

> “There are people on the streets that want to be on the streets. They don’t want to go anywhere else. They are hardened to it. Some people think to go in there it’s like prison. They don’t want to be inside, they want to be outside. […] That they can go that they are not feeling it’s like a prison, or they are not permanently in hospital waiting to die. If people know that they can take a break to know that they can go and just carry on.”
>
> **Focus Group Participant**

However, many participants also responded that they felt that this was only a 'sticking plaster' when people would be discharged to the streets or back into temporary accommodation.

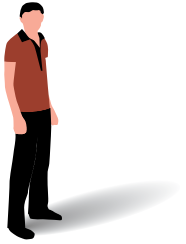
> "I am thinking about if somebody is homeless and you are going to do something like that [respite care] – forget about holiday for the time being. Get them the home first. Get the home first. And put something in place to help them to stay in that home."
> **Focus Group Participant**

Hospital Discharge

Focus group participants shared many stories of going through hospital discharge processes. Negative experiences were widespread, with one of the key issues highlighted having been discharge to the street without any sign posting to relevant services. This was particularly so with 'frequent flyers' who, due to their regular attendance can sometimes have their medical needs overlooked by staff at the hospital. This can mean that people are caught in a cycle of using hospitals for respite, but without a decisive intervention regarding their discharge. One participant explained his experience of regularly using Emergency Healthcare:

> "Nearly every other weekend [I was in hospital]. Every two weeks, I was ill again, back on the streets. Ill again, back on the streets. It was just insane. But that's just the routine. You easily get into a habit. A lot of homeless will be able to stay [in hospital], that's probably their experience and it quite universal in homelessness. Absolutely."
> **Focus Group participant**

For others, while written information on services was provided, it didn't help them to avoid moving to the streets. In one case, a participant who had just been thrown out of his parent's home attended A&E to get support:



> "I spent a night in hospital, but the Doctor kind of gave me a list of night shelters and then…see you later! And I wasn't sure what to do with it all. It was really very basic information. They didn't examine me or anything to check I was OK. That was my first experience with being street homeless."
> **Focus Group Participant**

Importantly, for some participants a decisive intervention at the point of discharge had been a turning point in their lives. Well informed staff, who had identified an accommodation situation early and had taken the time for a stable exit route from hospital to be identified, can be key to changing an individuals' lives.

> "My last experience of the hospital was really beneficial. Really beneficial, because they were able to…took a lot of the burden and expectation that they had in dealing with homeless clients, like myself so to speak. They had a homeless team based on site at St Thomas's. And it was only through that that all that madness stopped. And that's when it stopped. At that weekend, at that time, I have never been in-patient since. What stopped it was… again it was the homeless team who actually helped me – they actually facilitated all of it – was the discharge from St Thomas's to [hostel]. So that's what made the difference. Them having the expertise and… knowing what to do. And that's three years ago and I haven't been an inpatient since."
> **Focus Group Participant**

The above case demonstrates that effective interventions are not only positive for the patient involved, but also result in a reduced usage of emergency care in the long-time.

Health Services as a route to accommodation & Support

All participants have experienced a breadth of inappropriate, insecure and unsafe accommodation. As one participant explains:

> "I used to know somebody at the time… somebody from far distance related. And this person let me stay, to sleep on the floor in her house. But same time I was again very… you know embarrassed… because it is so many things involved…. [For] some people it is a shame to be homeless. […] And I can tell that they wanted me to leave as soon as possible. But I think I was wondering what would happen now. That was very scary time. Being homeless, and being… sleeping in halls [winter night shelters] with other people, no privacy. Anything could happen. Some person could steal from you. Feeling sick at the time and […] All the stress and everything."

A theme that was highlighted is the key role that healthcare staff can have in supporting individuals to access secure, appropriate accommodation. Whether this is through facilitating bed spaces, effectively sign posting, or adding 'weight' to applications for accommodation with the local authority – healthcare staff can play an important role in improving access to appropriate support.

> "Yeah same time I was seeing my doctor. And my doctor, yes…went to my doctor. He was then… Actually… advised me to see a specialist. When I was transferred to specialist and had treatment there and then got a letter. But the help came good, it helped me. And they gave me a letter and went to a council… And council then they shifted me to the bed and breakfast. I was… there was relieved there, yes. And it then started from there that I was in bed and breakfast."
>
> **Focus Group Participant**

When meeting with patients, healthcare professionals may be privy to personal information about unstable housing even before individuals have engaged with support services. At times of crisis they may also be best placed to support individuals to find relevant support before situations deteriorate further. Medical professionals identifying unstable accommodation statuses and linking up with local non-medical services, and primary care services offering a 'social prescription' to sources of support within the community, can offer an important intervention. One participant explained how "joined up" services, with clear communication between them, led to them being placed in more stable accommodation by the local authority:

> "I asked for the letter… for the council, I was under treatment and I was provided that letter by the psychiatrist and… yes. They talked to me about my housing situation and that I was homeless. They were supportive. The psychiatrist was really supportive. And I appreciate GP as well because he just passed my information to the psychiatrist and the mental health team."
>
> **Focus Group Participant**

Data Recording and Sharing

The topic of data recording and sharing was addressed in all of the focus groups. Data collection was generally seen as a positive, with participants seeing a link between well-informed records accessible across NHS services, and service quality. A common rationale was that it meant that patients do not have to 'explain themselves' to medical staff repeatedly, particularly around accommodation and substance misuse. As one participant explains:

> "The NHS is computerised so everyone's notes are online. So anyone should be able to access them if they are within the NHS system. I think it's brilliant. Because the doctor doesn't have to go..Ask you a thousand questions, he's got it all on hand. I see you are this, you have been suffering from that for a while, you are on that medication. Let it go on from there."
>
> **Focus Group Participant**

Participants were also asked whether they would be happy for their information to be shared more widely beyond NHS services to relevant support services (services discussed included homelessness, drug and alcohol and mental health services). Again, there was agreement across focus groups that this was a good idea, if done with consent from the patient.

Interviewer: So you were talking there about different services. You talked briefly about data sharing. But also the drug prescribers and you know, substance misuse centres. Do you think you would be comfortable with them being able to access your information? And vice versus the NHS…?

Participant: Yeah. No problem. That would be very helpful. And also as long as they tell me who they have provided this information to. It saves a lot of time, doesn't it? If there is something wrong with you, they have got all the information there instead of waiting to question you if you are unconscious or whatever. It saves repeating yourself as well. Telling two or three different people the same thing."

Participants also felt that it was important for people's accommodation status to be recorded on their NHS records so that medical staff could be aware of this support need at an earlier stage, and therefore plan treatment and discharge appropriately. It was also highlighted in two focus groups that this could add to the accountability of health services, and help services to understand how homeless people may have been treated in medical settings. The risk of being held to account could also lead to better quality of care for homeless people. For example:

> "It would have a really positive impact in the sense that they would feel more accountable, also if it was linked up. The one hospital will think, well why didn't they treat him properly at that one? Why wasn't this person treated, see appointments that were missed and waiting quite a while. This person's limb or whatever is about to be removed. But this could have been stopped a year ago, this didn't have to happen. And if it was linked, that would be I think a validation around that, so it would be accountability. And they would feel more accountable also in the hospitals."
>
> **Focus Group Participant**

Although some participants did have concerns around data security, it was generally felt that as long as the purposes of the data collection were for support, and systems used were secure, then it would not be a problem:

> "The data could end up in some other hands. I mean like hackers or otherwise so… its.. It depends – who are you going to pass it to? I mean could end up with people… salesmen or salespeople trying to sell you something or… You don't know how might be researching my data, even on Google. And you don't want such information to appear. If it is going to be within the framework of the health service, no problem. But if it is going to outside with information being about this person homeless or not… I don't like the idea of that"
>
> **Focus Group Participant**

A question was raised on two focus groups over when people had moved away from homelessness and whether being 'homeless' would continue to 'follow them around'. One participant explained his concern:

> "Why –the only reason I am concerned with this, even with this… er… form we are holding here now is in times of my status as homeless – I am not homeless. I don't want it out there…. We don't know five years from now what you have got… maybe you are successful businessman, successful doctor. Me too like I said, self-employed, I mean we don't want this information end up in the hand of some people who… its gets like you know… public".
>
> **Focus group Participant**

Public Health

Public Health: Case Study

Damon is in his late 50s and has been experiencing homelessness on and off for over 10 years. He explains that his drinking has been the main reason he has been unable to keep a tenancy. Luckily, he has good relations with his family and his daughter, who happens to be a doctor. With her knowledge of the healthcare system he was able to access an emergency detox, as Damon explains:

> "Well I was in hospital about two years ago. My daughter is a doctor. And I tried to stop drinking just to try and… without supervised detox. Absolute disaster and I just reached a stage where I couldn't – we'd been out visiting relatives and I just couldn't get out of the car. We were on the way back to where I lived at the time, which was just down the road from Whittington Hospital, North London. And she drives me there. She said look Dad, you have got to [go to hospital] – I know what's wrong. You are going straight to them now for emergency detox. So there was no waiting around in A&E because she knew the things to say and how to get it through. So I was still sitting in the car in an ambulance bay. She whisked me through – she got staff to whisk out a wheelchair for me and I was straight in.

I was on a right crash programme of Librium. And whatever else they give you. It was an emergency detox because I was on my last legs. […] And they said yeah you are OK to go home, but we would suggest you try and get involved with a longer term detox programme and then rehab. Which I did. So I went to [organisation]. I found somebody who could do a referral. I am still involved with them because I am waiting for another detox. Because this was about two years ago. So things happened and… if I don't have my medication in the morning, I wouldn't be able to hold this pen. You know, you guys know…"

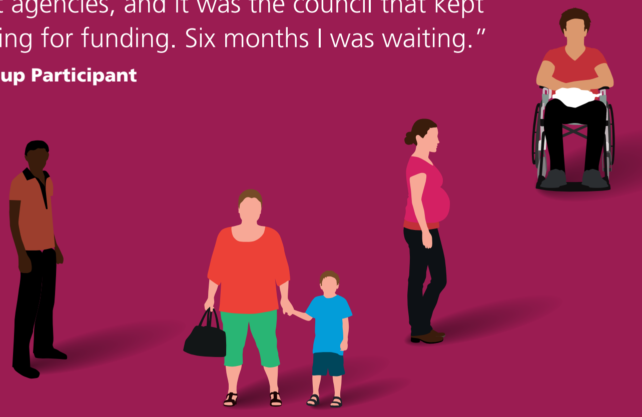
Substance Misuse

With the high levels of substance misuse among people experiencing homelessness, drug and alcohol support is an essential service. The impact of substance misuse on physical health was a topic highlighted in a number of the focus groups and a point raised on a number of occasions was that by tackling drug and alcohol misuse and dependency, the burden on the NHS would be significantly lessened. For example:

> "The thing is if we tackled the drug and alcohol issues there would probably be loads of staff left over, because the beds are that filled up with alcoholics and drug addicts. If we did have more time I would say that sometimes… well we can be difficult people… but by sorting that you will be better off."
>
> **Focus Group Participant**

As discussed in relation to mental health support, the dislocation caused by dual-diagnosis is a key issue for people attempting to access drug and alcohol support. However, for some participants for whom mental health issues were not immediately an issue, they still faced significant waiting times and requirements for access to detox.

> "Where I had to do pre-detox and pre-rehab classes with my local drug and alcohol agency if you like. But my big issues, well it wasn't attending. I could do two or three groups a week. But my thing was I went in for funding from my council to get into this rehab that I wanted to go to. And that took like six months. I was just constantly waiting, waiting, waiting… doing all these meetings. Feeling that I was engaging and motivated, I'd asked for help, I'd gone to the local hospital, they referred me, signposted me to all these different agencies, and it was the council that kept me waiting for funding. Six months I was waiting."
>
> **Focus Group Participant**



For this participant, and many others who shared their stories, the delays in getting support had led to what they felt was a decline in their physical and mental health conditions:

> "It had an impact on my mental health yeah. Definitely. Because I was struggling, I was having to reduce by half all my using – whether it was drugs or alcohol. I wasn't on a script for my drug use, so I was still using. Yeah it was just a constant.. you know, the washing machine thing, you know, as time goes on, you think bloody hell, you see other people moving on into their rehabs. And you think why them and not me? So you get all the resentment side of stuff. So yeah, it didn't do me any good. But its good – I mean the good thing about my detox was my outreach workers at the time came and picked me up from detox in West Sussex and took me straight to rehab so I didn't have the opportunity of stopping for a quick beer or anything. They wanted to safeguard me. So once I got into detox, it was great. Because I knew from there I would be going straight to rehab."
>
> **Focus Group Participant**

Smoking Cessation

Smoking tobacco is rife among people experiencing homelessness, with 85% of the population smoking compared to 18% of the general population[9]. Smoking and access to support to quit was a topic that was raised in a number of the focus groups. The challenges of mental health and other substance dependency issues further complicate the homeless population's ability to cut down on smoking. Most participants who did smoke were aware of the damage that it was doing to their health. For some participants the impact on health had been severe:

> "For me, it was smoking. Cigarettes. I had asthma as a child, but the COPD came in… as an adult, obviously with the cigarettes. But I have a current chest infections because I don't always take care of myself. So I am not always getting the right nutrition and I am not always taking my medication properly and so my immune system get slow and it makes me very vulnerable to chest infections. This year alone I have had three. And… er… yeah I quite often have breathing difficulties."
>
> **Focus group participant**

In all of these focus groups, participants had made unsuccessful attempts to stop smoking. The key barrier that participants highlighted was the environment that they were living in where smoking was normalised. The following participant highlighted how he was able to move away from smoking, only to start again when he was discharged:

> "Again where I first come out of hospital I weren't smoking at all. You see I was in there twice. One for nine days and another for seven days and you know not once I even thought about cigarettes. […] And then when I was at home after a couple of weeks, others coming in and… or I smelt it. I said let me have a pull. And I took a pull and I never… I thought I was going to die. I coughed so much. And I said no I am not smoking. After a while your body gets back into it and you are smoking again".

Awareness of smoking cessation services, and knowledge about how to access support, was a key issue, with many participants feeling that they were unsure of their options for quitting. This was both within services and in wider healthcare. In one focus group there was an example where some of the participants were aware of a smoking cessation project in their hostel, while others weren't.

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[9] Groundswell (2016). Room-to-Breathe: A Peer-led heath audit on the respiratory health of people experiencing homelessness. Available at: http://groundswell.org.uk/room-to-breathe/

The reality for people experiencing homelessness is that smoking is a widespread and hugely damaging practice that could be preventable with tailored support. However, whether for a lack of information or services not meeting the needs of individuals, this is an area where an intervention tailored to the needs of homeless people could not only improve health but save considerable money in the long term around treating health conditions.

Providing Information for Patients

A key issue raised in focus groups was the need for information on healthcare and wider support services to be not only readily available, but be proactively provided for people with experience of homelessness. It was acknowledged, however, that communicating through conventional mediums would be difficult for people experiencing homelessness. As one participant explains:

> "I don't know how you are going to [communicate with homeless people]. They are homeless, they don't access the paper and TV and everything. They don't get no proper service, they don't have a phone, most of the homeless. How we can you know. That's going to be difficult."
>
> **Focus Group Participant**

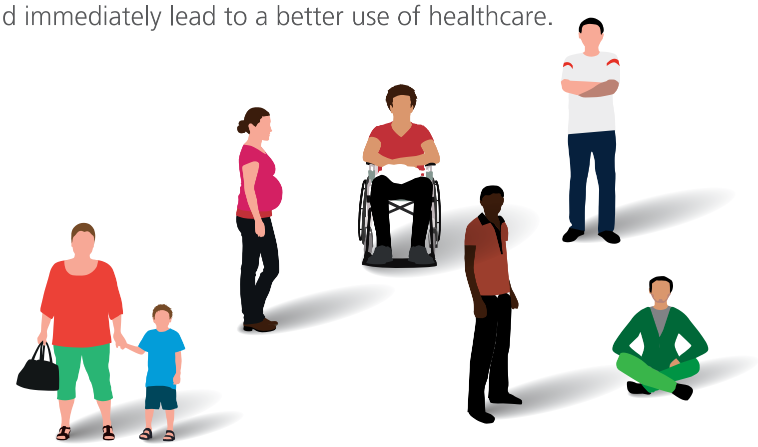
This was both in terms of paper and online information and literature. The same limited availability of relevant and helpful information was also held by healthcare and support staff, who could be in a prime position to direct people to appropriate support. This highlights the need for both better information on healthcare and on homeless services. As one participant explains, he found it difficult to approach services to ask for and find appropriate support.

> "I know people don't have the confidence to go and get the – you know like even in the daytime they go… but they don't have the confidence to go and find out where to go and get the help. Sometimes we don't have the information or the confidence like to take the courage and go…"
>
> **Focus Group Participant**

A number of participants highlighted how it was other people who were homeless who were the best source of information, as they had already used services and could communicate it in a way that people could understand. This raises the need for information to be delivered in a way that is clear and easily understood.

> "What I have noticed in London, they haven't got a lot of information on what to do [when you are homeless]. See like yourself, coming from another country, unless you actually go and meet another homeless person you wouldn't have a clue where the things are. There is no information, nothing really like. Advertisements sort of thing."

While information on which services are available and how to access them was key, many participants felt that they simply did not know their rights around healthcare. All focus groups were asked the question 'are you aware of your rights around healthcare': few could answer this question. There was a sense that while participants felt that they could access emergency care, many were unsure of their rights around accessing primary care, around making choices about their own care, and about other rights such as accessing healthcare records. All the focus groups welcomed the opportunity to have a better understanding of their rights to healthcare. As this conversation from a focus group illustrates, some participants felt that having a better knowledge of these entitlements would immediately lead to a better use of healthcare.



Interviewer: "Do you feel like that would be helpful, to know your rights [around healthcare]?"

Focus Group Participant: "Yes."

Interviewer: "How would that help you?"

Focus Group Participant: "So I could change… you know, my situation if I know more about or was aware of services and rights. I know where to go and I know I can perhaps change things quickly for me or the need to go to the right person to start the right conversation and say the right things."

Participants were asked whether a 'rights to access healthcare' card specifically designed for homeless people would be a useful tool. Again, the idea was welcomed by all of the groups, although some practical issues were highlighted:

> "Well immediately you are in the system aren't you? You don't have to open your mouth really to hand the card to receptionist and everything just flows from there. Brilliant idea. But there is a catch there. Because when you are homeless you tend to – a lot of guys are on drugs, a lot of guys are alcoholics. They will lose those cards and within ten seconds they are back to square one."
> **Focus Group Participant**

On-going engagement with People Experiencing Homelessness

Participants welcomed the opportunity to be involved in this study, and on the whole valued the opportunity to feed in to the decision making process. As previously discussed, many participants felt that their opinions and choices were not ordinarily valued – and that the opportunity provided by the London Homeless Health Programme systematic consultation was a chance to begin to communicate and influence service provision in a meaningful way. As one participant explains:

> "This is a contact point. Make good by being here. And like [name] said, this kind of forum should be made easily more frequent. I know it doesn't have to be… every week or every month. But people need to be made aware that somebody is coming – some people just naturally do this, talk about their problem. Let's see what.. just by discussing it with the right people, you can make a difference."
> **Focus Group Participant**

The idea of the London Homeless Health Programme providing an opportunity for on-going engagement with people with experience of homelessness was welcomed by all groups that it was discussed with, with many participants feeling that they would like to be involved in this process:

> "Definitely I am going to participate. Because I am here nearly 12 years. I am doing voluntary work. I have had a chance to work with other people multi culturally, not only particular one community. So its good chance for me I can hear all those people. So many people are – homeless people and health is a problem. […] So we have to change everything."
> **Focus Group Participant**

End of Life Care

End of Life Care – Case Study

'JD' is a Homeless Health Peer Advocate and has been working for the last seven months supporting Peter, a resident in a hostel in a central London borough, through the final stages of his life. JD built a relationship with Peter and worked with him until his final day. This case study shares JD's experience of working with Peter and going through the palliative care system. It also highlights some of the challenges they faced.

"I was supporting Peter for approximately seven months on and off with his cancer treatment and then palliative care. This included chemotherapy, radiotherapy, blood transfusions, and all the other healthcare he needed. Seeing someone suffer from cancer is not nice and we all know that, but it was a privilege to be with Peter, to see what he had to go through and I was with him until the end."

"He did not want to go into a hospice. He wanted to die in the hostel to be around people that he knew. We had to go 'behind-the-scenes' to make his wishes happen as the pathway that most people would follow would be into a hospice. Luckily he had a good manager at the hostel and me to fight for what he wanted."

"He was at the [Hospital], the members of staff and nurses were really helpful and the Macmillan nurses were working hard to make sure he had everything he needed, anything he wanted he got in relation to his medication."

"On his last trip to the hospital it was to accident and emergency and the nurses explained to him that he only had around five days to live and all he wanted to do was go back to the hostel and be with people that he knew. It was nice to see that he got his wishes then even though the Macmillan nurses had to come to him in the hostel."

"The mentality was very much about making these last few days of life worth living, making him comfortable, and making him happy, letting him get everything he required. He did get everything he required by going back to the hostel and having the end of care nurse and a care plan put in place. We did all we could to respect his wishes and we did all that was in our power to get him what he wanted. A few days before he died we took him to Madame Tussaud's for a day out to take his mind off it. Even though it was a struggle with his mobility, Peter loved it. I don't know what it was but something inside me said to go and visit him on the Monday. Then the next morning I found out he passed away on the Tuesday. I was glad that I visited him then."

Social Exclusion & Isolation in final Days

Palliative care was a topic discussed with participants in focus groups. Perhaps understandably not one of the participants we spoke to had personal experience of using end of life care. However, it was common for participants to have had experiences where fellow residents in homelessness support services had passed away, either as an unexpected incident or following a protracted bout of illness.

"We have lost four people in this one year, in this place [Hostel]. Just this year in the first five months. A lot of people have died here and other residents have been close with those people, close friends. And I have seen those people really, really down and I have said to staff and it's like have a chat with so and so because he looks a bit blah blah." – Focus Group Participant

In the above case the participant felt that there was a need for more support, particularly as the staff at the hostel were unprepared (or unable) to offer emotional support to the individual who was passing away, or to the other residents in the hostel. In another case a participant had seen the benefit of palliative care with a fellow resident in a hostel:

"Very recently I have had experience of palliative care. With a guy who passed away, bless him. And again I think that's… I don't know what to tell you, other than… it's a good thing. And he was in an organic environment. As much as this is organic sort of thing. People who are going through are very considerate actually. And it touches people."

Focus Group Participant

Generally, participants saw the merit of specialist palliative care for people experiencing homelessness, with the key motivation being that there was recognition that homelessness involves elements of isolation and social exclusion, support networks tending to be fragmented or unavailable. For this reason, more proactive support is needed to fill this gap:

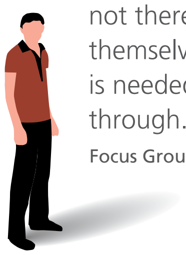
"If people come to the end of their lives and they are still homeless, I think there is a good calling for a support service for those people because a lot of them, I am sure the majority of them will have more or less no family, not many friends. But yeah I think people coming to the end of their lives definitely need a support services because you probably find that they don't have a lot of support coming from anywhere else."

Focus Group Participant

However, for some participants the discussion around palliative care sparked a debate on how an individual's paths to death had occurred. For some, it was felt that a lack of support from mainstream healthcare had resulted in people passing away. There was a feeling that if individuals were better supported to address health needs, there would not be a need for a specialist palliative care service for homeless people. As one participant explains:

"They [homeless people] don't get the support now, that's what's lacking. That's why [name] was in hospital and it was that which killed him. Sorry. I really do think that. […] I definitely think the support is just not there and anyone who doesn't see that is blind themselves. Because that is such an obvious thing that is needed. They don't know what people are going through. People are dying every day."

Focus Group Participant



Giving choice for a final decision

Throughout all of the focus groups where palliative care was discussed it was highlighted that whether there was a specialist palliative care service for people experiencing homelessness or not, the key is that people are given the choice to make decisions about where they pass away and how they are supported.

"Personally I would rather know when I was going to die. It just happened to a friend of mine just before Christmas. He died of liver cancer. But he knew when he was going to die. And he died almost exactly on the day that they predicted. If I was to have any sort of support when my days were numbered and I was aware, I would rather have the choice of where that support [came from] – probably want to go home, amongst loved ones. As opposed to going to a centre and receiving special care."

Focus Group Participant

Conclusion

This study has highlighted the need for a more effective and proactive approach to commissioning for homelessness health services. Participants in this study have reported that general services are not meeting the needs of people experiencing homelessness and our findings reveal that it is the most vulnerable people who are experiencing homelessness; migrants, people with mental ill health and substance misuse issues, and who are impacted the most.

Specialist homelessness health services like homelessness GPs, mobile services, outreach medical care and Independent Peer Support were valued by participants as providing support that is tailored to the needs of homeless people and can offer a more holistic approach to support. When further implementation of specialist services for people experiencing homelessness have been discussed (like respite and palliative care) there has been general agreement that these would be beneficial services to support people. However, an underlying sentiment is that if homeless people could make better use of regular healthcare, on a level with people who are 'housed', then these services would not be in such great need. This would require change in the way that regular health care is delivered, and also highlights Peer Support and Care Navigation as effective tools to achieving this.

While specialist homeless health services are doing important work to bridge this gap, and should be extended to reach a greater number of people, it is clear that the practices that make them effective should be extended to general needs health services as well when working with people who are experiencing homelessness. Participants reported that key to their success was: consistency in service, flexibility, meeting patients in their own surroundings, and a well trained staff who have understanding of issues related to homelessness and how to access support. In terms of training in particular, there is a need for NHS staff to have a better understanding of the causes and consequences of homelessness, and the routes to support, so that NHS staff in all areas of care can use their engagement as a chance for a more holistic intervention beyond immediate health needs.

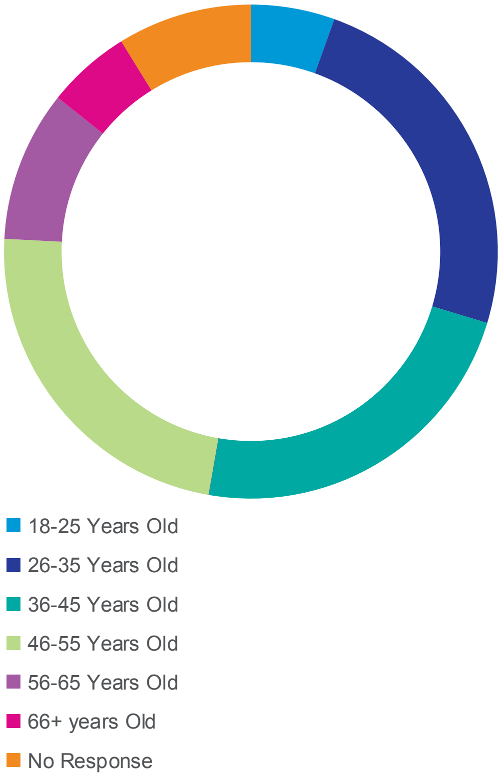
This project has also revealed that while health may be one of a number of competing priorities for people who are currently homeless, that by no means is an indicator that people do not want the opportunity to improve their health. By delivering services in a way that allows people who have experience of homelessness to be involved in making decisions on their own care, and by providing more opportunities for input into the way that services are run more generally, it will result in better quality care for all.

Appendix

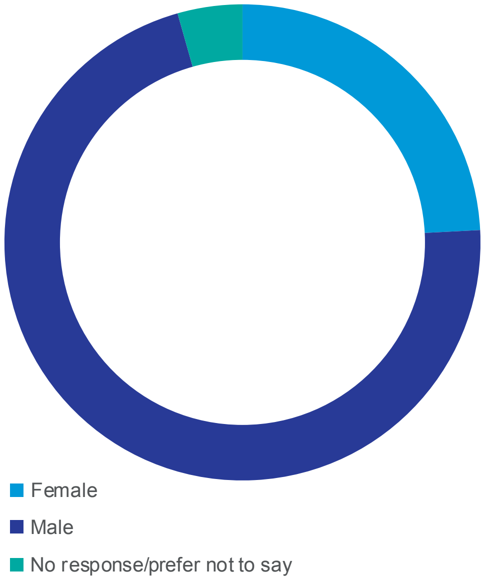
Appendix 1: Monitoring Information from Participants

Period since participants first became homeless	Count	%
less than a month	2	2%
1mth, less than 3mths	8	9%
3mths, less than a year	12	13%
1yr, less than 2 years	20	22%
2yrs, less than 5 years	12	13%
5yrs, less than 10 years	10	11%
10 years or more	15	16%
no response/prefer not to say	12	13%
Grand Total	91	

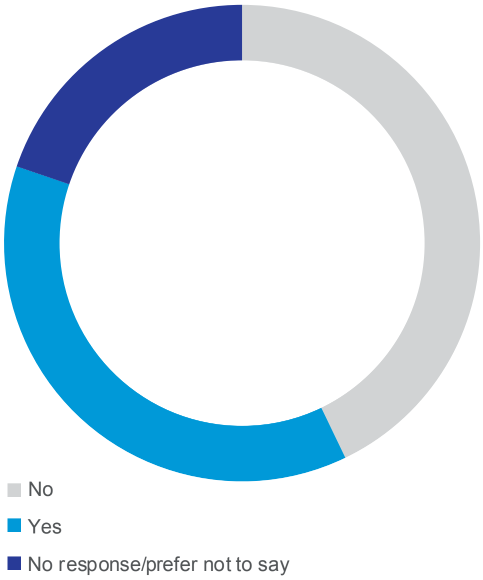
Age Group of Participants



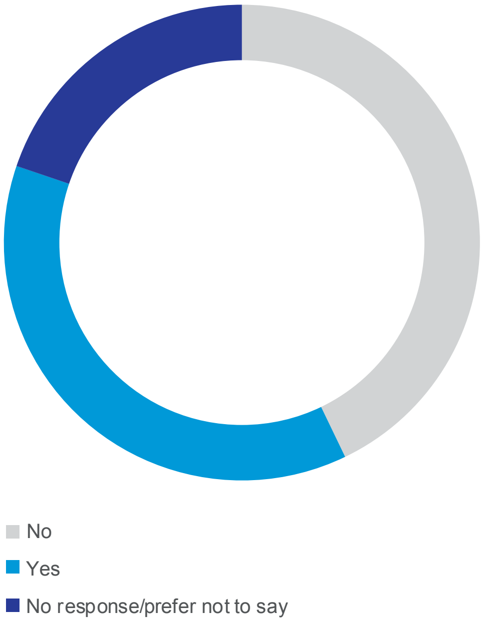
Gender of Participants



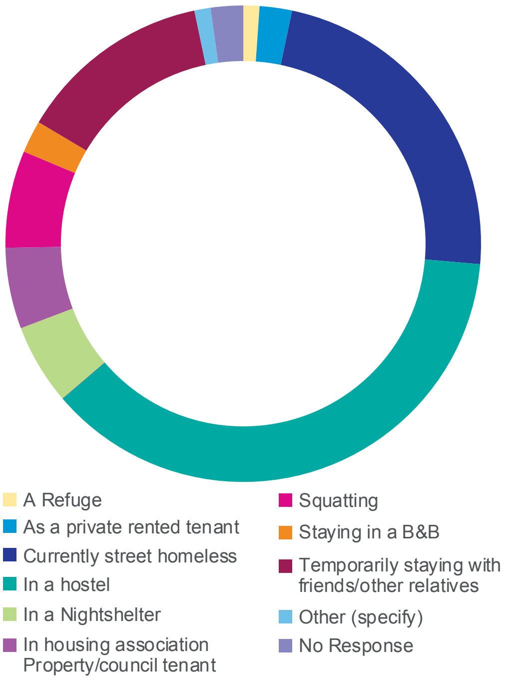
Participants with a Disability



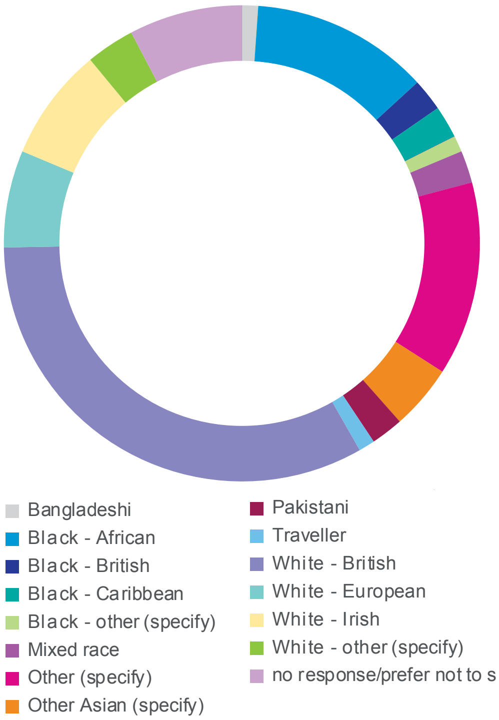
Participants with a Disability



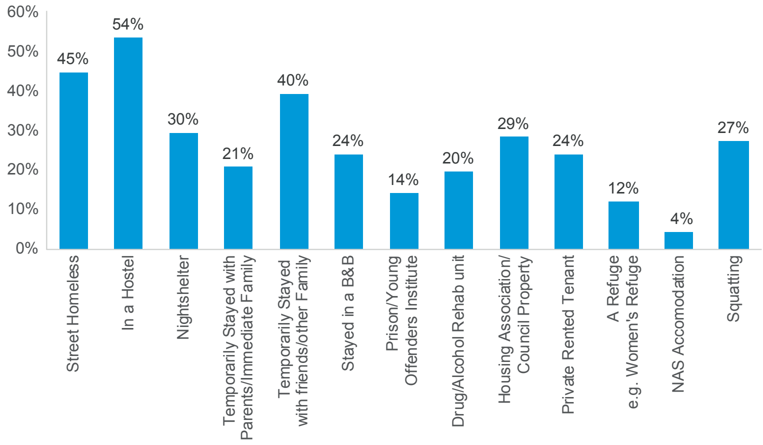
Current Accomodation Status of Participants



Ethnic Group of Participants



Accomodation status experienced in the past



Appendix 2: Authors

Martin Burrows

Martin oversees Groundswell's Insight and Action Programme which uses peer-led research and participatory practice as a tool for driving positive social change. He joined Groundswell in April 2014 and has delivered various research projects exploring homelessness and health. Previously Martin has worked for a number of leading homelessness organisations, at home and abroad, including Crisis, Broadway, Homeless Link and Casa Ioana (Bucharest). His work is underpinned by a theoretical understanding of social science gained through study at Cardiff University and the London School of Economics.

Rob Edgar

Rob is a board member for the London Homeless Health Programme and works as Peer Researcher for Groundswell.

Rob credits his volunteering work with Groundswell and Build on Belief as playing a key part in his own move away from homelessness. Having spent over 20 years drifting in and out of homelessness he has used what he has learnt to support others to overcome the barriers homeless people face to improving their lives. He began volunteering with Groundswell in 2014 offering one-to-one support as a Homeless Health Peer Advocate, first specialising in supporting people diagnosed with tuberculosis. This has given him a deep understanding of the health issues homeless people face and the barriers they often meet to effective treatment. He strongly believes that homeless people have a right to have their voices heard and that this is key to improving services and creating meaningful change.

Théa Fitch

Théa is a board member for the London Homeless Health Programme, and currently works as a peer support worker for Central North West London NHS Foundation Trust at the Homelessness Prevention Initiative. Alongside this she also works as a peer recovery trainer for the Trust's Recovery and Wellbeing College, delivering psychoeducational training to people using services and people in supportive roles.

Théa uses her personal history of homelessness, and a long history of accessing mental and physical health services, to support others to overcome challenges with their health, wellbeing, and social inclusion. Therapeutic optimism and the maintenance and communication of hope have been cornerstones of her recovery, and are a large part of what drives her. She is passionate about helping people to be seen as more than their labels, and to see themselves as deserving of compassion and a satisfying and meaningful life as anyone else.