

# Transforming Primary Care for Homeless and Inclusion Health



Building on recommendations to address ongoing barriers - registration, access, and provision of care

# Contents

.....	1
Executive summary .....	3
Introduction.....	4
Background to primary care workshops.....	7
Key issues and proposed recommendations.....	8
1. Developing shared models of care between organisations with clear referral pathways between services in the community .....	10
2. Collaboration and joined up working between primary care, community, and secondary care .....	14
3. Training and education.....	15
4. Access and registration.....	17
5. Addressing the barriers to engagement.....	18
6. Data collection and coding.....	21
7. Addressing digital barriers and exclusion.....	24
8. Promoting practices to become Safe Surgeries .....	26
9. Workforce .....	27
10. Funding.....	28
Recommended work underway .....	30
Next steps .....	31
Conclusion.....	33

## Executive summary

Individuals experiencing homelessness face significant disparities in health outcomes compared to the general population and encounter barriers in accessing healthcare, including stigma, discrimination, and inflexible service structures. The absence of trusted relationships with healthcare providers can further compound difficulties in receiving timely and coordinated care, particularly given the complex health needs and vulnerabilities of this population.

In order to bridge gaps in primary care, namely GP registration, access and provision of care, the London Homeless Health Primary Care Steering Group held three workshops in 2023 to discuss and propose recommendations to improve things. These were overseen by Dr Jasmin Malik, and delivered by colleagues from Transformation Partners in Health and Care, as well as volunteer practitioners and commissioners. These workshops built upon research and deep dives conducted by various stakeholders over the past few years, including NICE guidelines, as well as engaging with current services seen as providing good practice in the region. Key priority areas and recommendations emerged from the workshops convened by partners from various sectors, including primary care, mental health, substance use, and social care. These recommendations are broken down into 10 themes, including:

1. Shared models of care with clear referral pathways
2. Collaboration and joined up working between primary and secondary care
3. Training and education on inclusion health
4. Access and registration to primary care services
5. Addressing barriers to engagement
6. Data capture and coding
7. Addressing digital barriers and exclusion
8. Promoting practices to become Safe Surgeries
9. Workforce
10. Funding

This report lists the issues that emerged from the workshops and several proposed recommendations under the above themes. It underscores the collective responsibility of inclusion health system partners to collaborate and implement person-centred strategies. Actions that have already been taken forward following the workshops have been listed. Some suggested short-, medium- and long-term next steps have also been outlined. Finally, limitations and areas for further work and research are also included.

The issues and recommendations in this report were presented during a webinar in February 2024. This report, with emphasis on the issues and recommendations within, will be circulated with members of the London Health Equity Group, to inform their meetings around the deep dive into inclusion health in May 2024.

## Introduction

The health inequity gap between the most and least deprived in society is stark. When comparing those who are experiencing homelessness with all other population groups, they have by far the worst health outcomes, with repeated or long-term homelessness associated with the most damaging health consequences. The mean age of death of someone who is sleeping rough or in emergency shelters is in their 40's,<sup>1</sup> and people frequently develop long-term conditions at a young age. A third of people who die while homeless, lose their lives from treatable conditions, yet accessing healthcare can be a challenge.<sup>2</sup>

People experiencing homelessness face barriers in engaging with primary care services, including registering and attending local GP practices. This is due to several factors including stigma and discrimination, inflexibility of services, and/or strict eligibility criteria.<sup>3</sup> Those from other inclusion health groups, including migrants, sex workers, or travellers come up against similar obstacles when engaging with primary care or mainstream services. Despite several specialist inclusion health GP practices, most people continue to access mainstream services. Therefore, it is important to recognise the barriers and challenges that impact engagement for both mainstream and specialist services.

One such challenge to engagement is developing trusted relationships with clinicians. There is a known association between adverse childhood experiences and homelessness in later life.<sup>4</sup> Abuse and neglect experienced in childhood can impact an individual's ability to form trusting relationships throughout their adult life.<sup>5</sup> For this reason, and ongoing social challenges, many people experiencing homelessness can find it difficult to build a rapport with medical professionals. Additionally, their care is often uncoordinated. Coupled with their vulnerability and complex multiple health needs, it becomes particularly crucial that they experience continuity of care, facilitating the development of trusting therapeutic relationships.

As well as the experience of homelessness, other disadvantages that are frequently present among inclusion health groups include harmful drug and/or alcohol use, poor mental health, domestic violence and abuse, and involvement in the criminal justice system. There is a clear association between severe and multiple disadvantage and

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<sup>1</sup> ONS. (2022). Deaths of homeless people in England and Wales: 2021 registrations. Available online: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2021registrations>

<sup>2</sup> Aldridge, R. et al. (2019). Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. Wellcome open research, 4, 49. <https://doi.org/10.12688/wellcomeopenres.15151.1>

<sup>3</sup> NICE. (2022). Integrated health and social care for people experiencing homelessness. Available online: <https://cks.nice.org.uk/topics/integrated-health-social-care-for-people-experiencing-homelessness/>

<sup>4</sup> Koh, K. A., & Montgomery, A. E. (2021). Adverse childhood experiences and homelessness: Advances and aspirations. The Lancet Public Health, 6(11). [https://doi.org/10.1016/s2468-2667\(21\)00210-3](https://doi.org/10.1016/s2468-2667(21)00210-3)

<sup>5</sup> Kendall-Tackett K. (2002). The health effects of childhood abuse: four pathways by which abuse can influence health. Child abuse & neglect, 26(6-7), 715–729. [https://doi.org/10.1016/s0145-2134\(02\)00343-5](https://doi.org/10.1016/s0145-2134(02)00343-5)

# Introduction

adverse childhood experiences, psychological trauma, poverty, stigma, and discrimination. These factors need to be taken into consideration to fully understand the needs of this population and implement meaningful changes within the system.

In this report, 'people experiencing homelessness' refers most specifically to single adults experiencing homelessness, and covers those who:

- are sleeping rough;
- are temporary residents of a hostel, bed and breakfast (B&B), nightly paid, privately managed accommodation and other types of temporary accommodation;
- use day centres that provide support for people experiencing homelessness
- are obliged to stay temporarily with other people
- are squatting
- have a history of homelessness (as defined above) and are at high risk of becoming homeless again because of ongoing severe and multiple health and social care needs.

During these workshops, gender or age wasn't specifically discussed or considered as a factor impacting on registration, access or provision of care received. However, women fleeing domestic violence or those who have a history of sex working, may have additional barriers impacting their ability to engage with health services for example. Similarly, families and children experiencing homelessness, and young adults (aged 16-25) who often face challenges when transitioning between child and adult services, also fall outside the scope of this report. However, it is important to recognise that there is a significant number of children living in temporary accommodation who are not currently registered with a GP. Although some of the issues and recommendations outlined in this report could apply to women as well as families and children experiencing homelessness, further work specifically identifying and addressing the challenges for these specific groups is required.

This report is intended for inclusion health system partners working across the following sectors:

- Primary care
- Mental health
- Substance use
- Health and care service commissioning
- Acute and intermediate care
- Local authority
- Social care
- Community
- Voluntary, community and social enterprise (VSCE)

# Introduction

It provides a summary of key issues impacting access to services for people experiencing homelessness with multiple disadvantage and provides recommendations to be considered at the appropriate levels of the system, including place, primary care network (PCN), neighbourhood, borough, integrated care systems (ICS), regional and national level.

# Background

## Background to primary care workshops

The London Homeless Health Primary Care Steering Group was established in December 2021 and chaired by Dr Jasmin Malik and Dr Caroline Schulman, Clinical Leads for the London Homeless Health Programme within Transformation Partners in Health and Care (TPHC).

Three task and finish subgroups were formed and co-led by TPHC colleagues and ICB commissioners to tackle key priority areas identified by steering group members. These included:

1. registration, access, and provision of care in primary care;
2. training for clinical and non-clinical teams in primary care;
3. bringing together and working in a multi-disciplinary approach between mental health, substance use and primary care.

Between April and October 2023, three workshops were held covering each subgroup, with participation from system partners working across a wide range of sectors (primary care, mental health, substance use, commissioning, acute, digital, local authority, public health, VSCE and social care), with the aim to develop recommendations on key priority areas,

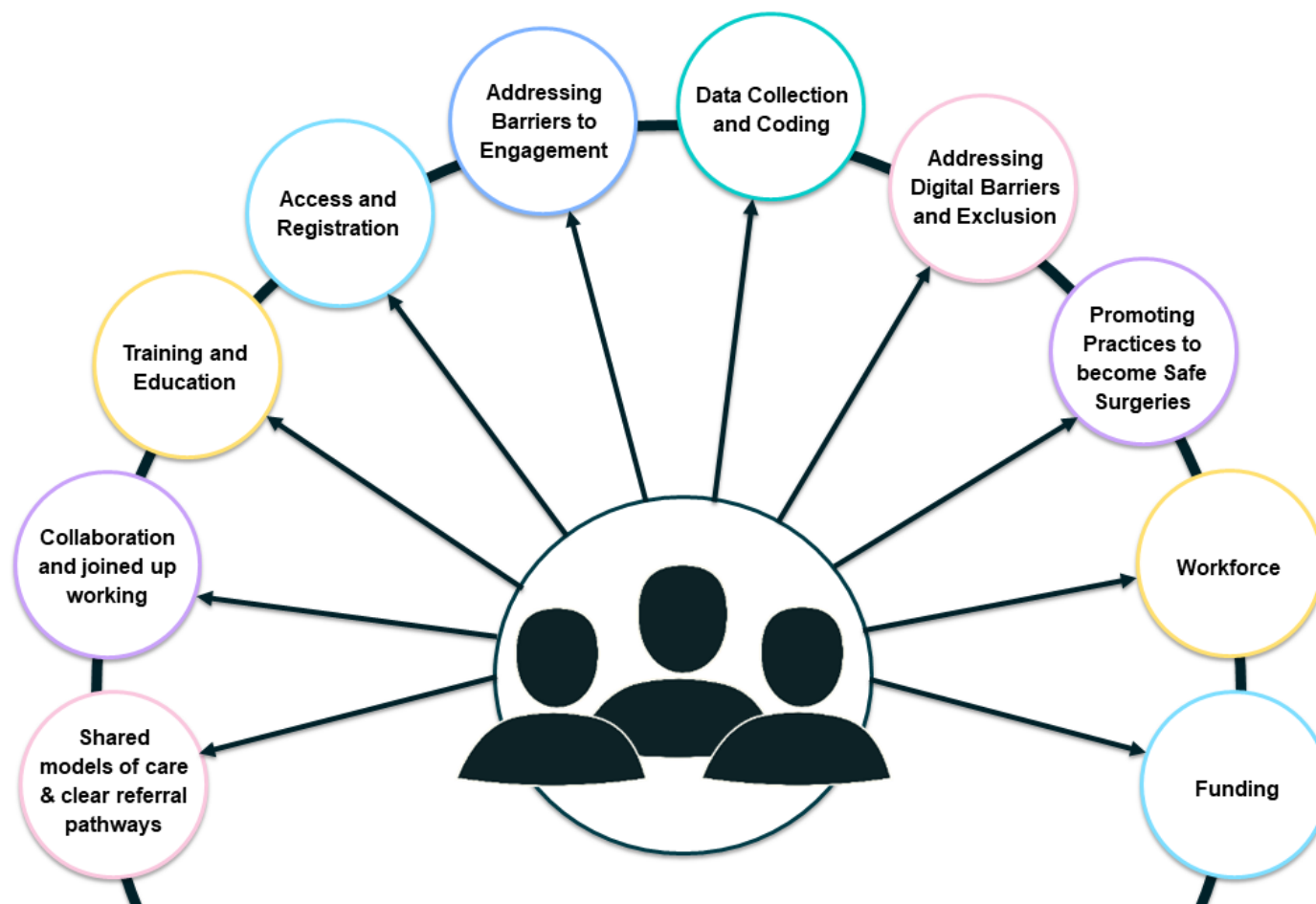
During each workshop, colleagues/partners heard from frontline practitioners who shared their experiences, as well as about outputs on existing work that has been considered as good practice. Discussions were had on some of the key challenges faced by individuals experiencing homelessness and their challenges with accessing services. Presentations from frontline practitioners demonstrated their commitment to quality, patient centred service and care.

Participants were asked to further identify key issues and challenges faced by people experiencing homelessness against respective subgroup priority areas, and to develop recommendations to address them. This report brings together and merges the overlapping themes and recommendations from the three workshops. There are ten priority areas with proposed recommendations for further consideration as part of next steps.

# Key issues & proposed recommendations

## Key issues and proposed recommendations

To understand the key themes and areas of focus, each of the key issues identified and proposed recommendations across the three workshops were amalgamated and the following ten priority areas emerged:





# Key issues & proposed recommendations

The following pages outline a collated overview and accumulative perspective of key issues identified and proposed recommendations relating to the ten priority areas by participants for further consideration. The individual workshop recommendations can be found on the Transformation Partners in Health and Care website.

Implementing the recommendations laid out in this report is not a statutory requirement, however, doing so will allow organisations to design and deliver services in a way that applies the fundamental rights of all people to be treated with dignity, compassion, and respect.

When reviewing the recommendations to inform decision-making discussions, it is acknowledged that system partners will need to consider the needs of their inclusion health population, the extent of their local service offer, the current landscape, and the most effective approach to delivering the improved outcomes that are central to working with this vulnerable population.

# Key issues & proposed recommendations: Shared care models

## 1. Developing shared models of care between organisations with clear referral pathways between services in the community

<b>Key issues</b>	<ul style="list-style-type: none"><li>• Inconsistency of approaches and pathways across the system.</li><li>• Lack of shared care type of approach between mental health, substance use and primary care – for prescribing and holistic management. Although there are some shared care agreements in place between primary care &amp; mental health relating to some mental health drugs, and between substance use services and primary care, there is inconsistent communication between primary care, mental health and substance use services making safe prescribing and clinical management difficult.</li></ul>
<b>Proposed recommendations</b>	<p>1.1. Create a homeless/inclusion health community of practice in each ICS/sub-region to:</p> <ul style="list-style-type: none"><li>• Review established homeless community healthcare teams already in operation, identify and share good local practice within ICSs and across region, and what can be replicated through other boroughs.</li><li>• Improve communication between primary care, community care and substance use services, with secondary care, as well as improving outcomes around safe discharge from hospital back into the community.</li><li>• Extend support and skills for inclusion health practitioners in both primary and secondary care and identify gaps on ground issues in local provision.</li><li>• Multi-professional teams to consider taking a proactive care approach for those with multiple disadvantage and co-occurring conditions such as those on the Target 1000 list held by the Greater London Authority (GLA) and Local Authority.</li><li>• Expand the area of work started at the Health, Housing and Social Care Summit. Local exploration of developing proactive care models that address health, housing and social care. Consider a mapping exercise to look at common themes where each sector overlaps, such as safeguarding.</li></ul>

# Key issues & proposed recommendations: Shared care models

	<p>1.2. Embed care navigation into referrals so that people who are referred to other services have improved chances of engagement.</p> <p>1.3. Sub-regions to develop multi-professional teams and multi agencies that include primary &amp; secondary care teams for physical, mental health, substance use services, adult social care and safeguarding, local authority rough sleeping outreach teams, as well as relevant VCSE agents.</p> <ul style="list-style-type: none"> <li>• Multi-professional teams to review referral pathways and approaches taken by the different agencies and address what is required to bring these in alignment with improving engagement.</li> </ul> <p>1.4. Consider establishing joint community clinics with primary care, community, secondary care, Local authority, voluntary sector, which are focused on supporting patients and each other. (e.g., community clinic in Barking).</p>
<b>Key issues</b>	<ul style="list-style-type: none"> <li>• Current sharing between services is very difficult as different systems do not talk to each other.</li> <li>• Weak relationships and poor understanding of purpose and benefit between primary care and the voluntary community and social enterprises (VCSE).</li> </ul>
<b>Proposed recommendations</b>	<p>1.5. Frontline teams to gain consent during consultations, or at the point of GP registration, to include hostel staff or support workers in key discussions.</p> <p>1.6. Support the assistance provided by key workers, care navigators, peer advocates and the VCSE when available. Link hostel staff with local neighbourhood teams. Assigned Case Manager to work alongside the client to aid with coordinating care &amp; collaborate with what the client wants and needs.</p> <p>1.7. Co-produce a homeless template and include it in the London Universal Care Plan. Address formal agreements for sharing information and unifying systems of communication.</p>

# Key issues & proposed recommendations: Shared care models

<b>Key issues</b>	<ul style="list-style-type: none"> <li>• Insufficient information on services available within the local community for patients experiencing homelessness.</li> </ul>
<b>Proposed recommendations</b>	<p>1.8. Review and develop information on services available within the local community so that this can be given to all patients experiencing homelessness when they approach acute sites. This can also be used by frontline teams to help direct patients/clients to support services.</p>
	<p>1.9. Promote the use of the Universal Care Plan for patients who are experiencing homelessness, to assist sharing of important health care plans between health services.</p>
<b>Key issues</b>	<ul style="list-style-type: none"> <li>• Current referral criteria and rigidity excludes a large proportion of people who are homeless, have co-occurring conditions and multiple disadvantage, resulting in significant challenges around engagement.</li> <li>• This lack of flexibility within referrals contributes to inability to address health matters and consequently causes disengagement.</li> <li>• This is most often seen for people who are homeless that have a dual diagnosis, in that it is not possible to obtain the mental health treatment and management that they require due to their drug or alcohol dependence.</li> </ul>
<b>Proposed recommendations</b>	<p>1.10. Consider where services can be streamlined and where the individual can self-refer, therefore bypassing the GP to receive care – this can then be outlined on the website. (Part of The Delivery Plan for Recovering Access to Primary Care [PCARP] implementation is a self-referral pathway for various services including MSK, audiology etc.).</p>
	<p>1.11. Mental health, drug, and alcohol services to adopt a no wrong door approach and recognise the interplay within co-occurring conditions and factor in a dual diagnosis approach to service delivery.</p> <p>1.12. Mainstream services to review their referral pathways and to consider what adaptations may be required to aid engagement for those facing homelessness. Examples can be learnt from the current</p>

# Key issues & proposed recommendations: Shared care models

	pilot work taking place around cancer screening adaptations for those who may be experiencing homelessness.
<b>Key issues</b>	<ul style="list-style-type: none"><li>• Weak relationships between primary care, hostels and other homeless services.</li></ul>
<b>Proposed recommendations</b>	1.13. If a GP practice catchment area has or is in close proximity to a hostel, temporary accommodation or other homeless services, practices should work towards improving their working relationships with these services to aid in engagement. This could be addressed at practice level or in collaboration with the PCN/neighbourhood teams. <ul style="list-style-type: none"><li>• Training for GP practices to help them recognise the limited time available from support teams, and that they may be supporting several clients at one time.</li></ul>
	1.14. Local Authority hostels to explore the role of a designated health champion who links in with the practice to aid engagement.

# Key issues & proposed recommendations: Joined up working

## 2. Collaboration and joined up working between primary care, community, and secondary care

<b>Key issues</b>	<ul style="list-style-type: none"><li>• Weak links between various services during hospital admission, e.g., mental health, substance use, adult social care.</li><li>• Weak links between emergency department (ED) teams and hospital psychiatric liaison teams, with poor communication between community teams, therefore potentially leading to unsafe discharges.</li></ul>
<b>Proposed recommendations</b>	<ol style="list-style-type: none"><li>2.1. Admissions process: Identify opportunities to strengthen links and build relationships between hospital and community services during admissions.</li><li>2.2. Strengthen links between ED, hospital psychiatric liaison and community teams to support with homeless cases and prevent unsafe discharges.</li><li>2.3. Use training hubs to support staff working in out-of-hospital settings to better integrate hospital and community services.</li></ol>

# Key issues & proposed recommendations: Training and education

## 3. Training and education

<b>Key issues</b>	<ul style="list-style-type: none"><li>• Limited understanding within mainstream primary care regarding education on the needs of people experiencing homelessness and multiple disadvantage.</li><li>• Lack of awareness and understanding of co-occurring conditions and multiple disadvantage by clinicians in primary and secondary care.</li><li>• Limited trauma-informed and psychologically-informed approaches within health care services.</li><li>• Lack of awareness of the health equity agenda amongst trainee GPs.</li></ul>
<b>Proposed recommendations</b>	<p>3.1. Introduce trauma-informed care training, with a focus on the vulnerabilities of people experiencing homelessness. <a href="#">Such as this free CPD-accredited training</a></p> <p>3.2. Create short educational video for GP practices around multiple disadvantage and how to engage this cohort. For example, having flexibility around appointments and offering alternate forms of booking an appointment.</p> <p>3.3. Introduce a crib sheet at reception desk to support staff with processes, e.g., registration, etc.</p> <p>3.4. Establish opportunities for site visits by reception staff to practices more likely to receive referrals of people experiencing homelessness or other inclusion health populations to boost knowledge and understanding.</p> <p>3.5. Develop training around coding and ensure consistency on entering information on the electronic patient records.</p> <p>3.6. Training for staff around care navigation.</p>

# Key issues & proposed recommendations: Training and education

	<p>3.7. Training for health care providers on how to address sensitive questions such as identifying those who may be experiencing hidden homelessness, for example, if someone is exchanging sex for accommodation.</p>
	<p>3.8. Include local inclusion health teams in acute, mental health &amp; community trust staff inductions to raise awareness, build an understanding of the needs of inclusion health populations and understand the implications of an unsafe or unplanned discharge.</p>
	<p>3.9. Homeless and Inclusion health training for all practice staff (clinical and non-clinical). This will empower front-line staff to better support people experiencing homelessness.</p>
	<p>3.10. Practices to consider signing up to become safe surgeries and adopt the principles into daily practice.</p>
	<p>3.11. Engrain Making Every Contact Count (MECC) within training and as part of daily practice.</p>
	<p>3.12. Identify channels to promote existing guidance on evidence-based good practice, e.g., NICE guidance.</p>
	<p>3.13. Incorporate information on local inclusion health teams as part of staff inductions in acute, mental health and community trusts to raise awareness, build an understanding of the needs of inclusion health populations and the implications of an unsafe or unplanned discharge.</p>
	<p>3.14. Training on using and accessing the London Care Record system that captures all health input from different organisations.</p>
	<p>3.15. Training and information should be provided on the how to adapt and engage people who are neurodivergent and experiencing homelessness.</p>



# Key issues & proposed recommendations: Access and registration

## 4. Access and registration

<b>Key issues</b>	<ul style="list-style-type: none"><li>Operating procedures within primary care potentially limit access (e.g., opening hours, appointment times and appointment length).</li></ul>
<b>Proposed recommendations</b>	4.1. Practice staff in mainstream services can help manage expectations with the patient in terms of potential delays between registration application, full registration (medical history is attached to the SPINE), and the first appointment with the GP. Suggestions to aid discussions and consultations if the patient is temporarily registered could be to enquire of any recent hospital admissions or documentation that may support the clinician during the consultation if patient data is not yet available through the SPINE.
	4.2. GP practices should register all patients unless their list is closed or there are reasonable grounds for refusal. These should not include a lack of ID, proof of address, immigration status or any protected characteristic.
	4.3. Whilst the full registration process is underway, practices can allow immediate and necessary clinical care and temporary registration is an option. Parameters for safe practice under temporary registration should be considered.
	4.4. If registration is refused by the practice, this should be recorded explaining the reasons. This should be communicated to the patient at the time of refusal.
	4.5. The reception team should have access to support within the practice or PCN to deal with registration queries (e.g., senior receptionist, practice manager or GP partner).
	4.6. Where possible, services to adopt a making every contact count (MECC) approach.

# Key issues & proposed recommendations: Barriers to engagement

## 5. Addressing the barriers to engagement

<b>Key issues</b>	<ul style="list-style-type: none"><li>• Organisations' frequent misunderstanding and misconception behind the challenges around engagement. Most people experiencing homelessness are seeking to achieve their basic level of physiological need and as such they are likely to prioritise seeking food/shelter etc. above other needs such as health (as can be outlined by Maslow's model of the hierarchy of need).</li><li>• On the ground, this translates as:<ul style="list-style-type: none"><li>- Finding a safe space to bed down for the night which may be in the borough or in a neighbouring borough. Sleep sites change.</li><li>- Soup kitchens and support networks that may be local or in another part of the region.</li></ul></li><li>• Appointment times in the early morning or late afternoon/evening, may not be the most appropriate.</li><li>• A lack of recognition that people experiencing homelessness are disproportionately neurodivergent compared to the general population which can impact their ability to engage.</li></ul>
<b>Proposed recommendations</b>	<p>5.1. Increase understanding of the barriers to engagement, and how delays in being seen can cause disengagement. If an appointment is offered sometime in the future, enquire of any support or key workers who may be able to assist them with attending. Also consider referrals to peer advocacy services (e.g., Groundswell) to aid attendance to appointment.</p> <p>5.2. Check with the patient how they would like to be reminded for their future appointment. If they do not have a phone, enquire if they have a key/support worker who can assist on their behalf, and if the patient is happy for them to be contacted.</p> <p>5.3. When appointments are being made, check which day of the week and times work best for the patient. Ensure sufficient time (double appointments) is available for the consultation.</p>

# Key issues & proposed recommendations: Barriers to engagement

	<p>5.4. Currently, there is some information available regarding GP registration on the London MECC (making every contact count). Further development of content page is recommended.</p> <p>5.5. Practices should offer support to complete registration forms for those who require assistance.</p> <p>5.6. Co-location of welfare, debt &amp; legal advice with health care. Also consider co-location with social care colleagues and voluntary sector services.</p> <p>5.7. Enabling outreach and in-reach into hostels. Joining up community clinics and providing outreach that takes into consideration the population they are trying to engage.</p> <p>5.8. Use events such as vaccination events to establish health and wellbeing events alongside welfare, food e.g., Street Fest in Islington and Haringey.</p> <p>5.9. Correspond with Care Quality Commission (CQC) colleagues about addressing their key lines of enquiry on homeless and inclusion health for practices when regulators attend for practice assessments.</p>
<b>Key issues</b>	<ul style="list-style-type: none"> <li>• There is limited education, training or patient information conveyed for the layperson and specifically developed for those experiencing homelessness.</li> <li>• An example of work being developed in this area includes the Cancer Alliances teams in London working jointly with Groundswell to develop a London-wide resource for people experiencing homelessness, to access bowel, breast, and cervical screening. This is supported by Local Authority and ICB teams.</li> </ul>
<b>Proposed recommendations</b>	<p>5.10. Develop information or education material appropriate to those experiencing homelessness for health issues and possible management. For example, how to address things such as wound care, respiratory health, musculoskeletal, post-operative care if you are homeless.</p>

# Key issues & proposed recommendations: Barriers to engagement

	5.11. Include information for inclusion health groups about their rights to health and social care services on the practice website.
<b>Key issues</b>	<ul style="list-style-type: none"><li>• Language barriers are a common issue with people who may be homeless or from other inclusion health backgrounds and can cause significant problems with understanding and engagement.</li></ul>
<b>Proposed recommendations</b>	5.12. Patient information leaflets to be available in multiple languages.
	5.13. Clarify with patient at the point of booking if interpretation is required. Use of language interpretation services. Details to be entered clearly by administration ahead of the consultation and appropriate consultation time to be provided. A note to be placed on clinicians list on appointment page if interpreter is required.

# Key issues & proposed recommendations: Data collection and coding

## 6. Data collection and coding

<b>Key issues</b>	<ul style="list-style-type: none"><li>• It is important to code correctly as a proactive measure in aiding the identification of individual health need, but also in demonstrating the scale of health need in a practice and PCN locality, as well as within an ICS and at region.</li><li>• Data is staying within the practice system, and although it helps the practice improve their provision of clinical care, limited amounts of data are going to any form of benchmarking. If practices within PCNs/boroughs/ICBs used the same coding and recording system imbedded in the homeless template, consistency with coding will significantly aid data extraction for demonstrating health need for this population across the local level. If consistency was achieved across all the ICSs in London, we would be able to develop a more accurate representation of health requirement for this population.</li></ul>
<b>Proposed recommendations</b>	<p>6.1. Training on coding to achieve consistency across services for people experiencing homelessness, enabling clinicians to identify people who may require a different approach (e.g., longer appointments, MECC approach), and to better develop the understanding of local populations and health needs.</p> <p>6.2. Consistent electronic patient record (EPR) coding from the point of registration of someone who is experiencing homelessness.</p> <ul style="list-style-type: none"><li>• Correctly identifying patients experiencing homelessness when registering them on the system so that they are coded appropriately. This can be at the point of registration or during the new patient health check.</li><li>• During the new patient check, enquire about and identifying if someone maybe 'hidden' homeless (training should address questions to be considered, for example, if someone is exchanging sex for accommodation).</li></ul>

# Key issues & proposed recommendations: Data collection and coding

<b>Key issues</b>	<ul style="list-style-type: none"> <li>EMIS/System1 and Electronic Patient Record (EPR) template on homelessness exists however codes need to be aligned with SNOMED codes.</li> </ul>
<b>Proposed recommendations</b>	<p>6.3. Consistent EMIS coding for people experiencing homelessness to enable clinicians to identify people who need a different approach (e.g., longer appointments). The current EPR homeless template to be reviewed and adapted according to SNOMED coding.</p> <p>6.4. Aim to include cancer screening within GP EPR templates for GP practices in NCL as a pilot and across London via Primary care teams. (Cervical, bowel and breast screening codes).</p> <p>6.5. Include nutrition screening tool within EPR homeless template; codes are not linked to urgent care records (999/111).</p> <p>6.6. Usage of the template as a health passport to allow easy access for patient and move information easily between services to support the new practice with their coding. Health passport is already used across mental health and learning disabilities services and will be piloted in Camden with their residing homeless population.</p> <p>6.7. Locally commissioned services have smaller paired version of the EMIS template – it is suggested that the codes used in those versions are pulled from the main EMIS template to meet standardised data set. For example, Camden’s EMIS template is very similar to the Islington outreach EMIS template – it has mandatory and non-mandatory fields.</p> <p>6.8. The EPR homeless template can be used to record consultations in patients’ medical records – therefore encouraging writing patients’ information in a more consistent and coded way rather than free text that may use various other codes which makes data collation difficult.</p>
<b>Key issues</b>	<ul style="list-style-type: none"> <li>At present, alternative provider medical services (APMS) practices across London are not collecting the same data nor using the same templates or tools.</li> </ul>

# Key issues & proposed recommendations: Data collection and coding

	<ul style="list-style-type: none"><li>• Having consistency across London's specialist homeless primary care practices would be helpful in benchmarking output as well as outcome measures. Moving towards the inclusion of qualitative outcome measures rather than only quantitative ones would aid in exploring more in-depth understanding of efficiency and level of service provision offered by a practice.</li></ul>
<b>Proposed recommendations</b>	6.9. Use KPIs not just as a measure of service performance, but as a measure to develop a more detailed picture in terms of true health needs that reflect the need of different inclusion health groups and engagement. This in turn will aid building a more detailed picture of the needs of this population across London. Develop a universal set of standards and outcome measures around data collection and KPIs for APMS practices across London. This to include both qualitative and quantitative data capturing.
	6.10. Future service contract to include sharing anonymised data to demonstrate needs across the patch and improve care at the practice, PCN, neighbourhood, borough and ICB level.
	6.11. Housing status should be included in all national health data sets, ongoing conversations with NHS Digital Services.

# Key issues & proposed recommendations: Digital barriers

## 7. Addressing digital barriers and exclusion

<b>Key issues</b>	<ul style="list-style-type: none"><li>• Digital barriers include e-consultations which do not take into consideration a person's limited phone data, or complete lack of access to online systems. The questions that require answering can cause challenges due to multiple irrelevant questions needing to be answered to progress to the next stage.</li></ul>
<b>Proposed recommendations</b>	7.1. Explore who is the lead developer for the e-consultation platform to suggest improvements in engagement in relation to people experiencing homelessness and a user's perspective.
<b>Key issues</b>	<ul style="list-style-type: none"><li>• GP websites often create barriers to engagement in their context and wording, for example, some GP websites ask for an address that someone has been living at or intends to live at for the next six months.</li></ul>
<b>Proposed recommendations</b>	7.2. Practices to review their websites to address any possible barriers to registration for people who are homeless or from other inclusion health groups.
<b>Key issues</b>	<ul style="list-style-type: none"><li>• As primary care is moving towards a more digitalised approach there is risk of creating further gaps in provision of care for inclusion health populations.</li><li>• Services need to be mindful of the impact and put in place approaches that can mitigate against these additional barriers.</li></ul>
<b>Proposed recommendations</b>	7.3. PCNs and neighbourhoods to look at ways of improving support to enhance engagement for this population i.e., if practices are using a digital platform an individual may require their support worker and support network to assist them with engagement. Not everybody will have a support system in place, therefore non digital options should be explored and implemented, including non-digital registration processes.



# Key issues & proposed recommendations: Digital barriers

	<p>7.4. Digital teams to produce easy digital access for patients and their support network to access the service. If digital solutions cannot be adopted, then offer an alternate approach for accessing the service.</p>
	<p>7.5. Practices should use communication methods based on the person's preferences and abilities (e.g., phone call, text message, email, letter, face to face).</p>
	<p>7.6. If hostel staff or key workers are assisting and supporting their clients to register online, the practice to provide support where required.</p>
	<p>7.7. Digital borough leads to create a resource sheet/website for GPs that contains a list of local services relevant to homelessness, with select referral links embedded in S1/EMIS.</p>
	<p>7.8. Borough/ICS digital leads to include cancer screening within homeless template on electronic patient record (S1/EMIS) templates.</p>
	<p>7.9. Develop health passports (e.g., the Camden health passport pilot) that incorporates the annual health checks - embedding a dedicated member of staff at each hostel to ensure these take place for every service user.</p>
	<p>7.10. Practices to correctly identify patients experiencing homelessness on the system so that they are consistently coded appropriately. This can be at the point of registration or during the new patient health check.</p>
	<p>7.11. During the new patient check, enquire about and identifying if someone maybe 'hidden' homeless (training should address questions to be considered, for example, if someone is exchanging sex for accommodation).</p>

# Key issues & proposed solutions: Safe Surgeries

## 8. Promoting practices to become Safe Surgeries

<b>Key issues</b>	<ul style="list-style-type: none"><li>• Safe Surgeries initiative not sufficiently embedded across primary care.</li></ul>
<b>Proposed recommendations</b>	8.1. Boroughs and ICS' to review the number of Safe Surgeries within their patch and look to promote practices signing up to the principles of the Safe Surgery initiative.
	8.2. Practices that are signed up as Safe Surgeries to appoint a lead to champion the initiative and include training in their practice induction process as well as forming part of their yearly practice refresher updates.
	8.3. Regional Clinical Lead to correspond with CQC colleagues to explore their key lines of questioning in relation to inclusion health, when interviewing practices during CQC assessments.

# Key issues & proposed recommendations: Workforce

## 9. Workforce

<b>Key issues</b>	<ul style="list-style-type: none"><li>• It is important to recognise that there is limited capacity within primary care as well as with social services, and that there is significant workforce fatigue.</li><li>• Asking more under these circumstances can cause workplace stress and mitigation is needed to avoid contributing to workforce burnout.</li></ul>
<b>Proposed recommendations</b>	9.1. Conduct a local review of workplace plans to increase capacity amongst primary care services.
	9.2. Conduct a local review of workplace plans to increase capacity amongst social services.
	9.3. Review of current local wellbeing initiatives in place. If nothing exists, consider local arrangements to address this and to make it available for frontline teams.

# Key issues & proposed recommendations: Funding

## 10. Funding

<b>Key issues</b>	<ul style="list-style-type: none"><li>• There are differing approaches towards addressing homeless and inclusion health needs between boroughs and ICSs across London. It is also recognised that funding is not consistent between boroughs and ICSs, which contributes to the vastly different approaches taken sub-regionally.</li></ul>
<b>Proposed recommendations</b>	10.1. Funding to increase the amount of peer advocacy and care navigation roles.
	10.2. Prepare funding bid via service development funding (SDF) (sometimes called 'System Development Funding') to support integrated neighbourhood working and streamline access to care and advice for health inclusion populations.
	10.3. Some practices are in boroughs which have locally commissioned services (LCS) or locally enhanced services (LES) in place. Commissioners to consider the benefit of having an LCS/LES in places where the prevalence of homelessness may be high. Where an LCS/LES exists, consider local reviews to ensure content and framework includes things outlined in workshop three around LCS/LES framework.
	10.4. Consider conducting a deep dive into current LCS/LES in place across London and exploration of content, providing a systematic review and recommendations for inclusions into future LCS/LES around homelessness.
	10.5. Some of the adjustments that would make the biggest impact e.g., longer appointments, outreach to street/hostel will need additional funding and may form part of an LCS – for borough or ICS consideration.

# Key issues & proposed recommendations: Funding

	10.6. Recognise limits within hostels and from hostel staff – further investment for “Health Champion” in hostels, and how they work with primary care teams to improve engagement.
	10.7. Extra payment for health checks for patients experiencing homelessness – This could be incorporated within an LCS/LES.
	10.8. Further consideration when designing a local LCS/LES - extra consultation time to make adopting a MECC approach more feasible.

## Recommended work underway

Over the course of the year, and in between the workshop sessions, some workshop actions and areas of work that would fall under the regional workload, have commenced by the regional clinical lead as well as some ICBs. This includes:

- Providing training and a presentation on homeless and inclusion health to London region's CQC colleagues. Following which, the clinical lead provided feedback to the national CQC key lines of enquiry around homeless and inclusion health that is planned to be published in the next financial year.
- Building on conversations between ICB colleagues and commencing plans for developing a homeless template for the London Universal Care Plan.
- Contributing to the development of a national training programme on homeless health and registration for non-clinical primary care staff.

# Next steps

## Next steps

When reviewing the recommendations to inform decision-making discussions, it is acknowledged that system partners will need to consider the needs of their inclusion health population, the extent of their local service offer, current landscape and the most effective approach to delivering the improved outcomes that are central to working with this vulnerable population.

Below are a few of the proposed recommendations from each of the ten priority areas with a breakdown of short, medium and long term deliverables which could be considered when having discussions within your own teams/organisations. A further breakdown of proposed recommendations in relation to the workshop they originated from, can be found in the subgroup reports found on the TPHC website.

- Short term: Relatively straight forward to develop and implement **within 6-12 months**
- Medium term: Further scoping required with development and implementation **within 12 months**
- Long term: Further scoping and on-going engagement required, and implementation may **be possible within 12-24 months**

Priority areas	Next step	Timeframe
1. Developing shared models of care between organisations with clear referral pathways between services in the community	Create holistic shared care model for primary care, mental health and substance use services.	Medium term
2. Collaboration and joined up working between Primary Care and Secondary Care	Create a community of practice in in each ICS/sub-region to share local practices, improve communication between primary and secondary care, as well as substance use services.	Short term
3. Training and Education	Introduce trauma-informed care training, with a focus on the vulnerabilities of people experiencing homelessness for all non-clinical and clinical staff.	Medium term
4. Access and Registration	Establish a key support contact within practices/PCNs for reception teams to go to for any enquiries e.g., registration.	Short term

# Next steps

5. Addressing Barriers to Engagement	Develop information/education material appropriate to those experiencing homelessness for health issues and possible management – for example – how to address things such as wound care, respiratory health, MSK, post-operative care if you are homeless.	Medium term
6. Data Collection and Coding	Aligning the EPR Homeless template with SNOMED codes and incorporating the template within GP practices.	Medium term
7. Addressing Digital Barriers and Exclusion	Develop the Homeless template for the London Universal Care plan, and incorporate information contained within the Health Passports (e.g. the Camden health passport pilot).	Medium/ Long term
8. Promoting Practices to become Safe Surgeries	Boroughs and ICS to review the number of Safe Surgeries within their patch and look to promote practices signing up to the principles of the Safe Surgery initiative.	Short term
9. Workforce	Review of current local wellbeing initiatives in place to identify any gaps and potential opportunities for improvement. If nothing exists, consider local arrangements to address this and to make it available for frontline teams.	Short term
10. Funding	<p>Subject to local provision, consider conducting a deep dive into current LCS/LES in place across London and exploration of content, providing a systematic review and recommendations for inclusions into future LCS/LES around homelessness.</p> <p>Embed Annual Health Checks within homeless LCS/LES and align with hostel/support staff who can assist with engagement and uptake.</p>	Subject to local provision



# Conclusion

## Conclusion

This report brings together the work co-produced between the Homeless Health and Partnership Programme at TPHC and commissioning colleagues from London's five ICBs over the course of 2023, incorporating the outcomes of the three regional workshops held around primary care and the homeless population in London. The workshops built upon research and work conducted in London over the past few years. Ten priority areas have been shown as important factors in transforming primary care for homeless and inclusion health groups, and recommendations have been proposed to both implement at ground level, as well as take further at system level.

Addressing the healthcare needs of individuals experiencing homelessness demands a collective and sustained effort across multiple sectors and levels of governance. By acknowledging and confronting the systemic barriers people encounter, such as stigma, discrimination, and fragmented services, we can begin to narrow the stark health disparities faced by this population. The recommendations put forth in this report serve as a practical guide for action, but their implementation will require ongoing collaboration, dedication, and innovative approaches from all stakeholders involved. Only through concerted and meaningful action can we move closer to a system where equitable access to healthcare is a reality for everyone, regardless of their circumstance.

During the final workshop, the concept of a London region primary care 'campaign' for change to improve registration, access, engagement and quality of care was discussed and favourably received. Taking on board the above recommendations and developing a theory of change model, could be a first step in developing this initiative. To ensure its sustainability, any campaign at London region, should align with national campaigns around primary care.

### *Limitations*

As indicated in this report and the three workshops on which its based, it could be said that the issues and recommendations proposed were based on the adult single male experience due to demographics of people experiencing homelessness. Similarly, as outlined, women, families, children and young people aged 16-25, were not explicitly discussed during the workshops. Although some issues and proposed solutions may apply to a universal experience of homelessness, further work should be done focusing on different demographics or intersections amongst those experiencing homelessness. Similarly, further work is needed to identify and address the barriers of other inclusion health groups in registering, accessing and receiving good quality primary care. These groups include people experiencing drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

# Conclusion

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