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Findings and implications for NHS primary care and integrated care commissioners

Maureen Crane, Louise Joly, Blánaid JM Daly, Heather Gage, Jill Manthorpe, Gaia Cetrano, Chris Ford and Peter Williams

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Authors

Maureen Crane, National Institute for Health and Care Research (NIHR) Policy Research Unit in Health and Social Care Workforce, King's College London

Louise Joly, National Institute for Health and Care Research (NIHR) Policy Research Unit in Health and Social Care Workforce, King's College London

Blánaid JM Daly, Special Care Dentistry, Division of Population and Patient Health, King's College London

Heather Gage, Surrey Health Economics Centre, Department of Clinical and Experimental Medicine, University of Surrey

Jill Manthorpe, National Institute for Health and Care Research (NIHR) Policy Research Unit in Health and Social Care Workforce, King's College London

Gaia Cetrano,National Institute for Health and Care Research (NIHR) Policy Research Unit in Health and Social Care Workforce, King's College London

Chris Ford, Retired general practitioner

Peter Williams, Department of Mathematics, University of Surrey

Integration, effectiveness and costs of different models of primary health care provision for people who are homeless: an evaluation study

Findings and implications for NHS primary care and integrated care commissioners

This briefing summarises the findings of an evaluation of the effectiveness and costs of different models of primary health care services in England for single people who are homeless (HEARTH study), and their implications for primary care commissioners and commissioners of integrated care and specialist multidisciplinary teams.

A separate briefing is available for primary care managers and practice staff: https://www.kcl.ac.uk/research/hearth

Full report: https://www.kcl.ac.uk/research/hearth

Summary report: https://fundingawards.nihr.ac.uk/award/13/156/03

Overview of study

The HEARTH study started in 2015 and fieldwork ended in 2019. It involved a mapping exercise across England of primary health care services for people who are homeless, followed by an evaluation of four common models in operation:

1. Specialist health centres primarily for people who are homeless (Dedicated Centres).
2. Mobile homeless health teams that hold clinics in hostels or day centres for people who are homeless (Mobile Teams).
3. Mainstream general practices that also provide targeted services exclusively for people who are homeless (Specialist GPs).
4. Mainstream general practices that provide 'usual care' services to the local population, including to people who are homeless (Usual Care GPs, included as a comparison).

Two Case Study Sites (CSSs) were recruited for each of the specialist models (1-3), and four for the Usual Care GP model. A total of 363 patients who had been homeless during the previous 12 months were recruited as 'case study participants' and interviewed three times: at baseline, four and eight months. At each interview, we collected information about their circumstances, health and service use in the preceding four months (totalling 12 months data). We also obtained medical records for 349 participants. We interviewed 65 CSS staff and sessional workers, and 81 other service providers and stakeholders.

Several outcomes were evaluated during the study to assess the effectiveness of the four Health Service Models. These included: (i) the extent of health screening (and evidence of an intervention if indicated) for six conditions, e.g. smoking, alcohol use, mental health and tuberculosis; (ii) the management of four 'Specific Health Conditions' (SHCs) that may be long-term or require integration with other services (chronic respiratory problems, depression,

alcohol problems and drug problems); (iii) changes over time in health and wellbeing; (iv) oral health status and receipt of dental care; (v) use of health and social care services over 12 months and service use costs; and (vi) satisfaction with the service by patients, practice staff and external agencies. Comparisons were made between models using regression analyses, adjusting for factors such as participant characteristics and CSS features. Statistically significant variations were found between models and between sites within the same model.

Case study participants

- Most (80%) of the 363 participants were men and their average age was 41.6 years.
- Almost three-quarters were White British or Irish; most (86%) were born in the UK or had British citizenship. A small percentage (6%) were born outside the UK and had no recourse to public funds.
- Health and substance misuse problems were prevalent (this partly reflects the study sample which was recruited from primary care services). Nearly all (95%) reported physical health problems, and 91% mental health problems. Using NICE's classification of alcohol consumption[1], 11% were 'hazardous' drinkers and 32% were 'harmful' drinkers. Three-fifths (60%) reported drug problems, including 23% who injected drugs. Many described both mental health and substance misuse problems.
- Almost one-tenth (9%) had been homeless for less than one year, while 32% had been homeless continuously or intermittently for 10 years or more.
- At their baseline interview, 52% were staying in a hostel or supported accommodation, 21% were sleeping rough, and most others were in makeshift living arrangements such as bed-and-breakfast hotels. Many changed accommodation several times during the study, and some moved to different locations and changed GP.

Performance of the Health Service Models

Key findings

- Outcomes for **Dedicated Centres** were consistently among the best. Many factors are likely to have attributed to their success. Dedicated Centres worked primarily with patients who were homeless and had fewer registered patients than most mainstream general practices. They provided flexible and holistic services, such as drop-in clinics, longer than customary GP consultations, outreach, and on-site mental health, substance misuse and social services. They were well-integrated with homelessness sector services and local hospitals.
- With regards to the **Specialist GP** model, outcomes for one site (SP1) were comparable to those of Dedicated Centres, but the other site (SP2) performed less well for health screening and continuity of care. Service delivery factors are likely to have attributed to performance differences. SP1 provided similar services to Dedicated Centres for patients

who were homeless, namely designated nurses and caseworkers, on-site specialist services, clinics in hostels and day centres, and street outreach. SP2 ran a weekly clinic at homelessness services but, according to CSS staff, insufficient resources prevented them undertaking more intense work with patients who were homeless. It also had no on-site substance misuse service.

- **Mobile Teams** comprised specialist nurse practitioners but no GP, and patients were encouraged to register with a local general practice. Compared to other models, Mobile Teams scored less favourably for health screening and continuity of care for long-term conditions, even when interventions by GPs were included. Service delivery factors are likely to have attributed to poor performance for some outcomes. Whereas health care by Dedicated Centres and Specialist GPs was delivered by GPs and nurses from the *same* general practice and patients were registered with a *single* primary health care provider, Mobile Team participants received health care from *both* Mobile Team nurses and a separate general practice. Moreover, patients of each Mobile Team were not registered at a single general practice, and therefore Mobile Team nurses had to coordinate care with several general practices.
- **Usual Care GPs** scored favourably regarding health screening but performed less well with regards to continuity of care for long-term conditions and patient satisfaction. This model operated very differently to other models, and service delivery factors are likely to have had an impact on outcomes. The CSSs had no dedicated staff or targeted services for patients who were homeless. There was no street outreach or clinics in hostels, and CSS staff had few links to homelessness sector services. According to CSS staff, insufficient resources prevented them from working in more proactive and targeted ways with patients who were homeless.

Service use and costs

- Dedicated Centre participants had substantially more GP contacts and nurse contacts during the 12 month study period than participants registered in the other GP-led models. Participants recruited through the Mobile Team model had the most contacts with nurses, and fewer GP contacts than all other participants except for those attending Usual Care GPs. This pattern of service use was reflected in costs, and to some degree in outcomes. Dedicated Centre participants incurred significantly higher costs than all other participants and, as described above, outcomes were among the best. The Usual Care GP model was associated with the lowest costs and provided less continuity of care and lower patient satisfaction. The two case study sites in the Specialist GP category displayed variability, one being aligned more with the Dedicated Centre model, the other providing only a few targeted services for patients who were homeless. The Mobile Team model is not directly comparable to the other models.

What needs to happen

- Although Dedicated Centres had the most favourable outcomes, this model may only be financially viable in locations with considerable numbers of people who are homeless. The benefits of enhanced and targeted primary health care services that encourage engagement and integration, such as drop-in clinics, lengthening contact time with patients and outreach, should be taken into consideration when commissioning primary care services for people who are homeless. One of the Specialist GP sites performed as well as Dedicated Centres when such services were in place.
- The relatively poor performance of Usual Care GPs for some outcomes raises questions about their capacity to support patients who are homeless, and the threshold at which additional support for practice staff is required. It might be time to rethink the capitation formula for patients who are homeless, and to introduce a 'homelessness lead' into mainstream general practices that have several registered patients who are homeless. Such a role would involve a clinician having responsibility for such patients and facilitating more targeted and integrated care on their behalf. NICE similarly proposed 'homelessness leads' in mainstream services to coordinate care for patients who are homeless.[2] Commissioners should also be guided by self-audits of usual care provision by primary care networks, and local health and social care needs assessments (see below) about when a more enhanced service is required.
- Consideration needs to be given to the function of Mobile Teams and whether they would be more effective operating as part of a GP practice rather than the current arrangements (Mobile Team plus separate GP). It would mean patients would be registered with a single primary health care provider, have a fixed site from which to obtain health care, and there would likely be improved collaboration between GPs, nurses and other practice staff. It would be important that the outreach element of the Mobile Teams' work continued.

Access to mental health services

Key findings

Across all models, mental health problems were common among study participants (see secin on case study participants).

CSS staff and external agencies from *nine out of ten* (90%) of the CSSs reported that mental health treatment services were poorly available in their area, and this was affecting patients' health and the work of primary care providers. Shortcomings included:

- Long waits for people to be assessed and start treatment;
- Insufficient services for people with mild to moderate mental illness;

- Long waits or barriers to services for people with combined mental health and substance misuse problems; and
- Lack of community mental health nurses and hospital provision.

What needs to happen

- Commissioners need to consider ways to improve the availability of mental health services in their local area for people who are homeless. This should include coordinated treatment and care for people affected by concurrent mental health and substance misuse problems.

Oral health and dental care

Key findings

- Across all models, poor oral health was common, many participants did not seek dental care, and dental pain and other dental needs were unaddressed. At baseline, most (82%) participants reported needing dental treatment, yet only 39% were registered with a dentist. Over the study period, dental registration rates increased slightly to 49% but many participants did not seek help, and more than three-quarters (77%) reported unmet dental needs at eight months.
- Compared to the general population, dental anxiety and dental phobia were more common among HEARTH participants. Dental fear was the main reason given by participants for not seeing a dentist. Other common reasons included having other priorities, and embarrassment about the state of their teeth or about being homeless.
- NHS dental services specifically for people who are homeless or vulnerable were available at or nearby several CSSs, but many participants did not use these services. There was little integration or established formal networks between most CSSs and dental services.

What needs to happen

- Oral health care should be integral to health and social care commissioned for people who are homeless. Health care commissioners should work collaboratively with local heads of community and special care dentistry services to ensure responsive and accessible dental care.
- The most effective configurations of dental care for people experiencing homelessness need to be explored. At present arrangements vary, from dental services being co-located with other homelessness service provision, to special care dentistry in the community, and NHS dental practices for the general population.

Local assessments of health and social care needs

Key findings

- In many localities, CSS staff and external agencies reported increases in the number of people sleeping rough or staying in temporary accommodation, and in the complexity of health and substance misuse problems among people who were homeless. Several front-line workers were aware of people sleeping rough who were not engaged with health services.
- The mapping exercise found that around one-half of hostels and day centres in the homelessness sector were not linked to a specialist primary health care service, and people who were homeless in these areas relied on mainstream general practices. In these areas, just over half (57%) of hostel and day centre managers reported their service users had difficulties accessing primary health care, including registering with a GP and arranging GP appointments. This applied to all NHS regions.
- In some locations restructuring of homelessness services and the closure of several hostels had resulted in people who were homeless being dispersed to small temporary housing schemes or sleeping rough outside city centres. CSS staff reported difficulties maintaining contact with these patients and their keyworkers.

What needs to happen

Through Integrated Care Systems, it is important that primary care and integrated care commissioners work with commissioners from other sectors, such as housing and public health departments, to plan and fund health and care services for people who are homeless as well as for the general population in their area. This requires *regular* reviews and analyses of:

- *The scale and nature of homelessness in a locality over time*, including numbers of people who are homeless, their use of temporary accommodation and rough sleeping, and their movement into and out of an area.
- *The characteristics and needs of people who are homeless,* particularly demographic features, health and substance misuse problems, housing and social care needs, and the extent to which their needs are being met.
- *The availability, capacity and performance of mainstream and specialist primary health care services for local people who are homeless,* including their accessibility and flexibility, their success in engaging with this patient group, and their integration with other health, social care and homelessness services.

Monitoring and evaluation of services

Key findings

Specialist primary health care services for people who are homeless have been established in England since the 1980s and have become more widespread since 2000. However, there have been few evaluations of these services to determine their effectiveness in meeting the needs of this patient group. The HEARTH study found:

- Different methods were used by CSSs to measure performance and outcomes. Some relied on indicators from the Quality and Outcomes Framework (QOF), while a few used other measures. The QOF is a voluntary annual reward and incentive programme for general practices which identifies practice achievement levels rather than performance management. It also does not capture the problems experienced by many people who are homeless. For example, QOF indicators referring to alcohol use pertain only to people with hypertension or serious mental illness. Mobile Teams are unlikely to use QOF unless they are part of a GP practice.
- Two Usual Care GPs used a computer based 'homeless template' to assess the needs of patients who were homeless and had relatively high scores for health screening (comparable to Dedicated Centres). This suggests the benefits of such an assessment tool.
- There were mixed views among CSS staff and external agencies about the merits of having regular health clinics in hostels and day centres. Apart from one Dedicated Centre, CSS staff in the three specialist models but not Usual Care GPs held such clinics. The staff believed these clinics are invaluable in encouraging people who are homeless to attend a GP surgery, and in delivering basic health care if a person declines to do so. Some questioned, however, whether such clinics should be available to *all* hostel residents and day centre users, or whether it deters use of general practices. Furthermore, the health care that can be provided in such settings is limited, and some settings lack suitable facilities for clinical work.

What needs to happen

- The inclusion of effective monitoring and evaluation of services in the commissioning process are critical. According to the Royal College of General Practitioners,[3] commissioners should be able to determine which services are working effectively, and those that are not meeting their objectives.
- As proposed by the Faculty for Homeless and Inclusion Health, locally designed key performance indicators to cover health screening and access to treatment should be drawn up to capture the work undertaken with patients who are homeless.[4] NICE also recommends that commissioners should define and measure health and social

outcomes and service use, when developing services for people experiencing homelessness.[2]

- Consideration should be given to the role and frequency of outreach clinics held by health workers in hostels and day centres for people who are homeless.

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