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An exploration of GP care in outreach settings for people experiencing homelessness: a qualitative study

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Abstract

Background

Although people experiencing homelessness (PEH) have the worst health outcomes in society, they have a low uptake of primary care services. GP outreach has developed as a way of increasing access into primary care but little is known about the experience of patients receiving care in this way.

Aims

1) To explore homeless patients' experiences of GP care in community outreach settings in UK;

2) To seek staff/volunteer views on the strengths and weaknesses of the GP community outreach services.

Design and setting

A multi-method qualitative study with PEH and staff/volunteers working in 3 different community outreach settings in the UK.

Method

Individual semi-structured interviews with 22 PEH and two focus groups with key staff/volunteers. Data was analysed thematically using framework analysis.

Results

GP outreach services better enabled PEH to access medical care and staff/volunteers valued GP support to promote, and facilitate access to, health care services. In particular, findings illuminate the high value that PEH placed on the organisational environment of the GP outreach service. Valued aspects of GP outreach were identified as: 1) comfortable, safe and engendered a sense of belonging; 2) convenient, opportunistic and a one stop shop; and, 3) being heard, having more time and breaking down barriers.

Conclusion

Organisational environment is important in enabling PEH to engage with GP services. The physical and organisational environment of the outreach settings were the most important factors: they created a space between the GP and patients where professional barriers were flattened and facilitated a therapeutic relationship.

How this fits in

Although people experiencing homelessness (PEH) have the worst health outcomes in society, they have a low uptake of primary care services. GP outreach has developed as a way of increasing access into primary care but little is known about the experience of patients receiving care in this way. By exploring the experiences of PEH and staff/volunteers working within community outreach settings, this study uncovers the reasons why PEH engage with GPs in a community outreach setting but not a specialist or mainstream GP service. Clearly, physical space and organisational environment are important factors. These findings can help to inform GPs caring for PEH to build an environment which supports the development of stronger doctor-patient relationships within the confines of their current system.

Introduction

Homelessness has been recognised for over a decade as a healthcare issue[1]: it is a 'late marker' of severe and complex disadvantage[2] and the result of enduring health and social inequities[3]. A 2014 health audit of over 2500 people experiencing homelessness (PEH) in England found a higher prevalence of physical, mental and substance misuse issues in the homeless population compared with the general population[4]. Standardised mortality rates for excluded populations, including PEH, are 7.9 times higher for men and 11.9 times higher for women[5]. PEH are at increased risk of non-communicable diseases[5], infectious disease[6,7] and multimorbidity[8].

Nonetheless, PEH often experience substantial barriers to accessing health care and report feeling excluded from health services, including mainstream substance misuse and mental health services[9,10]. Barriers to accessing mainstream primary care services include inflexibility of the health care system [11], negative staff attitudes[12], difficulties with GP registration following hospital or prison discharge[8] and a lack of specialist primary care centres for homeless people (SPCCHP). While continuity of care from secondary to primary care is recognised in the UK as crucial for PEH[13], the reality is often discharge to the streets, resulting in the fragmentation and delay of treatment.

Nearly one in three deaths of PEH are due to causes amenable to effective health care interventions [5] and GPs play an important role in homelessness prevention[6]. The first data linkage study in Scotland between health and homelessness services found that, in the months immediately preceding a first episode of homelessness, visits to mainstream GP services increased [14]. Nonetheless, it seems that preventative opportunities are often missed. While SPCCHP exist in many areas[15] - increasing access to health care services for those who engage [9] - many PEH do not access primary care services at all, exacerbating already poor health outcomes and increasing the risk of premature death[8]. This is particularly concerning given the steep rise in the numbers of PEH in the UK since 2010[16]– particularly in England - and the projected recession following the COVID-19 global pandemic, which is expected to trigger a wave of newly-homeless people as unemployment increases and people are unable to secure affordable housing[17].

In response to these challenges, GP outreach services to hostels, the streets and day centres have been developed to increase access to primary care services for PEH[15]. As these services have developed in an *ad hoc* manner, they vary greatly in scope of provision across different areas, and little is known about the experiences of PEH when GP care is delivered in this way. This study sought to more fully understand what PEH and front-line staff/volunteers working in community settings value about GP outreach services, so that primary health care services can be improved to meet the needs of PEH and reduce health inequalities.
Research aims: 1) to explore homeless patients' experiences of GP care in community outreach settings in England and Scotland; and, 2) to seek staff/volunteer views on the strengths and weaknesses of the GP community outreach services.
Research questions: 1) What are the enablers and barriers to using GP outreach services as experienced by PEH? and, 2) What do staff/volunteers see as the advantages and disadvantages of a GP service in an outreach setting?

Methodology

This study used an interpretivist approach to explore the experiences of PEH when using the GP outreach services. Interpretivism is based on an understanding of human experience that relies on the reflection and interpretation of lived experience to uncover how participants make sense of their individual and social worlds.

Interpretivism seeks to understand these experiences within the context of people's lives, as opposed to methodologies that seek to create an objective statement of the experience itself [29]. Therefore, consistent with interpretivism, this study sought to recognise meaning from the experiences of PEH and staff/volunteers of GP outreach service from their point of view. Themes and ideas are derived from the analysis of the data and hence the interpretation is grounded in, and supported by, the data.

Design

A multiple-method qualitative study was conducted with two phases and took place between May-September 2017. Phase one involved semi-structured face-to-face interviews with 22 PEH. Phase two involved conducting two focus groups with key staff/volunteers. Key staff included those working in 3 different community settings in the UK: one in Scotland (setting 1) and two in Northern England (settings 2 and 3).

Sampling

Convenience sampling was used to invite people who had used the GP outreach service - and were currently, or recently, homeless - to explore their experiences. Sampling across three different settings ensured a range of experiences were reflected in the interview data. Key staff/volunteers were invited to participate in two focus groups (setting 1 and 2) to explore their views on the GP outreach service. Study information posters were displayed in all 3 settings and community setting staff/volunteers explained the study to participants and invited them to participate. Prior to data collection, written consent was obtained and, where written consent was not possible due to poor literacy, oral consent was obtained and recorded digitally. All participants in the interviews were assured of anonymity and confidentiality, and pseudonyms used throughout. In the focus groups, participants were reminded to maintain confidentiality within the group in accordance with good ethical practice. Interviews and focus groups were conducted in a private room in the community settings and PEH were given £20 supermarket shopping vouchers in appreciation of their time.

Participants

Of the 22 PEH interviewed, (10 in the Scottish setting; 12 in the English settings), 15 were male; 7 female and 15 were UK born; 5 were born abroad (3 EU nationals; 2 refused asylum seekers). The ages of participants ranged from 19 – 60 years old. PEH who identified as currently homeless were either street sleeping, living in boarding houses or hostels. For those who had recently been homeless, they were now living in their own tenancy.

While the researchers did not explicitly ask about health needs, the participants disclosed a range of physical and mental health issues, including harmful substance use, infectious diseases, coronary artery disease and diabetes, depression, anxiety and bipolar disorders. All of the participants in the interviews had been to see the GP in the outreach setting in the last year, varying from one visit to regular weekly visits.

Of the 2 focus groups conducted with staff/volunteers, one focus group took place in the Scotland (n=4 staff) and one in setting 2 (n=7 volunteers). Both focus groups explored the reasons staff/volunteers thought that PEH came to see a GP in this community setting.

Data analysis

Interviews and the focus groups were recorded and transcribed verbatim. Individually identifiable data was removed and data analysed thematically using framework analysis, involving 5 stages of analysis: 1) familiarisation with the data; 2) construction of an initial thematic framework; 3) sorting and indexing the data; 4) creating a framework matrix; and 5) comparing and interpreting the data [18]. Framework analysis is not attached to any particular theoretical or epistemological position and provides a structured and rigorous process of data management, whilst simultaneously offering a flexibility that can be applied to a variety of research interests and theoretical positions to facilitate the analysis of patterns or themes within the data [29]. A distinctive feature of framework analysis is that it forms the basis of a series of thematic matrices where data can then be compared and contrasted, which allowed the researchers to move back and forth between different levels of abstraction without losing sight of the raw data. Data was analysed by both

researchers, individually and then together, to ensure the framework was agreed and consistent across the whole data set. Data was organised using NVIVO 10 software.

Results

This study found that GP outreach services better enabled PEH to access medical care, with additional benefits in supporting staff/volunteers in community settings to give better health advice. This was consistent across all three settings, which is interesting given the differences between the day centre and the food bank settings. The reasons that PEH engaged with health care services in outreach settings, but would not attend SPCCHP or mainstream GP practices, was reported as being due to the positive physical, social and organisational environment of the outreach settings. Compared to GP practices, outreach settings were reported as being: 1) more comfortable, perceived as safer and engendered a sense of belonging; 2) were convenient as they brought services together as a 'one stop shop' and, 3) patients felt that they were listened to more as the outreach environment was more relaxed and the GPs had more time.

While the staff/volunteers noted a lack of clinical tests and treatment facilities in the community outreach settings, they recognised it as additional to the SPCCHP, rather than a replacement service. Staff/volunteers said that they valued the support GPs gave them to better meet the ongoing health care needs of their clientele and to facilitate access to health services.

1. **Comfortable, safe and a sense of belonging; 'It's just like one big family'**

Participants came to see GPs in the outreach settings because they reported that they felt comfortable, safe and a sense of belonging. This was contrasted with mainstream GP or SPCCHP services, which were often seen as places where the waiting rooms were restrictive, stressful and heightened tensions. Staff/volunteers noted that in the community outreach settings, the participants didn't have to sit silently waiting for the GP - which made them feel frustrated, often exacerbating underlying mental health problems. Instead, they engaged with support workers and/or volunteers and had other meaningful activity while waiting to see the GP, such as washing clothes or collecting food.

1.1 Comfortable

The participants reported feeling more relaxed at the outreach setting when compared to the SPCCHP. It felt less formal and more familiar – some even described it as their 'own environment'. The staff/volunteers at the outreach setting noted that PEH appeared relaxed and felt this enhanced the doctor patient relationship. The staff/volunteers were an integral part of creating this friendly welcoming environment.

'They go into the doctors and sit in a formal room…and they find it hard to say what is wrong with them in that sort of environment. I think when they come in this environment they are already relaxed and calm and probably more truthful with the doctor.' [Eng, Volunteer]

Participants all reported the difference it made to have someone to talk to in the outreach setting, whether staff/volunteers or other guests, and this changed the atmosphere to make it much more conducive to waiting for the GP.

'It's ok going to the GP surgery but, when you go to the GP surgery, you are just sat there, you know, and there is nobody talking to you. Here it is different, you are free to talk, you know, like people to talk to while you are waiting. That's a really good thing, it calms you down as well.' [Scot, PEH, 28]

1.2 Safe

Many participants reported difficulties in SPCCHP GP waiting rooms with meeting people who were 'drug dealers' and from a 'previous life', so they avoided the GP surgeries. This heightened the tensions within GP surgery waiting rooms and several participants reported feeling unsafe – threatened or intimidated – as SPCCHP GP waiting rooms did not have any support workers to mediate the space.

'I hate going to the [SPCCHP] surgery as you're trying to get clean and there's dealers there and agro and it's nae right, you know. It's nae a good place to be and you can get threatened and fights and everything' [Scot, PEH, 34].

In addition, participants felt that they were treated with respect in the outreach settings, whereas many PEH felt that there was a lack of respect by staff at mainstream practices.

1.3 Sense of belonging

A sense of belonging that the support workers/volunteers engendered was clearly valued in the outreach settings: participants felt like they were 'part of one big family'. Of particular value was: being known by name; having a relationship with the support workers/volunteers; and a feeling of equity. In the GP service, many participants said that they felt ignored, just waiting around for the GP, but in the outreach setting they were noticed and welcomed.

'When I walk through the door I get greeted, you know, normally by name, and they (the volunteers) ask me how I am doing and stand and chat and they will ask me if I need the doctor or anything else that is here that day' [Eng, PEH, 60].

Relationships with staff/volunteers appeared to be important in facilitating engagement with the GP and outreach settings. Staff/volunteers talked about the priority they placed on getting to know people who used their services:

'We try to get to know people, to speak to them and, if they open up, to help them to access what they need. Some never go to the GP but really need to, so we try to help them. It's all about building up trust so people open up to you.' [Scot, staff]

Participants reported that they were more likely to see the GP if encouraged by a member of staff that they trusted.

2. Convenient, opportunistic and a one stop shop; 'It's a bonus thought here'

Health needs were often a low priority for PEH, even though some of the participants had severe health needs. Participants prioritised washing clothes, collecting food and having a cup of tea/food. Health care was seen as an opportunistic event that was good-to-have if available, but not something to especially seek out.

'I come here for a shower and breakfast, not to see a doctor, but if there's one here, then I might as well and they've started me on some pills now….I never really went to the doctor before.' [Scot, PEH, 32]

As a result, the GP outreach settings were seen as convenient places to see the GP and a 'one stop shop' for health care, food, washing and other needs.

2.1 Convenient

Participants said that they found the GP appointment system in mainstream services particularly difficult to negotiate, especially for those who were street sleeping. Many were awake late into the night and slept for much of the morning when the streets were safer, so they could access the community outreach settings as a drop-in whenever it was convenient for them.

'Sometimes it is difficult to get up at nine o'clock because of whatever circumstances you are in, so it is easier just to see the doctor here [outreach setting]…there is always a meeting place where you can meet them where it is actually convenient for you, you know what I mean' [Scot, PEH, 36]

Staff/volunteers noted the importance of meaningful activity available at the outreach setting.

'It's all a bit formal isn't it (at the doctors surgery), and a bit stuffy. They feel dirty, they feel unclean…they don't fit. Here they can have a cup of tea, have their breakfast, see the doctor, have some lunch, they can chat…' [Eng, Volunteer]

2.2 Opportunistic and a 'one stop shop'

As health care was not a priority for many PEH, participants highlighted the convenience of seeing a GP at the outreach settings and were actively approached by the support workers/volunteers or the GPs themselves to ask if they would like to see a GP.

'There are several people here who have never been to see the GP and just won't go. I don't know why – maybe a trust thing or bad experience in the past. If we can

get to know people and build up trust, they will see the GP here and then go up to the surgery' [Scot, staff].

'*I stumbled across it (the GP outreach service) at first. I was just told it was a food place and they clothe you and give you sleeping bags and what not because I was on the streets when I first came and then I got told there was a doctor here and they came round with a form and I put my name down.'* [Eng, PEH, 40]

Staff agreed that it was very convenient for PEH to see a GP at the outreach settings but also cautioned that this 'open access' system wouldn't work if numbers increased.

3. **Being heard, having more time and breaking down barriers; 'Less of a white coat syndrome'**

Both staff/volunteers and patients noted that the relaxed, non-clinical atmosphere within the outreach settings contributed to good communication between the GPs and the patients, resulting in stronger relationships and the breaking down of barriers.

'When the doctor started coming here, it changed their attitude towards GPs…they felt safe in this environment to talk to them' [Eng, Volunteer]

3.1 Being heard and having time

Participants reported feeling grateful that the GP had come to see them in 'their environment'. At the outreach setting, the GP was afforded more flexibility in their working. This allowed them more time to tailor the sessions to the particular needs of the patients on the day. This resulted in participants feeling less rushed by the GP and that their needs were being individually met.

'A homeless guy actually said 'Darren, there is a place up there where you can get a sandwich for free and there is actually a doctor what will sit and listen to you and not just give you a prescription and rush you out the door'' [Eng, PEH, 49]

While SPHCCs often have longer appointment times than mainstream GP services, the participants really appreciated the flexibility the outreach settings afforded the GPs to give time to listen to their concerns and address their needs.

3.2 Breaking down barriers

The organisational culture of the outreach settings broke down barriers between the GP and the participants in several ways: 1) the GPs were in a regular office space, not a clinical room, and so it was familiar to patients; 2) the GPs sat with the participants in the social spaces and were able to informally talk with people as they got food, drank tea and used the computers, encouraging them to come to see the GP; and, 3) the GPs were indistinguishable from the staff/volunteers in appearance, so the participants found them much more accessible than in the formality of a GP practice**.**

'The GPs are just like us – they sit out here [in the social space] and just chat to people until they trust them and then they will go and see the GP' [Scot, volunteer].

'It (GP outreach) is far more approachable, you know, there doesn't seem to be… I-am-a-doctor, I-am-a-nurse. You know, it's I-am-a-person, you-are-a-person , what's wrong with you? Which is the way it should be' [Scot, PEH, 58].

'Here [the outreach setting] it is far more approachable and friendly sort of atmosphere…a bit less of a white coat syndrome' [Scot, PEH, 46]

Discussion

Summary

This study examined the experiences of PEH in accessing GP services in community outreach settings in Scotland and England, including staff/volunteer views on the strengths and weaknesses of GP outreach. Findings show that the organisational environment is important in enabling PEH to engage with GP services, challenging the notion that lack of engagement with primary care services by PEH is due to people having 'chaotic' lives [19]. The physical built space and the organisational environment within the outreach setting were the most important factors in enabling PEH to engage with GP outreach services. Combined, these two factors created a

space between the GP and patients where professional barriers were flattened, and time was made available to nurture a therapeutic relationship. In addition, PEH were supported by staff/volunteers in the social areas to engage with the GP. While this study cannot comment on clinical outcomes for PEH, it can be assumed that engagement with GP services is a first step to accessing preventative care and treatment.

The findings from this study have important implications for clinical practice, as they call attention to the importance of the physical and organisational environment of health care delivery beyond merely the communication skills of the individual GP. While many studies have demonstrated the ways that inflexible systems and stigma act as a barrier to primary health care for PEH [15], this study highlights the importance of the built and social environment. In order for PEH to be able to engage with primary health care services, the waiting room space needs to have flexible time scales, meaningful activity available, staff/volunteer support and a welcoming atmosphere. It is also advantageous if services and facilities are together in one place, as PEH do not prioritise health care needs over other immediate needs [20,21].

Strengths and limitations

In exploring the perspectives of PEH and staff/volunteers in community outreach settings, 3 different settings were used in both Scotland and England, which enabled comparison within different practice contexts. Saturation of in-depth data occurred after 20 interviews and 2 focus groups, with no new themes emerging. The use of rigorous framework analysis increased the trustworthiness of the data.

Limitations: a purposeful sample would have ensured a wider range of different experiences were heard but it was only possible to recruit from a convenience sample given the difficulty with recruiting PEH in a community context. This study cannot comment on the literature around stigma, since the GPs who led the community outreach services all had a specialist interest in homelessness and it can be assumed that they held positive attitudes towards patients with complex needs.

Comparison with existing literature

Previous research has found that PEH do not access mainstream GP services due to the inflexibility of the health care system and difficulties in building a relationship with GPs [22,23]. In particular, the rigidity of the appointment system and the complexity of health and homelessness services make it difficult for PEH to navigate systems and engage meaningfully with preventative care and treatment options. While SPCSHPs offer more flexibility, many PEH do not access any primary health care, waiting until they require emergency hospital admission [24].Service standards for commissioners/service providers recommend that primary care is central to improving the health care of PEH through vaccination, prevention and screening for chronic conditions [25]. This requires improved advocacy, interprofessional working and engagement with the wider health care system beyond immediate medical treatment [26]. This can only happen if PEH, and other marginalised groups, are able to engage with primary care services in meaningful ways [5]. Relationships are seen as key to improving care [22] and education in trauma informed care are increasingly seen as a positive way to educate staff on how to build better relationships with PEH. Another suggestion recommended by the service standards [25] is that GP receptionists should become patient champions, ensuring access to primary care services. While these are positive steps forward, our study suggests that therapeutic relationships do not develop in a vacuum but are shaped by the physical and organisational environment of the service. As VanHeuvelen states [27], 'the physical environment operates as a dynamic force that influences organisational members' local cultural practices' (P.705). In order for local cultural practices and relationship dynamics between GPs and PEH to change, attention needs to be called to the local organisational environment.

One theoretical approach that has been shown to improve engagement with health services for PEH is the notion of psychologically informed environments (PIE). This approach calls attention to therapeutic relationships, staff training, the social and physical environment, psychological frameworks and evidence generating practice [28], but more work is needed to more fully understand PIE in a primary health care context. It should also be noted that just by altering the physical structure of an

organisation does not equate to altering the rules, culture or policies of that organisation [27].

Implications for research and clinical practice

This study reveals the importance of the waiting room environment when engaging PEH. Participants valued the opportunity for meaningful activity while waiting for the GP. Anxiety provoking environments made them less likely to engage. Although mainstream and SPCCHP will not have the same opportunities as the outreach settings, for example offering food, they can use these findings to help inform and plan the environment within their waiting space. A focus on a welcoming feel with support/volunteer worker presence is recommended.

Participants found it convenient to have many services, including the GP, all in the one place. This promoted engagement with the GP. These findings are useful when designing services for PEH where particular emphasis should be placed on working together with housing, social work and third sector colleagues to create a 'one stop shop' model of care.

Participants valued flexibility at the outreach setting, not only in appointments but also the availability of the GP to adapt their time and location to the individual patient's needs. Services should aim to be flexible on an individual and organisational level in order to better meet the needs of PEH.

Lastly this study has revealed the extent to which the environment can influence the relationship between GPs and PEH. Participants described a more fulfilling relationship with the GP when the consultation took place in a relaxed environment outside of the perceived 'institutional' norms. GPs caring for PEH should seek to work with their patients to build an environment which supports the development of stronger doctor patient relationships within the confines of their current system.

Evaluation of a range of different GP outreach approaches, including the impact on the health outcomes of PEH, are recommended for future studies.

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Ethical approval

Ethical approval for this study was granted by the University of Edinburgh and the NHS East of England Ethics Research Committee [**17/EE/0202]**

Competing interests

The authors have no competing interests.

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Table 1: Settings

Setting	Type	Services	Hours	*GP Outreach	Appointments system
1	Drop-in Day-centre	Shower facilities, washing machines, support work, internet access.	7am - 10pm Mon-Sun	1 regular day/week 8am – 12noon	PEH seen in order of arrival. PEH continued with usual activities at the setting while waiting, such as using computers, chatting in lounge area, using showers etc.
2	Food drop-in	Breakfast and hot lunch, clothing bank, literacy teaching, housing/legal advice, hairdresser.	9am – 1pm 1 day/week	1 regular day/week 9am - 12noon GP present at every drop-in session	PEH seen in order of arrival. PEH continued with usual activities at the setting while waiting, such as seeing advisors, getting lunch, clothing bank etc.
3	Food drop-in	Drink and hot meal, clothing bank.	9-11am 6-8pm Twice weekly.	GP present at every drop-in session	PEH seen in order of arrival. PEH continued with usual activities at the setting while waiting, such as having hot meal or using clothing bank.
*All of the GPs who worked as part of the outreach service were based at and supported by the local SPCCHP. In all settings, GPs had use of a private non-clinical space and could chat with PEH anywhere within the setting where appropriate.					