Health Without A Home

By Leah Regan

BA Criminology

School of Sociology, Social Policy and Criminology

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Executive Summary

Healthwatch

Healthwatch is a non-profitable organisation which was established in 2012 following the coalition governmental reforms of health and social care which ensures individuals voices about health and social care services are “heard, understood and met” (Healthwatch, 2018). The primary aim of Healthwatch is to make sure that “those running services, and the government” (Healthwatch, 2018) put people at the centre of care, wanting to make sure their health and social care needs are being met. Healthwatch England is the national body whilst there are 152 local Healthwatch’s operating across England in which the student, who produced the report, was a volunteer at Healthwatch Wirral.

Research Project Overview

The ‘Health Without a Home’ project, established by Healthwatch Wirral, is centred around how individuals, without a home, access health and social care services and their experiences when accessing these services. This report seeks to establish how and which health and social care services the client group access, good practice in these services, barriers which are currently in place which may prevent the client group accessing the services and recommendations to improve the delivery of care service users receive.

Research conducted for the project was held at the Charles Thompson Mission, in the Wirral, and consisted of a mixture of questionnaires for service users and semi-structured interviews of service users and staff, at the Charles Thompson Mission, to produce an all-round view on the experiences of service users accessing health and social care services. By using these mixed methods, it allowed both quantitative and qualitative data to be produced on the aims set out above. The report has established a valuable insight into the experiences of service users when accessing health and social care services.

Research Objectives

The central objective of 'Health Without a Home' is to understand how service users access health and social care services because Healthwatch Wirral believe homeless individuals often have the most complex needs and their voices are not frequently heard. Other key objectives include:

- To discover the views and experiences of service users when accessing health and social care services
- Identify good practices within the services and assess how well they make themselves accessible for service users
- Locate any barriers services which may stop service users from accessing these services
- From identifying barriers, make appropriate recommendations for change within health and social care services, so service users delivery of care can be improved

Research Highlights

From analysing the qualitative and quantitative data, it was found that the majority of staff and service users were satisfied, overall, with the delivery of care from health and social care services in the Wirral. Areas of good practice were identified from the research including establishing relationships with service users as well as displaying non-judgemental attitudes. The Charles Thompson Mission, a non-government funded organisation, is a vital service. This is because it provides free food, drink and shelter in the mornings and provides an on-site nurse Mondays-Fridays, a dentist, optician and chiropodist which service users access. The staff operate on a humane and non-judgemental approach which forms the foundations for a relationship to be developed with service users who, in effect, feel more comfortable talking to staff about their health and social care needs. The staff can then make the relevant referrals and link in with other services to ensure the service users' needs are being met. Barriers to health and social care services was a major theme with the most prominent barrier being poor staff attitudes. Further barriers of health and social care services in relation to accessibility and availability include waiting lists, distance from services, timings, transport, lack of variety of services and poor staff attitudes.

Literature Overview and Healthwatch

Literature Review

The Equality and Human Rights Commission have identified, amongst homeless people, their health problems are "considerable" (2016, p. 5) with their life expectancy being significantly lower. Barriers within the healthcare services were also recognised which included the chance of being judged and "poor staff attitudes" (2016, p. 6) as well as how homeless people access health and social care services. They found homeless people were three to six times more likely to access hospital services, which included Accident and Emergency, than the general population and 1.5-2.5 time more likely to access GP's (Equality and Human Rights Commission, 2016). Other research has found numerous barriers in place, when homeless people access health and social care services including limited access to healthcare services often due to "institutional factors" (Office of the Deputy Prime Minister, 2002) including opening and closing times, location and "appointment procedures" (Office of the Deputy Prime Minister, 2002). Previous research has, therefore, shown how service users access health and social care services and some of the barriers which are in place in health and social care service. Whilst this helps provide a valuable insight into the complex health problems and barriers service users face when accessing care, this does not mean the findings are universal across the United Kingdom. This is because each location can vary in terms of services made available, due to funding and the demographics of homeless people, and the barriers which people face. Homelessness is also rising year on year, especially rough sleeping (Ministry of Housing, Communities and Local Government, 2018). In 2010, rough sleeping was estimated at 1,768 in England, however in 2017 the rough sleeping estimate in England had risen to 4,751 (Ministry of Housing, Communities and Local Government, 2018). Given this background, providing effective services to deal with this particular problem of homelessness requires insight to conduct new research which is specific to the Wirral ascertaining service user's experiences when accessing health and social care services.

Policy Context

Several policies have been implemented with the aim to improve the health and wellbeing of homeless people. In 2010, the government launched Inclusion Health whose objectives are to improve the "commissioning of service and clinical leadership" (Homeless Link, 2014) ensuring every individual gets the care specific to their needs, with an increase emphasis on homeless people. The Royal College of General Practitioners, in 2012, urged for better provision for homeless individuals by publishing guidance for "GP commissioners" (Homeless Link, 2014). The Faculty of Homeless and Inclusion Health 'Standards for Commissioners and Providers' clearly sets out "minimum standards" (Homeless Link, 2014) for the commissioning, planning and delivery of healthcare. A year later, the Care Quality Commission committed to inspecting and assessing GP practices on how well they meet and assess the needs of homeless individuals ensuring that the service is readily accessible and provide "appropriate care" (Homeless Link, 2014). Also, in 2013, the Department of Health invested £10m to improve the post-hospital care for homeless patients. The recent policy, the Homelessness Reduction Act 2017, is an indirect policy to improve the health and wellbeing of homeless people by aiming to reduce the number of people who become homeless in the first place. Despite these policies being implemented to improve the health and healthcare amongst homeless people, they still experience complex health problems on a day-to-day basis and barriers to health and social care preventing them from accessing the health and social care services they require.

Healthwatch and Interchange

The research project, 'Health Without a Home', is a collaboration between the voluntary community organisation, Healthwatch Wirral, and Interchange. It is a registered charity which links third year students, from higher education, to voluntary community organisations from Greater Merseyside for "research and work-based learning projects" (University of Liverpool, n.d.). Interchange provides a remarkable opportunity which provides an all-important experience for both the students and the non-profitable organisations.

Overview of Healthwatch & Ethos

Context

Healthwatch, the non-profitable organisation, was established in 2012. This was a direct result following the coalition governmental reforms to health and social care in which they implemented the Health and Social Care Act 2012. Both the governmental reforms and Healthwatch's main aim is to put people at the heart of health and social care (Healthwatch, 2018). Healthwatch achieve this by listening to individuals experiences, finding out what they like about the services and if any improvements can be made as they have the "power to make sure people's voices are heard by the government and those running the services" (Healthwatch, 2018). The government has invested £3.8 billion which can allow for local Healthwatch's and health and social care commissioners to improve service user's experiences, the quality of services and their outcomes (Healthwatch, 2018). Healthwatch's network is made up of 152 local authorities which each respond to their specific community's needs (Healthwatch, 2018)

Ethos

The essential purpose of Healthwatch is to improve care for people by hearing individual's voices and their experiences on what they particularly liked about the services and any areas for improvement. It is a national, non-profitable organisation whose purpose is to locate and understand the experiences, needs and concerns of individuals who engage in health and social care services and "speak out on their behalf" (Healthwatch, 2018) to improve service user's experiences of health and social care.

152 local Healthwatch's operate across England seeking to speak to individuals about their views and experiences when engaging in health and social care. As a result of this, local Healthwatch share with Healthwatch England what individuals think of health and social care services. This includes any issues surrounding their experiences and areas for improvement. Healthwatch, then, recommend changes to those who run health and social care services to

"involve people in changes to care" (Healthwatch, 2018) after informing them on individual's experiences.

Healthwatch Wirral

Healthwatch Wirral aim to raise awareness of the local public views and experiences in relation to health and social care services and make these aware to the people in charge of commissioning provision and regulation. They believe homeless people's voices are not often heard in relation to the commissioning of services despite having the most complex needs. Therefore, they have identified the need for an investigation into how homeless people access health and social care services including good practice, any gaps in service provision and areas for improvements. The research was conducted by a final year student at the University of Liverpool, who was a Healthwatch volunteer. All research was conducted at the Charles Thompson Mission, in the Wirral, who are an independent charity which provide food, drink, clothing, support and care to the homeless and poor in the Wirral. The Mission receives high levels of engagement from its users and provided a stable and safe environment for the research to be conducted which allowed large samples to be obtained from the service users and staff.

Homelessness in the Wirral

The Wirral is situated in the North West of England, located in the Metropolitan Borough of Merseyside. Statutory homelessness in the year 2015/16 was 72 households with the main cause being violent breakdown of a relationship (Environment Overview and Scrutiny Committee, 2017). Single homelessness, which can be often referred to as sofa surfers, live in supported accommodation or squats. Whilst there are no statistics on the number of single homelessness in the Wirral, 'Mainstay' reported in 2015/16 there were "786 homeless" (Environment Overview and Scrutiny Committee, 2017) individuals who were accommodated in homeless accommodation services in the Wirral. In November 2016, there were 11 rough sleepers which were identified, which was a "37.5%" (Environment Overview and Scrutiny Committee, 2017) increase from the previous year. It is important to note, however, that these figures, especially for rough sleeping, may not be fully accurate because it is an estimate therefore does not cover the whole reality of homelessness. Due to these figures on

homelessness in the Wirral, they highlight the importance of this research project being undertaken.

Methodology

Interviews and Questionnaires

'Health Without a Home' is a small-scale research project. Projects surrounding small-scale research are pre-dominantly restricted to one location and a time period of 6 months with limited funding (Hall & Hall, 2004). These restrictions, can however be strengths due to the focus of the research is centred around the delivery of particular local services which means that the recommendations suggested will have a "greater chance of implementation" (Hall & Hall, 2004, p. 8) because of the increased focus on these services.

The rationale for questionnaires being administered to service users was that they are quick and easy to fill in, therefore more service users were willing to complete a questionnaire which ensures a relatively high response rate. Furthermore, they do not suffer from "interviewer variability" (Bryman, 2016, p. 223) where the interviewers ask questions in various ways which could influence the response. The questionnaire also allowed for both open and closed questions to be used, producing both quantitative and qualitative data which can be an effective way of generating data. This was completed at the Charles Thompson Mission and the researcher remained present at all times to help answer any questions the service users had about the questionnaires and to clarify any misunderstandings. In total, 20 service user questionnaires were completed.

Semi-structured interviews were used with three staff and three service users of the Charles Thompson Mission. These interviews were conducted as it deemed more of an "exchange of information" (Hall & Hall, 2004, p. 118) following more of a conversation, making the interview less informal so the participant feels more at ease. Conducting a qualitative interview also allows for clarification on any misunderstandings the participant may have regarding the questions allowing a more accurate answer to be given. The questions used in semi-structured interviews are open ended allowing issues to be discussed "more freely" (Hall & Hall, 1996, p. 158) compared to a questionnaire, allowing more information to be discussed by expanding on the questions used in the questionnaires. Every interview was different due to the points of

views the participants had and the depth of the answers with some ranging from 20-50 minutes long. Overall, three semi-structured interviews were conducted with staff who worked for with the Charles Thompson Mission which allowed for a rich source of qualitative data. Five out of the six interviews were conducted at the CTM with one staff interview being a telephone interview.

Ethical Considerations

Throughout the research process, ethical considerations were paramount. Informed consent was obtained by the use of participant information sheets which informed service users on the reasons why the research project is being carried out and consent forms where participants ticked the appropriate boxes if they wanted to participate in the questionnaires/interviews. Confidentiality was ensured at all time due to the fact all service users and staff were given pseudonyms and were made aware of this through the participants information sheet and consent forms. Two of the staff interviews were audio recorded, after they had given their consent for the interview to be recorded. This was to ensure vital information was not omitted. After the interviews were transcribed the audio recordings were later deleted. Throughout the research, there were no extra risks of harms to anyone involved in the study. This was ensured by carrying out a risk assessment of the Charles Thompson Mission to establish if it was deemed safe for research to be conducted there. At all times of the research process, my link worker was present at the Charles Thompson Mission to ensure my safety. Due to the vulnerable nature of the service users, no sensitive questions or topics were raised in the questionnaires and in the interviews, if they agreed to take part.

Data Analysis

All of the data collected from the interviews and questionnaires went through a process of thematic analysis. The researcher took an inductive approach when analysing the data allowing the data to speak for itself which enables themes and patterns to emerge. Conducting thematic analysis involved “identifying and analysing patterns (themes)” (Gray, 2014, p. 609) within the data which can capture anything important within the data that relates to the research question. It can also highlight anything meaningful within the data and represent a “patterned response” (Gray, 2014, p. 609). From this, two themes emerged from the data.

Findings, Conclusion and Recommendations

Research Findings

From interviews and questionnaires conducted with the service users and staff of the Charles Thompson Mission (CTM), two themes emerged. These were: **service access and availability** and **relationships**. The theme service access and availability discusses how service users access health and social care services and the methods of transport used in accessing these services. It also considers factors affecting access and availability including: distance, waiting lists, opening and closing times and the lack of a variety of services. The theme of relationships explores the importance of establishing relationships with service users as well as discussing the difference in attitudes between staff members of health and social care services.

Service Access and Availability

Access of Services

There were a variety of ways service users accessed health and social care services, but the Charles Thompson Mission was one of the first ways in which service users accessed health and social care services which was established through the interviews amongst staff and service users. This was because it opens at 7am providing a shelter for service users and could access food and drink from 9am as well as having an onsite nurse Monday and Friday morning. Whilst having an on-site nurse, it was identified that they also provide other services such as an optician, dentist and chiropodist who visit the CTM every couple of weeks. It was identified that service users accessed the on-site nurse quite regularly for a variety of reasons. This included, Staff A described:

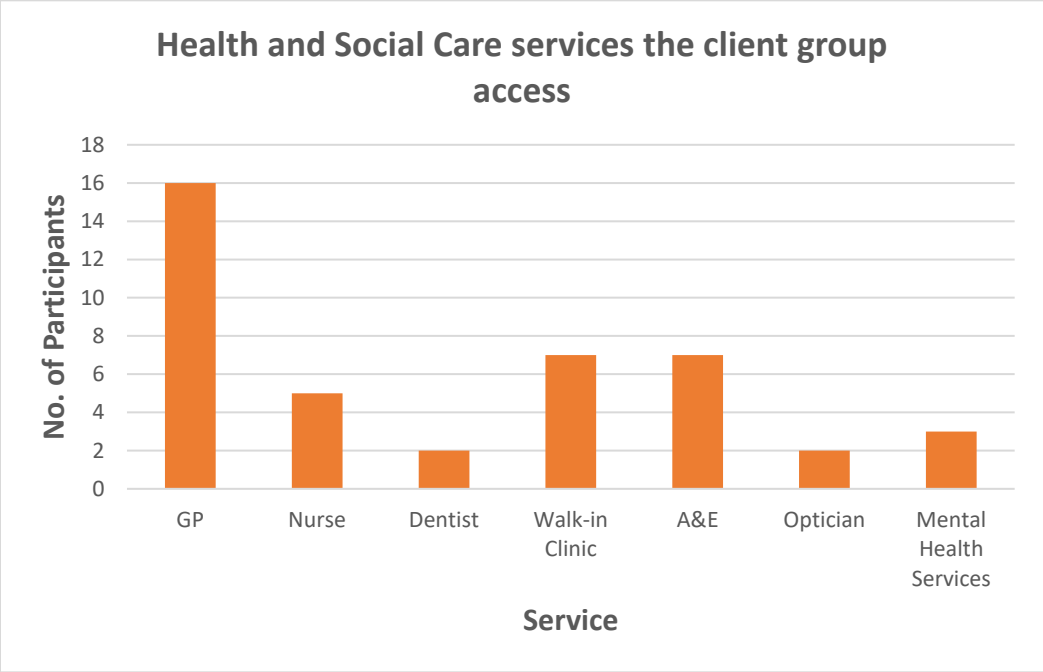
"flu jabs, painkillers, SDI testing, treatment for cuts and to see if the staff can link in with other services and make relevant referrals which cuts out the middle man"

The dentist, optician and chiropodist also provide services for the client group by regular check-ups as well as making referrals to other services which are better suited to the client's needs. Staff C was very positive about the CTM describing it as:

"the best service on the Wirral because of the variety of services they provide, and service users know they can access the services. They know they can visit the onsite nurse and, if needed, get a referral to visit a mental health nurse"

The CTM can be regarded as a beneficial service for the service users because their health and social care needs can be improved. This is due to the variety of health and social care services they provide as well as linking in with other services and making the appropriate referrals.

Figure 1



Through the use of service user questionnaires, it was established service users also access other health and social care services including GP's and A+E. It was found, from the questionnaires, that GP's were the most popular service in which the client group accessed with A+E and walk-in centres being the second most popular service (see figure 1). This research contrasted with the Homeless Link research found that service users were "more likely to use

A&E" (2014, p. 5). The majority of the semi-structured interviews highlighted participants do not usually want to engage in A&E which is highlighted by Staff B:

"service users do not access A+E by choice. If they do access A+E, it is usually because it is their last resort"

This can be evidenced by service user A who described his experience of accessing A+E:

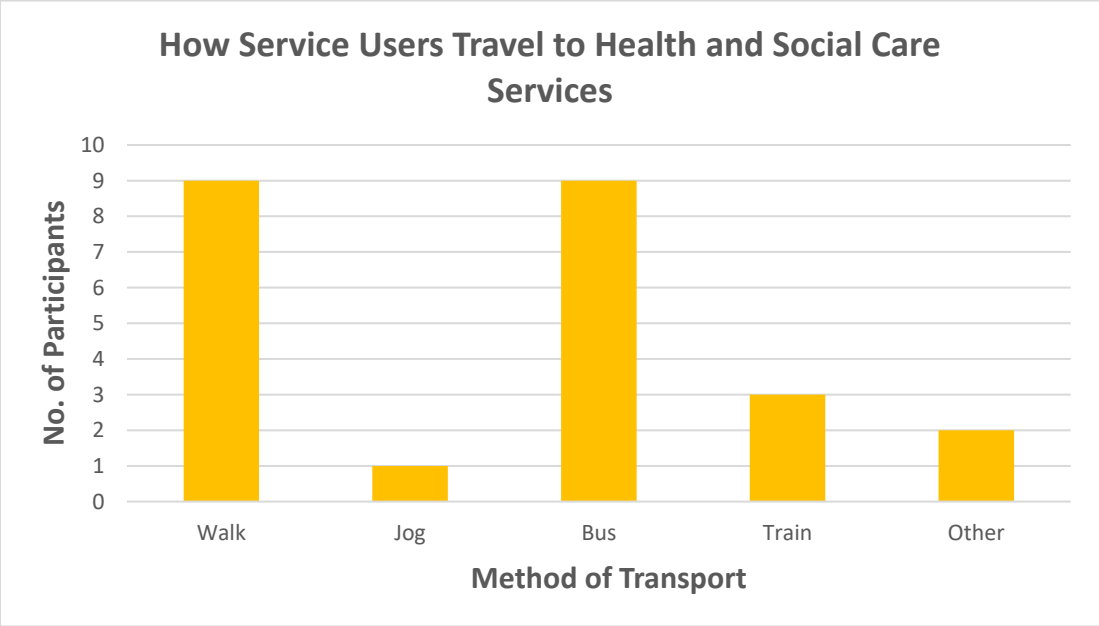
"the only time I ever access A+E is when I am unconscious"

It was also found that some service users did not engage in any other health and social care services apart from the Charles Thompson Mission. This was highlighted in both the questionnaires and the interviews. The questionnaires found that 25% of service users do not engage in any health and social care services per month despite 65% having a chronic or long-term health condition. This was echoed by interviews with staff who reported that some service users did not engage in any other health and social care services, apart from the CTM. Staff C expressed:

"some service users are not registered with a GP because they think they are not eligible to register with one"

Service users not engaging in any other services apart from the CTM can have negative effects on their health. The reasons as to why service users do not access any other health and social care services will be considered later on in the report.

Figure 2



The last notable point is measuring access to services is regarding transport. Service users were also asked, in the questionnaire, about how they accessed health and social care services. The method of transport used to access services which proved the most popular amongst service users was walking or taking the bus (see figure 2), however from the interviews it emerged that the use of transport, other than walking, was very limited for service users. This was especially the case when service users had Staff B described:

"no change to get either the bus or train and if it is too far in walking distance, service users will not access the services or turn up to appointments"

The interview data coupled with the answers from the questionnaire highlight the importance of both transport and distance in relation to service users being able to access the services that are available. Also, if the user lacks the means to use the transport services that are available then that can act as a barrier to service use.

Factors affecting service access and availability

There were many different factors which affected the availability of services for service users which included distance, timings, waiting lists and a lack of variety of services which were all common themes in both the interviews and questionnaires. All six interviews with staff and service users established at least one issue surrounding the availability of services.

Distance

Distance to and from health and social care services emerged as a key barrier to access from the interviews. This goes in line with previous research which identified barriers to healthcare service for homeless people with one being the "geographical location" (Patient and Client Council, 2015) of healthcare services because they are too far for homeless individuals to access. Whilst Staff C acknowledged some services in the Wirral are quite close together which makes the services more readily available for service users. However, other services in the Wirral have been identified as being far apart from one another making it difficult for service users to access due to lack of travel options. Staff C highlighted this view by:

"once you get to a service for example A+E, there is no way of getting back especially in the early hours in the morning"

Staff B also reinforced the view about the distance of services from one another by saying:

"overall all the services are too far away from each other"

From the staff interviews, it can be established that distance is a barrier affecting the access and availability of health and social care services for service users. Although it was recognised that some of the services in the Wirral are close together which is beneficial for service users, other services are far apart from each other. In effect, this can deter service users from accessing the health and social care services they need.

Waiting Lists

From the data, it emerged that waiting lists also affected health and social care services availability. This was established in the questionnaire with 65% of service users finding waiting lists were a barrier in place affecting the availability and access of services and this was also reflected in the staff and service user interviews. Previous research into the barriers homeless people face when accessing healthcare has also highlighted waiting lists which can cause "difficulty" for homeless individuals when trying to access health and social care services (Patient and Client Council, 2015). From the staff interviews, it emerged that waiting lists can be hard for service users because of their chaotic, transient lifestyles. Staff B stated:

"with the service users chaotic lifestyle, they cannot remember if they have an appointment in three weeks"

This was reflected by Service User C:

"I cannot remember the day or time my next appointment is"

The difficulty of waiting lists was echoed by the service users with Service User B expressing:

"I had to wait one month for my medication"

Waiting a month for the service user's medication is a lengthy period, especially when service users have complex health problems which highlights the difficulty of waiting lists for service users. Staff A also described waiting lists as a barrier for people because:

"a lot of GP surgeries you have to phone up on the day for appointments and if you ring up and 8:05am appointments for that week have gone"

Waiting lists can be identified as a barrier for service users which can restrict the service's access and availability which is highlighted from the evidence above. Further difficulty with

waiting lists is experienced when service users do not have access to a phone, so they cannot ring up and make appointments on-time. GP's then offer home visits if there are no appointments the same day, however a major flaw in this is the "lack of address" identified by Staff A and therefore cannot gain access to a home visit. The problem of waiting lists, therefore, can impact health and social services access for service users because of the difficulty in making an appointment as well as the lengthy period in which service users need to wait.

Opening Times

There was a mixed response from both service users and staff in terms of opening times affecting health and social care availability, with some questionnaires and interviews expressing it was a problem and with others showing it was not a problem. However, opening times did prove to be a problem due to how service users are discharged from hospital, at any time when there are often no places to go. Even though, overall, the opening and closing times did not affect the availability of services during the daytime because Staff C identified:

"the client group have time during the day to access the services they need"

The problem of access and availability, however, came when service users are discharged from hospital at early hours in the morning and often have "nowhere to go", which was expressed by Staff B, because of the night shelter being closed, so:

"service users have to resort to sleeping on the streets because they have nowhere to go"

Because of the discharge from hospital combined with the distance, it was also identified from the staff interviews that this has deterred service users visiting A+E because Staff C believed service users would think that they will:

"get discharged in the early hours of the morning and think I am not going there, how am I going to get home?"

Thus, because of opening and closing times, as well as distance, service users have nowhere to go when discharged from hospital at early hours in the morning because even the night shelter does not accept service users after 10pm.

Lack of a Variety of Services

From one staff interview who works with homeless people in both the Wirral and in Liverpool, there was some difference between health and social care services between the two locations, with health and social care services in Liverpool being better suited to homeless individual's needs. Staff B expressed this by:

"I would say Liverpool targets homeless needs more than the Wirral and their medical needs are linked into services where recognised"

The Wirral was identified at needing more "readily available services" Staff B established because some service users are not registered with a GP's and the distance can be an issue for service users. Also, from two of the staff interviews there was a great focus upon the lack of readily available mental health services, despite the fact Homeless Link research has identified 80% of service users reported some kind of mental health issue whilst "45%" (2014, p. 3) have been diagnosed with a mental health issue. Staff B remarked:

"I don't think there is enough readily available services around mental health"

Staff C also reflected this view by:

"I think there needs to be more access to mental health"

Furthermore, Staff B expressed how there needs to be more "intensive support" around health and social care services in the Wirral and:

"[they] need more homeless support workers"

As a result, they will have the means to link service users in with the relevant health and social care services and put them in a state of stability. Hence, from the staff interviews, there needs to be more readily available health and social care services, especially for mental health.

Relationships

The experiences of service users are not only defined by access and availability, the quality of relationships between staff and service users also proved to be an important factor. This was something emphasised as an area of focus for staff because in all three staff interviews the staff expressed how it is vital to establish good relationships with the service users as well as other relevant health and social care services/individuals. Staff A reported how it was critical to build relationships with the service users:

"you have to become a buddy to them, so they trust you and come to you for advice [on their health"

Staff C also mentioned how it was important to have a relationship with service users even if it is just a:

"shoulder to cry on because people can come to you and have a chat about whatever is going on in the world for them"

The relationship between the staff and service users is vital because it was reported by Staff A how service users opening up to staff about their health and wellbeing, they can then make the "relevant referrals" needed to improve the service user's condition. Staff B also described how the service users of the CTM had a relationship with the on-site nurse because they know they can:

"trust the on-site nurse which is a major hurdle to overcome [which is] the most important part of the job- the relationship and the trust of the client base"

Therefore, good relationships are vital to ensure staff have the trust of the service users and to link in with other health and social care services to provide a good delivery of care.

The three staff that were interviewed demonstrated a caring and non-judgemental attitude towards service users. An example of the staff's caring attitude comes from Staff A and Staff B:

Staff A- *"I could refer someone for a GP to see them the next week and they haven't gone so often it's like right let's get you an appointment and I'll take you"*

Staff B- "if they do not turn up to an appointment they get dismissed or taken off the system, so I sometimes drive them to their appointments"

Staff B expresses the benefits of acting with a non-judgemental attitude:

"The CTM can fit in with everybody and acts with a non-judgemental approach and they do not see many aggressive people because they understand the clients and they act with a non-judgemental approach, service users are more likely to open up to staff"

As well as the staff acting with caring and non-judgemental attitudes, they also displayed proactive attitudes which can improve the delivery of care service users receive. Staff B reported how he tracks some service user's appointments:

"If I can track appointments then I do so I can remind them when they have an appointment and if I am available then I will take them"

Tracking appointments can be beneficial for the service user's because Staff B can remind them when they have an appointment because some service users can often forget when they have an appointment, which was established earlier. Furthermore, to make sure service users attend their appointments, Staff B will take them to the service if he is available. Staff A also displayed a proactive attitude by bringing her services (as a nurse) to service users because they stated:

"I bring my services to people, so I go to places like the CTM to link in with people who would not normally link in around their health"

Thus, Staff A is being proactive because she brings her services to service users and helps them engage in health and social care services to improve the overall quality of their health. Building

relationships and demonstrating caring and non-judgmental attitudes to service users can be essential to improve the delivery of care service users receive because they are more likely to open up to staff around their health and the staff can help service users engage in more health and social care services.

However, whilst some staff operate on non-judgemental attitudes, it was established from the staff and service user's interviews and the service user's questionnaire that hostile attitudes amongst staff also existed and were cited as being the most significant barrier in place within health and social care services. This echoes the Equality of Human Rights Commission research in which they also identified "poor staff attitudes" (2016, p. 6) as a barrier for homeless individuals accessing services. This was found in all the staff interviews with Staff C mentioning:

"I was shocked at the way certain staff spoke to service users"

Staff B also reported how staff demonstrate poor staff attitudes by stating:

"some of them [staff] have antagonism towards the homeless population"

"I understand they have much on their hands, but they do lack empathy"

"If they are frequent attenders of a service e.g. hospital some staff will go 'oh they're bloody back again'"

The service users have complex needs which need addressing, however when staff demonstrate abrupt and judgemental attitudes, some of the service users do not go back to the service which can negatively affect their health.

The service users also mentioned, from the questionnaire, how poor staff attitudes were a barrier in place affecting the access and availability of health and social care services with 65% of service users saying they had experienced poor staff attitudes (see figure 3). From the interview Service User A reported:

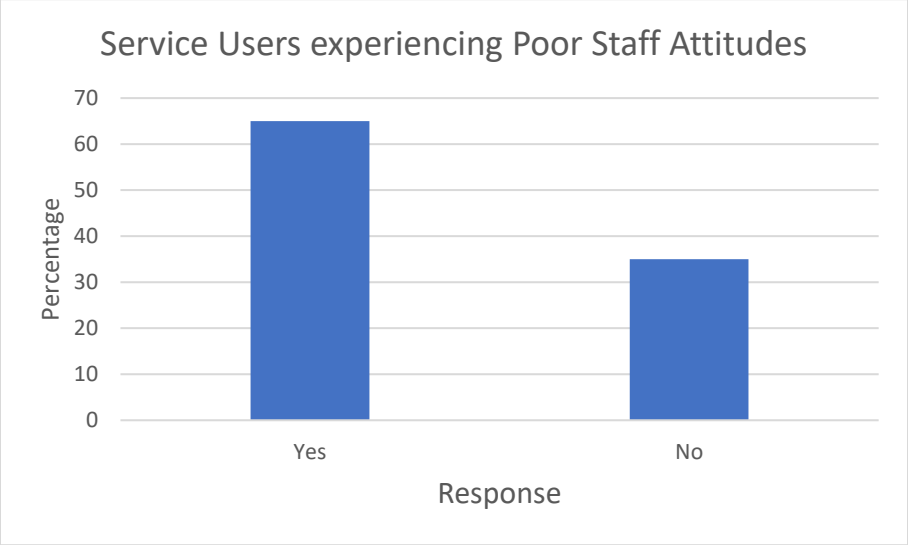
"the staff was being funny and displaying hostile attitudes with me so when I displayed hostile attitudes back I got kicked off the waiting list and was reported"

Service User B identified how staff attitudes angers him a lot and discharges himself from the service because of the way they:

"look down on you and speak to you"

From the interviews conducted with both staff and service users and the service user questionnaire, it can be established that poor staff attitudes can be detrimental to service user's health because some do not want to engage in that service anymore. Poor staff attitudes appear in a variety of forms including: hostility, lacking empathy and being judgemental. It is, therefore, necessary to establish relationships with service users and act with caring and non-judgemental attitudes so service users can receive the delivery of care they need.

Figure 3



Overall, staff and service users were satisfied with the health and social care services which are provided and their delivery of care. In all three staff interviews they were satisfied overall with the health and social care services which are provided for service users. In the questionnaires, it was recognised that overall service users are also satisfied in the delivery of care with 50%

stating they are slightly satisfied with the delivery of care from health and social care services compared to 25% stating they are slightly dissatisfied to very dissatisfied (see figure 4). However, only 40% were either very or slightly happy with the health and social care services which are provided compared to 30% who were unhappy (see figure 5). Whilst slightly more people are somewhat happy with the health and social care services which are provided, the percentage is still relatively low which means issues surrounding geography, timings, waiting lists, lack of readily available services and poor staff attitudes need to be addressed.

Figure 4

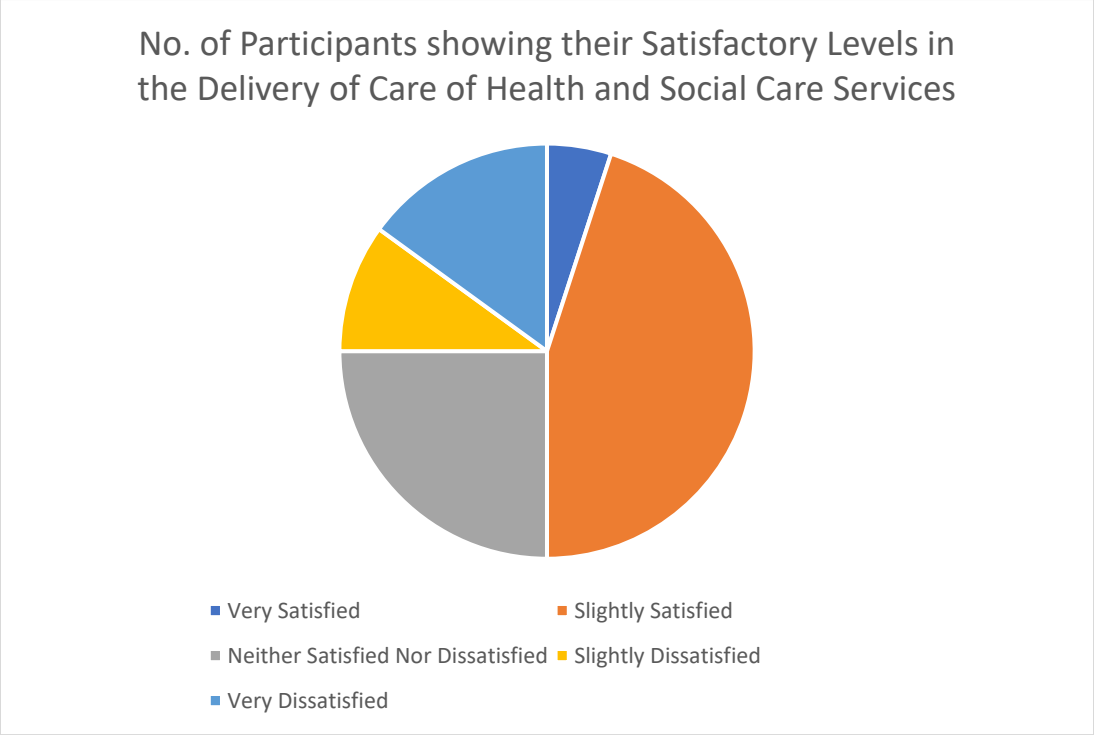
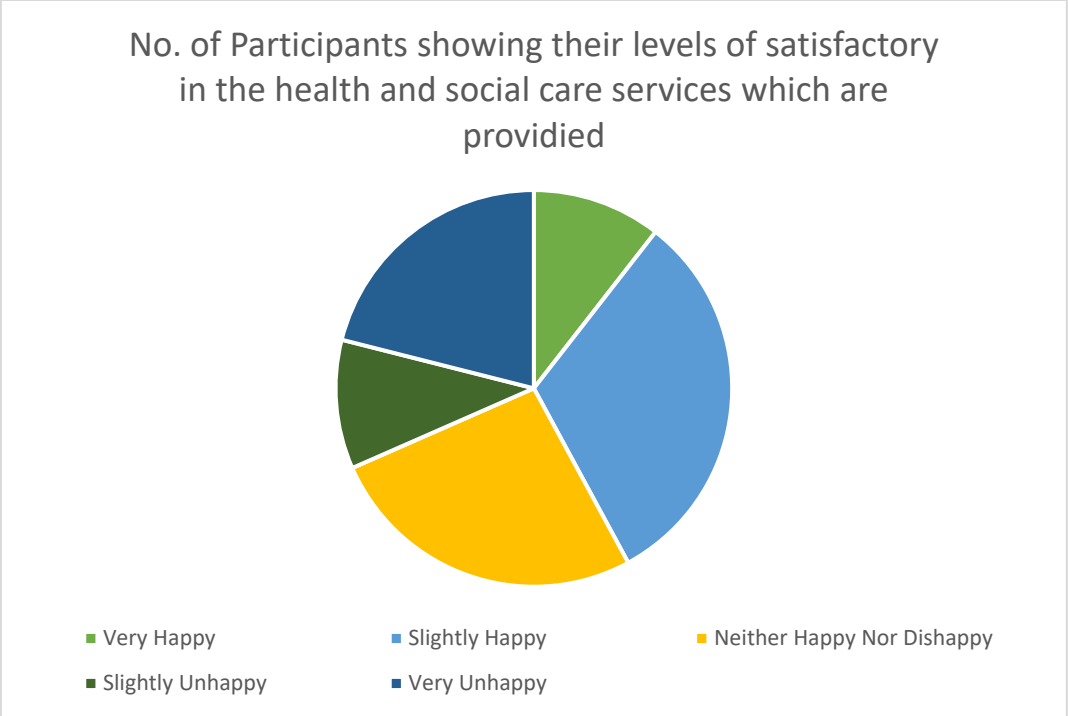


Figure 5


No. of Participants showing their levels of satisfactory in the health and social care services which are providied
Very Happy
Slightly Happy
Neither Happy Nor Dishappy
Slightly Unhappy
Very Unhappy

Conclusion

The 'Health Without a Home' research project provides a valuable insight into service users experiences when accessing health and social care services. The findings are gathered from the voices of service users and staff at the Charles Thompson Mission. Questionnaires were targeted for service users and interviews were targeted for staff at the Charles Thompson Mission and for any service user who was willing to expand on the questions within the questionnaire.

The findings from the research project are specific to health and social care services in the Wirral, however general findings about areas of good practice and barriers to services can be applied to other health and social care services across the United Kingdom which have a relatively high number of homeless people.

Whilst the report has highlighted how service users access health and social care services, good practices including establishing relationships with service users, operating on a non-judgemental attitude and barriers in place which affect the service's access and availability. The barriers include distance, timings, lack of transport and services, waiting lists and negative attitudes. It is also important to consider the limitations of the research project. The project was small-scale research only involving the student as the researcher and their link worker as well as a small sample of participants taking part in the research project. Therefore, the findings are not representative to other locations in the United Kingdom because this research has specifically focused on services within the Wirral and services vary in different locations. The findings are also not representative to all homeless individuals and cannot be generalised because they all have complex needs which are different from one another and need addressing specifically.

Furthermore, it is also important to address the limitations of the methods used. Whilst the questionnaires were quick and easy to administer, the answers are standardised and doesn't allow any opportunity to expand on answers given in the questionnaire. Due to the chances of "response fatigue" (Bryman, 2016, p. 224) long questionnaires are not feasible. Also, there are a limited number of questions which cannot capture everything you wish to find out. This was why interviews were used to expand on answers given in the questionnaires. Whilst the researcher was able to expand on answers given, interviewer

effects can occur when participants do not give an honest response because of the characteristics of the interviewer or the way in which a question was asked which could give bias results. This is not to say however, this occurred in 'Health Without a Home' research project.

Overall, the findings have provided positive conclusions on how homeless individuals access health and social care services with the most popular being through the Charles Thompson Mission. It was identified the Charles Thompson Mission was a good practice of health and social care service by providing service users food and drink as well as other services including an on-site nurse, who can link in and make referrals to other services. Other areas of good practice include establishing relationships and implementing a non-judgemental attitude towards service users, so they are more likely to open up about their health conditions and in turn get the appropriate care they need. There are, however, barriers in place which may prevent or deter service users from accessing these services which include negative staff attitudes, waiting lists, distance and timings.

Recommendations

From the research project, below are recommendations which one suggested to help remove any barriers in place and make services more readily accessible for service users. The recommendations were identified from establishing the good practices and barrier in place within health and social care services.

- Health and social care services to administer questionnaires to their service users regularly to find out about their experiences and how the service could be improved to make sure service users are receiving the delivery of care they need to support their health and social care needs.
- Due to the gap in services at night, night shelters can extend their opening hours in the evening to make sure service users have shelter for the night time.
- When discussing future policy planning, local authorities can take into account logistical considerations in terms of distance and travel so that health and social care services are in walking distance from one another, so they are more accessible for

service users. Local authorities can also help support their costs in travel by implementing bus passed for service users.

- To implement training programmes for staff who work in health and social care services to ensure they operate on a non-judgemental attitude towards service users in order to try and build a relationship as this was established from the data as an area of good practice which can improve the delivery of care for service users.

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Appendix

Appendix 1

‘Health Without a Home’ Questionnaire

Healthwatch Wirral is a new independent consumer champion which was created to gather and represent the views of the public in relation to health and social care services. They believe every voice matters especially when it comes to individual’s experience of health and social care services and is seeking to hear your voice.

In relation to health and social care services, Healthwatch Wirral is looking to hear your experiences. All answers are anonymous, and you can withdraw from the questionnaire at any time. Further information will be found on the participant information sheet and the consent form attached. Thank you.

1. Do you have a chronic or ongoing health issue which requires regular treatment?

☐ Yes ☐ No

2. Typically, how often do you access health and social care services per month?

☐ 0 times ☐ 1-2 times ☐ 3-4 times ☐ 5+ times

3. What kinds of health and social care services do you access? Please tick all that apply.

☐ GP	☐ Nurse	☐ Dentist	☐ Walk in Clinic
☐ A+E	☐ Optician	☐ Mental Health Services	☐ Other

If other, please specify which health and social care services.

4. How long do you usually have to travel to the health and social care services?

- ☐ 0-14 minutes
- ☐ 15-29 minutes
- ☐ 30-44 minutes
- ☐ 45-59 minutes
- ☐ 1 hour-1 hour 14 minutes
- ☐ 1 hour 15 mins- 1 hour 29 minutes
- ☐ 1 hour 30 minutes-1 hour 44 minutes
- ☐ 1 hour 45 minutes-1 hour 59 minutes
- ☐ 2 hours+

5. How do you usually travel to the health and social care services?

- ☐ Walk
- ☐ Jog
- ☐ Bus
- ☐ Train
- ☐ Other

If Other, please specify.

6. Are waiting lists an issue?

- ☐ Yes
- ☐ No

7. How much of an issue is opening/closing times? Please place a cross along the line wherever is appropriate.

Issue No Issue

8. Is discharge from hospital an issue for you?

Yes No

If Yes, please state why

9. Have you experienced poor staff attitudes within the services?

Yes No

10. Have you ever been turned away from a service?

Yes No

11. Have you received any health and social care advice?

Yes No

If yes, from which individual?

GP Nurse Stranger Charity worker Other

If other, please specify.

12. Are you happy with the health and social care services which are provided

Very Happy | Slightly Happy | Neither Happy nor Unhappy | Slightly Unhappy | Very Unhappy

13. Are there any other barriers when accessing health and social care services?

Yes

If yes, please specify.

14. Overall, from your experiences how satisfied are you in the delivery of care from health and social care services?

Very Satisfied | Slightly Satisfied | Neither Satisfied nor Dissatisfied | Slightly Unsatisfied | Very Unsatisfied

15. Are there any recommendations you can think of to remove the barriers that are currently in place or to improve the access available to health and social care

Yes

No

If yes, please specify.

Is there anything else you would like add or thought I have missed?

Thank you for taking part in this questionnaire, it is greatly appreciated. Please return completed forms back to Leah Regan (researcher) and Wendy Kay (researcher). Findings will be available in the 'Health Without a Home' report.

Appendix 2

Service users interview questions

- Do you think having an onsite nurse is beneficial?
    - Why?
- How do you access other health and social care services?
    - Travel
- Which other health and social care services do you access?
- Are these services suitable to your needs?
- Are there any other ways these services deliver good practice?
- Are there any services you want access to?
    - What are the reasons for this?
- Has anyone give you advice?
- Is there anything preventing you from accessing health and social care services?
    - What?
    - How so?
    - Which services?
- What other barriers are there when accessing these health and social care services?
    - Travel
    - Location
    - Waiting lists
    - Issues registering
    - Opening and closing times
    - Staff attitudes
    - Discharge from hospital
    - Turned away from a service
- What are the Main barriers?
- Any preferred health and social care services?
- How would you describe your experiences with health and social care services? Positive/negative? Why? What kind of things?
- How could accessing health and social care services be better?
- Any recommendations?
- Overall, are you satisfied with these services?
    - How?

Appendix 3

Participant Information Sheet

For Service Users

Health Without A Home

Version 1: 10/11/2017

You are being invited to participate in this research project. Before you agree to give your consent on whether to participate, it is vital for you to understand why the research is being carried out and what it will involve. Please take your time to read the following information carefully and if there is anything you are unsure about, feel free to ask us and we will provide you with more information and clarify anything you may wish. Please also feel free to discuss this with anyone you wish to. It is important to stress that you do not have to accept this invitation and it is entirely your choice whether to participate in this study.

Thank you for reading.

1. What is the purpose of the study?

The purpose of this research is to find out how users of the Charles Thompson Mission access health and social care services due to the fact service users have the most complex needs and can inform us on what services helped the most. In addition, the research aims to identify good practice in health and social care services, gaps and barriers when accessing the services and making recommendations for change, which can help inform commissioners.

2. Why have I been chosen to take part?

You have been chosen to take part because you are over the age of 18 years and are a user of the Charles Thompson Mission and you are based in the Wirral. Approximately 30-40 other individuals will be taking part in the process of completing the questionnaires.

3. Do I have to take part?

Your participation to this study voluntary and it is completely your choice whether you choose to participate. You are free to withdraw at any point whilst the research is being carried out without any explanation. Please do not feel any pressure to take part in this research study.

4. What will happen if I take part?

If you agree to participate in this research study, you will be taking part in completing a questionnaire. Whilst completing the questionnaires, the researcher (Leah Regan) and the link worker (Wendy Kay) will be present to clear up any misunderstandings or information. Users of the Charles Thompson Mission will be carrying out this questionnaire and it should take approximately 20-25 minutes to complete. After this, you may be asked to take part in a semi-structured interview with Leah Regan which will be approximately 30-45 minutes to discuss a little further what was mentioned in the questionnaires and to share some of your experiences when accessing health and social care services. Again, please do not feel under pressure to participate in the interview, it is completely your choice. If you choose to participate in the interview, it will be audio recorded to make it easier to transcribe the data, whilst recording notes during the interview. However, if you do not want the interview to be audio recorded, for whatever reason, then please say and I will not record the interview. Direct quotes may be added but if you do not want these to be used, then please state this to the researcher (Leah Regan).

If you choose to participate in the questionnaires, all you have to do is answer as many questions as possible. However, if you give your consent to be interviewed, then your responsibility is to answer the questions the researcher asks you.

If there is a medical risk identified, the researcher and the client organisation may refer you to an appropriate medical practitioner for examination.

5. Are there any risks in taking part?

There are no risks involved for anyone who agrees to participate in the study. Emotional harm will be avoided due to the fact there is no sensitive topics or questions involved in this research study. However, if any users do feel uncomfortable at any point whilst conducting the research, then place make the researcher aware and this will be acted upon.

6. Are there any benefits in taking part?

This research study aims to state gaps in service provision and from this, make recommendations for change in how homeless individuals access health and social care services. This information could then inform commissioners, and improve the access and to reduce the barriers in place when accessing these services which could benefit you as the participants.

7. What if I am unhappy or if there is a problem?

If you are unhappy, or if you encounter a problem, please feel free to let us know by contacting [Kirsteen Paton (academic supervisor) on 0151 794 2982] and we will try to help. If have a complaint or are unhappy with anything in which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study, the researcher(s) involved, and the details of the complaint you wish to make.

8. Will my participation be kept confidential?

Data will be collected using completed questionnaires, notes taken during the interviews and the use of audio recordings (if you agree to being audio recorded). This data will then be stored on the researcher's M Drive which cannot be shared with anyone else because it is password protected. This data will then be permanently deleted in summer 2018 when the researcher finishes university. Participants names will be converted into pseudonyms to ensure anonymity and confidentiality, ensuring no personal information can be tracked down to the participants. The data produced from this research project can be used to inform commissioners to improve access to health and social care services, however, throughout every stage of the research study to producing the report, anonymity and confidentiality will be ensured.

9. What will happen to the results of the study?

The research findings will be produced into a report which will be assessed by the University of Liverpool's academics in order to be graded. A copy of the report will also be given to Healthwatch Wirral, so they could hopefully inform commissioners on the recommendations stated. Confidentiality and anonymity will be ensured throughout the research process.

10. What will happen if I want to stop taking part?

You can withdraw from the study at any point whilst the researcher is in the process of collecting data, without any explanation. If you do wish to withdraw at any point, you can request any data about you to be destroyed. Once data is anonymised, however, the results gathered cannot be destroyed.

11. Who can I contact if I have further questions?

If you have any further questions then please contact Kirsteen Paton on 0151 794 2982

Appendix 4

Participant Information Sheet

For Paid Employees/Peer Mentors

Health Without A Home

Version 1: 10/11/2017

You are being invited to participate in this research project. Before you agree to give your consent on whether to participate, it is vital for you to understand why the research is being carried out and what it will involve. Please take your time to read the following information carefully and if there is anything you are unsure about, feel free to ask us and we will provide you with more information and clarify anything you may wish. Please also feel free to discuss this with anyone you wish to. It is important to stress that you do not have to accept this invitation and it is entirely your choice whether to participate in this study.

Thank you for reading.

1. **What is the purpose of the study?**

The purpose of this research is to find out how users of the Charles Thompson Mission access health and social care services due to the fact service users have the most complex needs and can inform us on what services helped the most. In addition, the research aims to identify good practice

in health and social care services, gaps and barriers when accessing the services and making recommendations for change, which can help inform commissioners.

2. Why have I been chosen to take part?

You have been chosen to take part because you are a paid employee or a peer mentor of the Charles Thompson Mission who has spoken to homeless individuals or yourself may have encountered experiences of being homeless when accessing health and social care services. There will be interviews with 5-6 other paid employees or peer mentors of the Charles Thompson Mission.

3. Do I have to take part?

Your participation to this study voluntary and it is completely your choice whether you choose to participate. You are free to withdraw at any point whilst the research is being carried out without any explanation. Please do not feel any pressure to take part in this research study.

4. What will happen if I take part?

If you agree to take part in the research study, you will be taking part in a one-to-one semi-structured interview with the researcher Leah Regan, whilst Leah's link worker (Wendy Kay) will be present in the room, however this is just to make sure the researcher doesn't work unsupervised. Leah will provide the different topics of discussion and will ask you various questions relating to how homeless individuals access health and social care services. The duration of the interviews will be approximately 45 minutes. If you choose to participate in the interview, it will be audio recorded to make it easier to transcribe the data, whilst recording notes during the interview. However, if you do not want the interview to be audio recorded, for whatever reason, then please say and I will not record the interview. Direct quotes may be added but if you do not want these to be used, then please state this to the researcher. (Leah Regan)

5. Are there any risks in taking part?

There are no risks involved for anyone who agrees to participate in the study. Emotional harm will be avoided because there is no sensitive topics or questions involved in this research study. However, if any users do feel uncomfortable at any point whilst conducting the research, then place make the researcher aware and this will be acted upon.

6. Are there any benefits in taking part?

This research study aims to state gaps in service provision and from this, make recommendations for change in how homeless individuals access health and social care services. This information could then inform commissioners, and improve the access and to reduce the barriers in place when accessing these services

7. What if I am unhappy or if there is a problem?

If you are unhappy, or if you encounter a problem, please feel free to let us know by contacting [Kirsteen Paton (academic supervisor) on 0151 794 2982] and we will try to help. If have a complaint or are unhappy with anything in which you feel you cannot come to us with then you should contact the Research Governance Officer at ethics@liv.ac.uk. When contacting the Research Governance Officer, please provide details of the name or description of the study, the researcher(s) involved, and the details of the complaint you wish to make.

8. Will my participation be kept confidential?

Data will be collected through notes taken during the interviews and the use of audio recordings (if you agree to being audio recorded). This data will then be stored on the researcher's M Drive which cannot be shared with anyone else because it is password protected. This data will then be permanently deleted in summer 2018 when the researcher finishes university. Participants names will be converted into pseudonyms to ensure anonymity and confidentiality, ensuring no personal information can be tracked down to you. The data produced from this research project can be used to inform commissioners to improve access to health and social care services, however, throughout

every stage of the research study to producing the report, anonymity and confidentiality will be ensured.

9. What will happen to the results of the study?

The research findings will be produced into a report which will be assessed by the University of Liverpool's academics to be graded. A copy of the report will also be given to Healthwatch Wirral, so they could hopefully inform commissioners on the recommendations stated. Confidentiality and anonymity will be ensured throughout the research process.

10. What will happen if I want to stop taking part?

You can withdraw from the study at any point whilst the researcher is in the process of collecting data, without any explanation. If you do wish to withdraw at any point, you can request any data about you to be destroyed. Once data is anonymised, however, the results gathered cannot be destroyed.

11. Who can I contact if I have further questions?

If you have any further questions then please contact Kirsteen Paton on 0151 794 2982.

Committee on Research Ethics

PARTICIPANT CONSENT FORM

Appendix 5

Title of Research
Project: Health
Without a Home

	Please initial box
1. I confirm that I have read and have understood the information sheet dated [10/11/2017] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.	
3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.	

4. I agree to take part in the above study. ☐

5. I understand that confidentiality and anonymity will be maintained, and it will not be possible to identify me in any publications ☐

6. understand and agree that my participation will be audio recorded and I am aware of and consent to your use of these recordings for the semi-structured interviews ☐

7. I understand and agree that once I submit my data it will become anonymised and I will therefore no longer be able to withdraw my data. ☐

_____	_____	_____
Participant Name	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

Researcher	Date	Signature

Principle Investigator: Kirsteen Paton (academic supervisor)

Telephone Number: 0151 794 2982

Email address: Kirsteen.Paton@liverpool.ac.uk

Lead Researcher: Leah Regan

Telephone number: 077525096246

Email address: hslregan@liverpool.ac.uk

Version 1 (10/11/2017)