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DOI:
10.3399/bjgp18X694577

Document Version
Peer reviewed version

Citation for published version (Harvard):
Paudyal, V 2018, 'Relocating patients from a specialist homeless healthcare centre to general practices: a multi-perspective study', *British Journal of General Practice* , vol. 68, no. 667, pp. e105-e113. https://doi.org/10.3399/bjgp18X694577

Relocating patients from a specialist homeless healthcare centre to general practices: a multi-perspective study

Background: The relocation of formerly homeless patients eligible to transfer from a specialist homeless healthcare centre (SHHC) to mainstream general practices is key to patient integration within the local community. Failure to transition patients conferring eligibility for relocation may also negatively impact on SHHC service delivery.

Aim: To explore barriers and facilitators of relocation from the perspectives of formerly homeless patients and healthcare staff involved in their care.

Design and setting: Qualitative semi-structured face-to-face and telephone interviews conducted in north east Scotland.

Methods: Participants were patients and healthcare staff including general practitioners, nurses, substance misuse workers, administrative and local community pharmacy staff recruited from one SHHC, two mainstream general practices and four community pharmacies. Interview schedules based on the 14 domains of the Theoretical Domains Framework (TDF) were drafted and reviewed by an expert panel, and piloted with each participant group. Interviews were audio recorded, transcribed verbatim and analysed by two independent researchers using a Framework Approach informed by the TDF.

Results: Seventeen patients and 19 staff participated. Key barriers and facilitators, aligned to TDF domains, included: beliefs about consequences regarding relocation; patient intention to relocate; environmental context/resources in relation to the care of the patients and assessing patient eligibility; patient skills in relation to integration; social/professional role and identity of staff and patients; emotional attachment to the SHHC.

Conclusions: Implementation of services, which promote relocation and integration, may optimise patient relocation from SHHCs to mainstream general practices. These include peer support network for patients, better information provision on the relocation process and supporting patients in the journey of identifying and adjusting to mainstream practices.

Keywords: homeless persons; general practice; delivery of health care; primary health care; Theoretical Domains Framework

How this fits in

The value of SHHCs has been highlighted in terms of overcoming the barriers associated with registration at a mainstream general practice and in the provision of specialised services that meet the distinct needs of the homeless population. Relocation to a local mainstream general practice is encouraged once patients are clinically stabilised and permanently housed, however there may be numerous barriers that are difficult to overcome. This research sought to identify the key barriers and facilitators of relocation from a SHHC to a mainstream general practice. The findings highlight how relocation may be supported further within the patient group and culminate in a series of recommendations.

Introduction

Homelessness embodies many forms, including rough sleeping, living in derelict buildings, temporary shelters, squats or sofa surfing (1). Homelessness is a widespread issue in the United Kingdom (UK) (2). An estimated 250,000 people are known to be currently homeless in England alone (3). Over 115,000 and 34,000 households submitted a homeless application in 2015/16 in England (4) and Scotland (5) respectively.

Evidence suggests that homeless individuals are significantly disadvantaged in terms of attaining health services and maintaining healthy lifestyles (6-9). For example, individuals facing homelessness often experience difficulty in registering at mainstream general practices due to issues such as being unable to provide evidence of permanent address (10,11) or photographic identification (12). Consequences include homeless patients attending accident and emergency departments to access healthcare, or failure to access any healthcare services (11,13).

There has been an emergence across the UK of specialist homeless general practices and general practices with particular expertise in homelessness (10-11). To our knowledge there is at least one such SHHC in every major city in the UK, including several in Greater London area, which mainly offer primary general practice services. Some of these centres constitute a registration list size of over 1,000 homeless population (personal correspondence with Health Xchange Birmingham). The establishment of these SHHCs have been led mainly by the specialist healthcare need of this population as well as the preference of homeless population to have a dedicated drop-in centres instead of facilitated access to mainstream general practices (14).

The value of such specialist services has been highlighted in terms of overcoming barriers associated with registration at a mainstream practice (15, 16) and providing specialist care, such as substance misuse services, to the specific needs of homeless populations (17).

Nevertheless, it has been suggested that transferring registration to a mainstream practice, once the patient has been stabilised, is an important aspect of improving recovery (18). This would facilitate appropriate utilisation of finite specialist resources, reduce health inequalities and support patient integration within the local community. There is a cognisance that relocation is not straightforward and there are barriers which may be difficult for the formerly homeless to overcome (19,20).

This study aimed to explore the barriers and facilitators of relocating patients from SHHC to mainstream general practice from the perspectives of formerly homeless patients and staff involved in their care. The Theoretical Domains Framework (TDF), which may be adopted as a framework in both implementation and behaviour change research, was utilised to elucidate the barriers and facilitators of patient's relocation. The TDF outlines 14 domains of behavioural determinants (see Table 1), each embodying individual constructs, and which represents a synthesis of 33 behaviour change theories. The framework may be used as a means to inform the development of behaviour change interventions (21). Within this study, the framework enabled theoretical characterisation of likely factors which may impact on patients' relocation behaviour from the perspective of formerly homeless patients and staff involved in their care.

Methods

The study utilised a qualitative methodology to collect rich data on the barriers and facilitators of relocation. The study was conducted within the north east of Scotland from February to October 2016 in a SHHC which has been operating since 2006 (22). The practice has a patient population of approximately 400, the majority of whom are homeless, aged 25-44 years old, with approximately 50% being prescribed methadone.

Qualitative in-depth interviews were conducted with patients at the SHHC (who were eligible to relocate based on health and accommodation) and those who had relocated recently from the specialist centre to a general practice in the locality of their permanent address. Patients deemed eligible for relocation were provided with details of the study when they presented for appointments at the SHHC. Those expressing interest were directed to the researcher, who was present on site, and was able to provide further information and answer any questions before inviting consent. All patients who consented to participate were interviewed. General practitioners (GPs), nurses and administrative staff from the SHHC and mainstream general practices in addition to staff from community pharmacies, involved in the care of homeless patients, were also invited to take part and those who consented were interviewed. Mainstream general practices that were invited to take part in the research were selected based on the knowledge that a significant proportion of patients from the SHCC had been relocated to these

practices. Pharmacies were identified and selected by the community health partnership pharmacist (JM) based on the extent of service provision to the currently and formerly homeless population.

The interview schedules were informed by the TDF and drafted by the research team. Separate interview schedules (available on request from the authors), for each stages of the research, were reviewed by researchers with expertise in health services research and health psychology for credibility. This was followed by piloting with two staff members and two patients and, as piloting resulted in minimal changes to the interview schedules, their responses were included in the study dataset.

Informed written consent and demographic data were obtained prior to conducting interviews. Semi-structured interviews were conducted by experienced qualitative researchers, either face-to-face or via telephone, depending on each participant's preference. Interviews were audio recorded, with permission, and transcribed verbatim. Each transcript was analysed independently by two researchers (DS, KFM, KGS, KM and VP) using Framework Approach (23). The analytical method involves multiple stages of: familiarisation with the interview; coding; developing an analytical framework; applying the analytical framework; charting, and interpreting data (24). The TDF was applied deductively to the data and used to inform the analytical framework. Transcription and analysis was ongoing throughout data collection. Saturation of data was assumed after no new themes emerged (25).

Table 1 to appear here

Results

Demographics

Patients (n=17) were aged 30 to 48 years (Mean=40.3 (SD.5.4)) and the majority were male, had experienced homelessness for more than one year and described their general health as 'fair' (see Table 2).

Table 2 to appear here

Nineteen staff participants (n=19) were recruited. They were aged 27-65 years old, with the majority being female administrative members of staff (see Table 3).

Table 3 to appear here

Qualitative findings are presented in relation to themes within the ten TDF domains identified in the analysis. Four TDF domains were not identified in the analysis and included: goals; behavioural regulation; optimism; memory, attention and decision processes.

Beliefs about consequences

Staff and patients described several consequences of relocation, which they perceived as barriers. Themes were identified relating to: patient concern over continuation of their ongoing healthcare needs upon relocation; apprehension about meeting new staff at mainstream practices; ability to integrate; and, perceptions of mainstream practice.

For example, one patient noted their concern regarding the establishment of new relationships at mainstream practices and potential stigma,

"*Obviously, you've got a little concern that you're going to get on with your doctor and you're going to like your doctor and they're going to like take to you and not look their nose down to you because of your past and stuff*" Patient 1 mainstream practice.

This was further emphasised by a staff participant,

"*…a lot of them feel if they go to a mainstream surgery they're classed as a, they're treated as a second class citizen*" Staff 9 pharmacy

Intentions

Patient intentions were described by staff and patients as key to relocation. Themes included intentions to relocate, and reluctance to relocate. Whilst some patients initiated the relocation process themselves, others expressed a reluctance to relocate. Factors affecting intentions included ongoing treatment and the negative experiences of others who had previously moved.

As noted by one staff participant, some patients were reluctant to relocate,

"*…a number of people who I suppose I've worked with over a period of time would probably rather just stay there because they know it and it's, you know, the people and it is probably a hassle to have to go and find a GP practice and go along and fill in forms and do it all*" Staff 7 mainstream practice.

One patient highlighted that they felt that they would not move due to the experience of others,

"*In my personal opinion I wouldn't move after what I've seen over the last six months of somebody moving from here to somewhere else. It's just an absolute joke and I just that pathetic*" Patient 7 SHHC.

Environmental context and resources

Staff and patients discussed the impact of environmental context and resources on relocation and integration. Key themes included: lack of effective means to establish a patients' housing status (although patient eligibility for relocation was also considered in terms of clinical stability); SHHC resources in communicating and assisting persons to relocate; communication between SHHC and mainstream practice; diverse policies and operating rules in mainstream practices in registering patients e.g. photographic ID requirements; patient's access to resources, for example telephone, and lack of continuity of services such as podiatry and dentistry at mainstream practices post relocation.

A staff participant at SHHC highlighted how continuity of services to mainstream practices could prove problematic,

"*Other care, dental services here, no longer homeless they wouldn't be able to access that, they would need to go and register elsewhere. Podiatry services that we've got here they wouldn't, they just would be unlikely to access that 'cause the services are not available for straight forward foot care*" Staff 5 SHHC.

Further, one patient, described how the SHHC offered a level of specialised care which was unparalleled,

"*…just the underlying issues that I have at the moment that I don't feel they can facilitate the best way as what this practice [SHHC] can, for me, at the moment*" Patient 12 SHHC.

Knowledge

Themes identified by staff and patients included: patients' knowledge of administrative processes involved in relocation; awareness of eligibility for relocation; knowledge of mainstream practices in their local area; lack of knowledge of rules and policies of mainstream practices, as well as knowledge and experience of SHHC staff in managing homeless and formerly homeless patients. One staff participant highlighted how it may be beneficial for patients relocating to be made aware of the regulations and policies of mainstream practices,

"*I think they need to have a bit of learning before they leave SHC to say that, I mean, I've worked at SHC so I understand that, I know what happens with them, they don't up for their appointment in the morning but they get their script in the afternoon, there's not a GP there. It's, appears quite easy to do that but they have to understand when they're at a practice like us we're nae going to do that*" Staff 1 mainstream practice

Skills

The importance of patient skills was identified in relation to a theme regarding integrating and adapting to the culture of mainstream practices. Whilst one patient experienced little difficulty in integrating,

"*Yeah, I've just been twice since I moved and everything's been okay, transferred nae problem at all*" Patient 3 mainstream practice,

it was suggested that some patients may experience issues integrating into mainstream practices,

"*…we do find them* [relocated patients] *challenging people to, to try and integrate into our way of working shall we say*" Staff 2 mainstream practice.

Social/professional role and identity

Both patients and staff identified the influence of social/professional role and identity in relocation. Themes included: patient self-identifying as homeless and expectation of negative perceptions; patients not perceiving the SHHC as a specialist practice for those experiencing homelessness; changing healthcare/lifestyle needs of patients serving as a prompt to relocation; the role of staff at the SHHC in facilitating relocation, and the ability of pharmacy staff to assist in the relocation process. One pharmacist described their potential role in the relocation process,

"*…because we see these patients everyday we're obviously in a very good position to be able to speak to them, we've got good relationships with them so we could use those relationships to be able to support them and find out more information about their movement from one practice to another*" Staff 1 pharmacy,

and from a patient perspective, the positive role of staff at the SHHC in facilitating relocation,

"*…she [staff member at SHHC] would always be like 'have you found another practice? If you need any help, if you go up and they're like, 'we're not taking anybody else', phone me and I'll speak to them if you want*" Patient 2 mainstream practice.

Beliefs about capabilities

Staff and patients described a key theme relating to self/patient's perceived ability to integrate into mainstream practice. Self-esteem and confidence were regarded as critical concepts impacting a person's ability to integrate. Whilst a staff participant discussed the ability of patients to integrate particularly in terms of building confidence,

"*…I think the self-esteem and the confidence and, you know, kind of that element of it takes so much longer to build back up in the person*" Staff 1 SHHC.

Social influences

Both staff and patients identified the impact of social influences on relocation. The principal themes identified illustrated the influence of health and social care professionals, administrative staff, family and friends in promoting relocation, and the experiences and influences of patients who had relocated previously. For example, the experiences of others who had previously relocated both positively and negatively influenced an individual's willingness to relocate and the practice that was selected for relocation,

"[patient's*] been cut off heaps of stuff* [services post relocation] *in the space of six month and just completely a joke…so, in my point of view, moving practice, just with personal experience with somebody that I ken I just, I wouldn't be happy about moving set up like*" Patient 6 SHHC,

a theme which was further emphasised by a staff participant,

"*…maybe they hae [have] friends that are here [mainstream practice] and thinking 'well, I'll just, I'll just go'* Staff 1 mainstream practice.

Reinforcement

Reinforcement was discussed by staff and one patient primarily in the context of healthcare professionals, administrative staff, social care workers, family and friends who were perceived as important in facilitating and reinforcing relocation. It was highlighted that staff often discussed the benefits of relocation, such as greater availability of appointments at mainstream practices, in an effort to incentivise and motivate eligible patients.

"*…we always try to portray the positive, you know, 'this is you moving on, the range of services, the timescales, you know GPs to choose from, you choose your own GP, you could get a late appointment after your work or before you work'*" Staff 4 SHHC.

One patient highlighted how patients were unlikely to relocate unless SHHC staff at the SHHC reinforced it,

"*No, just, just, the only way people are going to move is if somebody sits down and does it for them, and that's real, that's realistically the truth it is it?*" Patient 1 mainstream practice.

Emotion

Emotion was identified by staff and patients as influential in the decision to relocate. Themes identified were: patient expression of emotions in relation to relocation, and emotional attachment to the SHHC. For example, an individual's emotional attachment to the SHHC often presented as a barrier to relocation, this was highlighted by both staff

"*I guess the fact that if you had been seeing one doctor for a long time and then all of a sudden you need to go to somewhere different everyone would kind of feel that initial anxiety but I've never had anybody saying continuing problems they've experienced at a new practice"* Staff 8 pharmacy

and patient participants,

"*I'd be very, very upset if I was asked to leave*" Patient 10 SHHC.

Summary of key issues

The following facilitators and barriers to relocation and integration of patients from the SHHC to mainstream practices were identified in this study (Table 4).

Discussion

Summary

This study has highlighted the key barriers and facilitators relating to the relocation process of patients from a SHHC to mainstream general practices. Barriers and facilitators were identified

in relation to TDF domains and included: patients intentions to relocate (e.g. expression of reluctance to relocate); environmental context and resources in relation to specialist and mainstream practices (including assessment of housing and clinical stability, and the difficulties encountered in establishing the former); beliefs about consequences regarding relocation to a mainstream practice (e.g. patients' apprehension to establishing new relationships with staff at mainstream practices); knowledge of relocation processes and mainstream practices (e.g. patients' lack of knowledge of the relocation processes); skills in relation to integration (e.g. skills around adapting to mainstream practices); social/professional role and identity of staff and patients (e.g. the role of staff in facilitating relocation); beliefs about capabilities in relation to ability to relocate and integrate (e.g. perceived ability to integrate at a mainstream practice); reinforcement of relocation (e.g. the role of others in reinforcing and facilitating relocation); social influences and the positive/negative effect on relocation (e.g. the positive relationships established with staff at the SHHC serving as a barrier), and emotion attached to relocating (e.g. emotional attachment to the SHHC and the resultant negative impact on desire to relocate).

Strengths and limitations

This is the first study exploring perspectives of formerly homeless patients in relocating from a SHHC to a mainstream practice within the local area. The use of theory and steps taken to promote rigour and trustworthiness of the findings, particularly with regard to the expert review of study materials added to the strength of the study. A further strength of the research was in terms of reflexivity; the research team was multidisciplinary and thus, ensured that the study was conducted with a broad lens.

There are, however, limitations hence the findings should be interpreted with caution. Due to the nature of recruitment and identification of potential eligible participants, it may be that those recruited did not represent a broad demographic. Response bias may have also been a factor in the research, in that participants may have responded with socially desirable answers. Further, the number of patients who had moved from the SHHC to mainstream practices was low due to challenges in identifying and recruiting the target population. Lastly, there are potential limitations with regard to the transferability of findings since the key outcomes may be specific to the particular context, population and environment in which they were studied and thus, may not be easily transferred to other locations.

Comparison with existing literature

Participants in this study reported that formerly homeless patients often faced difficulty in relocating to a mainstream practice if they were not in possession of photographic identification.

Previous studies have highlighted that homeless patients often experience issues with registering at mainstream general practices due to a lack of fixed abode (11) and identification documents (12). This study has identified that even once settled at a permanent address, formerly homeless patients may still find it challenging to register at a mainstream general practice.

A previous report suggested that patients in a homeless healthcare centre appreciate the specialist nature of the services offered (26). This study has added to our knowledge that such high level of satisfaction to the SHHC services, as well as perceived lack of tailored services at the mainstream practices are associated with patient reluctance to relocate. With approximately 50% of the patients being prescribed repeat methadone through the SHHC involved in this study, lack of such substance misuse service provision at mainstream practices may also have posed a barrier to some patients' intentions to relocate.

This study also provides patient perspectives on the role of SHHC staff as well as the health and social care worker who dedicated time specifically to facilitating relocation. The results reflect the recommendation that specialist practices may benefit from having a 'GP liaison/resettlement worker' (27). This study provides indications that substance use workers are ideally suited to undertake such liaison role, not just for housing resettlement but also for enabling the relocation from SHHC to mainstream general practices in their resettled localities.

A potential barrier to relocation may be fear of stigmatisation or discrimination within mainstream practices. These findings corroborate with the extant literature, which suggests that poor prior experiences with healthcare professionals and negative attitudes from staff may serve as barriers to utilisation of a mainstream practice (10,28). This study has identified that in addition to the personal experiences, the perspectives of those who have previously relocated also strongly influence their peers waiting to relocate.

The findings from this study further highlighted the complexity of the relocation process in terms of barriers and facilitators. Barriers and facilitators of relocation often varied between individuals. These findings suggest that any approach to changing behaviour within the population should be tailored in accordance with the individual. This reflects guidance issued by National Institute for Health and Care Excellence on promoting behaviour change where it is advised that behaviour change programmes and interventions are tailored to individual needs (29).

Implications for research and/or practice

This study has identified the complexity of the processes involved in identifying and enabling formerly homeless patients to relocate to mainstream practices. The relocation process is both time and resource intensive with input required from patients, healthcare, administrative and social care staff at both practices. Accordingly, exploration of the key barriers and facilitators in accordance with TDF domains has resulted in identification of the following which may be beneficial in supporting patients during relocation:

(i) Increasing patients knowledge of eligibility for relocation and mainstream practices' policies and regulations
(ii) Peer support networks
(iii) Provision of reassurance with respect to continuation of healthcare and with regard to integrating and developing relationships at mainstream practices
(iv) Provision of information sources, such as the 'My right to access healthcare' cards, which outline guidance for patients on registering at mainstream practices (13)
(v) Greater involvement of community pharmacists in relocation processes
(vi) Development of individualised plans to promote behaviour change. This may involve mapping of TDF domains to behaviour change techniques, which are typically incorporated into intervention design for behaviour change programmes as a means to facilitate change (30)

Further, staff at specialist and general practices supporting relocation may benefit from the following:

(i) Provision of information regarding relocation processes
(ii) Support of newly relocated persons via proactive signposting to where additional healthcare services may be accessed
(iii) Support of a professional who is dedicated to facilitating relocation
(iv) Sharing of specialist knowledge and skills, between staff at both practices, in managing patients experiencing homelessness

Understanding the perspectives of those mainstream general practices which have been reluctant to register formerly homeless patients from SHHCs would also enable further insight into the barriers and facilitators to the relocation process.

Additional information

Funding: This study was funded by Health Improvement Fund, NHS Grampian

Ethical approval: NHS East Midlands approval (REC 2 15/EM/0535); NHS Grampian Research and Development approval Ref 2015RG007.

Acknowledgements: NHS Grampian; the general practices and community pharmacies that were involved in the research; study participants; Caroline McNiff for her part in data collection and Jeanette Lowe for transcription of audio recordings.

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