


BMJ Open Barriers and facilitators to accessing health and social care services for people living in homeless hostels: a qualitative study of the experiences of hostel staff and residents in UK hostels

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ABSTRACT

Introduction The number of people living in homeless hostels in the UK has steadily increased over the past decade. Despite people experiencing homelessness often having considerable health problems and a range of complex needs frequently in association with addictions, the experiences of hostel staff and residents especially in relation to accessing health and social care support have seldom been explored. The aim of this paper is to identify the barriers and facilitators to accessing health and social care services for people living in homeless hostels.

Design Exploratory qualitative baseline data were collected as part of an intervention to facilitate palliative care in-reach into hostels.

Setting/participants Interviews were conducted with 33 participants; 18 homeless hostel managers/support staff and 15 people experiencing homelessness, from six homeless hostels in London and Kent.

Results Three themes were identified (1) internal and external service barriers to health and social care access due to stigma, lack of communication and information sharing from services and assumptions around capacity and the role of the hostel, (2) the impact of lack of health and social care support on hostel staff leading to burnout, staff going beyond their job role and continuous support given to residents, (3) potential facilitators to health and social care access such in-reach and support from those who understand this population and hostel staff training.

Discussion Residents have multiple complex needs yet both hostel staff and residents face stigma and barriers accessing support from external services. Positive relationships were described between hostel residents and staff, which can be an essential step in engaging with other services. People experiencing homelessness urgently need better access to person-centred, trauma-informed support ideally via in-reach from people who understand the needs of the population.

INTRODUCTION

Prior to COVID-19, homelessness in Great Britain was increasing year on year, more than doubling since 2010.¹ ‘Homelessness’ includes

Strengths and limitations of this study

- The views of people experiencing homelessness are seldom heard in research. Due to the expertise of the team, including an inclusion health general practitioner, we were able to sensitively explore this topic.
- The people experiencing homelessness recruited were suggested by staff or self-selected, so potentially there may have been bias towards including residents who were more positive about hostel staff or hostel life.
- Hostels vary greatly in terms of the support available to them (eg, mental health services, in-reach primary care, in-reach addiction services, etc). We cannot conclude that the experiences would be the same in different hostels.
- Our topic guide was informed by an expert by experience and our interpretation of the findings was informed by a variety of professionals with expertise in this area.

people without shelter of any kind (‘rough sleeping’), those sleeping in temporary accommodation (such as hostels) and those living in insecure or inadequate housing.² In 2018, there were 35 727 bed-spaces in 1185 accommodation hostels across England and it is suggested at least 75 000 different individuals use hostels over the course of a year.³ The needs for health and social care support are high in this population, as evidenced by the high rates of premature ageing, frailty, multimorbidity and mortality rates.^{4,5} The average age of death for people experiencing homelessness in England has been estimated to be 51.6 years old.⁶

Hostels have been around since the 19th century, as a response to a need for shelter.⁷ The remit of most hostels is to support people to ‘recover’ and move out

of homelessness. This recovery focus may include an emphasis on supporting access to addiction services, training and meaningful activities. However, residents in hostels often have severe and complex needs, with a combination of mental health difficulties, substance misuse and physical health problems⁸; therefore, the recovery focus of hostels may not always be appropriate. Furthermore, negative experiences, such as feelings of being infantilised, objectified and stigmatised often result in people experiencing homelessness not accessing health and social care support.^{9 10}

Increasingly, the burden of dealing with a severely unwell population, including people with palliative care needs, is falling on hostel staff, who often struggle to access adequate support from health and social care professionals for hostel residents.^{11 12} Working in a hostel has been described as potentially traumatising.^{13 14} This lack of support is exacerbated by a lack of interventions aiming to support people experiencing homelessness manage their health and reduce unscheduled healthcare utilisation and mortality.¹⁵

Limited research has explored the experiences of living and working in a homeless hostel. One study explored the relationship between hostel staff and residents, specifically in relation to those who misuse drugs and found that people experiencing homelessness felt poorly treated by hostel staff, felt unheard and had no privacy.¹⁶ Exploring the experiences of both residents and staff allows for a more complete picture of an issue or situation and enables all perspectives to be considered. This paper is based on the analysis of baseline qualitative data collected as part of an intervention study evaluating the impact of twinning palliative care services with hostels,¹⁷ in which staff and residents expressed several challenges that went beyond those specifically related to palliative care. These baseline interviews explored the support residents receive from hostel staff and external services, the impact this had on the hostel staff and the views of staff and residents regarding what may improve health and social care access for the people that live within the hostels.

METHOD

Design

Exploratory qualitative baseline data collected as part of an intervention to facilitate palliative care in reach into hostels, guided by the Standards for Reporting Qualitative Research framework.¹⁸

Participants and procedure

Hostel managers, hostel staff and residents were recruited for baseline interviews from six hostels as part of an intervention study of palliative care in-reach into hostels¹⁷ between April 2019 and October 2019. The hostels provided for residents with medium to high support needs.³ All staff and residents with capacity to consent were eligible. Residents were approached by a member

of the hostel staff to see whether they were willing to talk to the researchers and were offered a £10 supermarket voucher as a mark of appreciation for their time. No participant declined to be interviewed. All interviews were conducted at the hostels and were conducted by two authors either together or separately (CS and MA). CS is an inclusion health general practitioner (GP) and MA is a research fellow. Interviews took between 30 min and 90 min and were audio recorded. A semistructured topic guide informed by an expert-by-experience was used to guide the interviews. Interviews with residents explored their history of homelessness, general health and health needs, experiences of accessing support from external services and hostel staff. Interviews with staff explored the health needs of the residents, the extent of any support that staff or their residents currently received from health and social care agencies and the impact lack of support causes.

Public and patient involvement

An expert by experience, who has lived experience of being homeless, sits on the advisory board of this project and has contributed to design of the wider project and the topic guide for the interviews in this paper. The remaining advisory board is made up of researchers, clinicians, social care providers and a hostel manager. Experts by experience will contribute to the dissemination of these findings.

Analysis

Thematic analysis guided by Braun and Clarke's framework¹⁹ was used to identify, analyse and report themes. Line-by-line coding was undertaken by MA using NVIVO V.12²⁰ and consensus was achieved through discussion (MA, CS and BH). Higher level candidate themes and subthemes were developed and discussed with all authors.

RESULTS

Characteristics of participants and hostels

Fifteen people experiencing homelessness who were residents, 5 hostel managers and 13 hostel staff from six hostels across London and Kent were interviewed. Residents had an average age of 45.7 years and 11/15 were men. All hostels were supporting people with medium or high support needs with the number of beds ranging from 23 to 60. Only one hostel had in-reach primary care. See [table 1](#) for participant characteristics and [table 2](#) for hostel characteristics.

Themes

Thematic analysis of semistructured interviews exploring health and access to health and social care services for people living and working in homeless hostels identified three main themes (see [table 3](#)).

Internal and external service barriers to health and social care access

Misconception of the role of a hostel

Staff felt that there was a misconception from health and social care providers about the support they were able

Table 1 Participant characteristics

	Support workers/ managers (n=18)	Residents (n=15)
Gender		
Male	5	11
Female	13	4
Mean age	38.8	45.7
Ethnicity		
White British	11	13
Black British	4	1
South Asian	1	1
White other	2	0

to provide within a hostel. A ‘complex needs’ hostel is not able to provide health or social care support. People discharging patients from hospitals along with other service providers often think that the presence of a member of staff in the hostel overnight equates to provision of 24-hour care, which is not the case. The overnight member of staff may, for instance, only be a concierge.

I think because a lot of people presume because it’s 24-hour manned project, they’ve got staff. They don’t

really realize that our job isn’t to be carers...It’s not always practical to see everybody every single day. What people see from the outside is 24-hour staff—support worker, hostel 5.

Lack of responsiveness from external health and social care services

All hostel staff described struggling to get support from a range of external services for residents. Hostels that did not have regular GP in-reach described considerable barriers in accessing primary care, such as difficulty getting residents registered, inflexibility and lack of appointments. Staff described how some residents struggled to fit in with societal norms and that this hindered their ability to access the mainstream services they required.

For me, she epitomizes...a Resident who doesn’t fit in what I would term as the social norms of society, where society tries to shoehorn you into a box that says you will do this and this, and this is how society works and you must behave like this et cetera. When you’re dealing with Residents like this they don’t operate on that level— support worker, hostel 5.

Staff also struggled to get adult social services to respond to referrals and to adequately undertake and/or act on

Table 2 Hostel characteristics

Hostel	Number of residents	Length of stay	Age range of residents	Level of need	Alcohol allowed on premises	Food provided	GP/nurse in reach	Mental health in reach	Drug and alcohol in reach
1	35	Up to 2 years	22+	High support needs with alcohol use	Yes	Yes: three meals a day	In-reach GP who attends once a week	No	No but was aiming to organise this
2	58	6 to 15 months	18+	Medium to high support	No	Breakfast and dinner; no meals for bedsits	No but good links with local homeless GP	No	No
3	60	6 months to 2 years	18 to 65	High complex needs	Yes (not in communal areas)	No	No	No	No
4	50	18 months to 2 years	18 to 65	Medium complex needs	Yes (not in communal areas)	No	No	No	Yes—was due to start shortly after interviews were conducted
5	23	2 years	18+	High complex needs	Yes but was due to become no	None	No	Not at time of interview: one due to start.	Yes—comes once a week
6	42	2 years	16+	High complex needs	No	None	No	Not at time of interview: one due to start.	Yes—comes once a week

GP, general practitioner.

**Table 3** Themes and subthemes on the experiences of accessing health and social care support for residents living in UK hostels

Theme	Subtheme
Internal and external service barriers to health and social care access	Misconception of the role of a hostel
	Lack of responsiveness from external health and social care services
	Stigma affecting quality of support
	Pressure to move on despite being unwell
	Lack of information sharing with health and social care services
Impact of lack of health and social care support on hostel staff	Assumptions regarding mental capacity
	Going above and beyond
Potential facilitators to health and social care access	Burnout
	Continuous support given to residents
	Support from those that understand this population
	In-reach
	Staff training

Care Act Assessments. Referrals for care act assessments were often made to obtain help for people who were self-neglecting and needing help with tasks like washing and dressing. Getting this support was especially difficult for people with active addictions.

There are some Residents here who not only don't self-care, but possibly don't know how to. That sounds silly, but there are a lot of Residents who don't wash or shower for days, and genuinely don't look after themselves...I think that is the main issue with our Residents, there is a lot of mental health, self-medicating and their mental health is interlinked, physical, mental health and substance use—support worker, hostel 5.

Often hostel staff felt there was a lack of communication or responsibility from external services when hostel staff made referrals. This inaction left hostel staff feeling responsible for people who were unwell.

There was no communication with us...[we don't know if] they've received it [the referral], that they're looking into it or it's gone to the wrong team or anything like that. It's only because we had to raise it [again that we heard anything]. You have to go that far until essential support is allocated to that person—manager, hostel 3.

On occasions, hostel staff described resorting to extreme measures to get essential services involved:

“Someone will get back to you. Someone will get back to you,” or “We'll get back to you,” and they [external services] never do, and you can spend days chasing it. It's frustrating. On some occasions in recent times there was a staff member here who actually had to get the police involved and get the police to action the Community Mental Health team because the Mental Health team wouldn't come out to what was deemed a crisis and was a crisis. It took police intervention to actually get them on our doorstep, which is not ideal—support worker, hostel 6.

It was acknowledged by staff that many services are underfunded and overstretched.

obviously, everyone's in the same boat and every service is flat out, understaffed, underpaid, under everything—support worker, hostel 5.

Stigma affecting quality of support

There were many suggestions of stigma towards residents from external services.

It's really difficult to get anyone to come in and do anything really. We've had district nurses come in to look and people's legs and things but trying to get them to understand our resident group. And they don't get it. They don't understand our resident group ...they look at our resident group as if they don't count—support worker, hostel 1

Staff from one hostel described an insistence from their local GP practice that a member of staff attended every appointment with the resident regardless of the needs of the individual concerned.

We have got one of the local GPs around here, they will not accept our Residents unless a keyworker is with them, and they have to attend all appointments with them and register with them. They won't accept them on their own—support worker, hostel 3.

This was echoed by residents who said they felt stigmatised, especially by GP receptionists who sometimes refused to register them.

You get the receptionist barrier, don't you? Very snooty, “Well no, we're not taking any new residents—resident, hostel 6.

Hostel staff themselves also described feeling marginalised, stigmatised and disbelieved by some services:

It's also being believed or trusted. When we are saying, “look, there's a problem here, they can't be struggling with this, they can't do it.” Then they're not taking our word for it—support worker, hostel 3.

Pressure to move on despite being unwell

Given the recovery focused nature of hostels and the limited number of hostel beds available, staff reported feeling under pressure from local councils or

commissioners to move residents on into less supported accommodation. The length of time for which hostels can house residents varies, but the longest was typically around 2 years for our sample. For many people, especially those whose health is poor, this can be challenging. There is often no suitable accommodation for people to move into, and residents may be too unwell to move into less supported accommodation. If residents were still at the hostel when they should be moving on, then staff often had no choice but to try to move the resident to another hostel or to less-supported accommodation, despite a high level of support needs.

The pressure is clearly high. We're feeling it to the point where we need to be able to move on Residents...we have to be explaining what we do and why they're here...Obviously, how do we move on someone when we feel the person perhaps may need more support to get all the valuable skills to be able to live independently—support worker, hostel 4.

Residents feared the thought of moving on and worried about where they would go next.

My key worker said they try to get you out of—Not get you out, but they try to move you on within six months. You can stay up to a maximum of two years here and I think I'll be up by the end of the year. That's a realistic option. It's not something that I welcome—resident, hostel 3.

Working with incomplete information

The lack of ease with which information flowed between hostel residents, staff and external agencies caused frustration and difficulties in providing person-centred care. Hostel staff were often not recognised by health services as being important for facilitating ongoing support for their residents. This meant that they often did not have access to the information that they needed to advocate for their residents.

Then I've got the doctor refusing me because I haven't got resident consent. I have the resident consent, it's just a fact that they don't believe what I have. It is very to-ing and fro-ing with resident consent. This whole GDPR thing, I understand it. I know why it's there; I know it's important, but I do find that the hardest thing—support worker, hostel 6.

Lack of information sharing was also frustrating and surprising for residents. Lack of continuity in care meant that residents found they had to retell their stories to different agencies involved in their care who were working with out-of-date information. This further eroded their trust in systems and services.

I was that upset and annoyed that she's [social worker] not speaking to anyone else that I'm working with. I said, "It's not keeping you up to date." I speak to you once every three weeks, you don't know

what's happening. So I could be going through a really difficult time and you're not aware of it and that something could trigger me to go back and you're not going to know until I've been arrested—resident, hostel 6.

In addition, some staff felt that residents were not always able or comfortable sharing information with external services about their health or symptoms. As a result, diagnoses could be missed.

I find a lot of the time purely because maybe some of our residents aren't the most articulate. It's just a lot of investigation work doesn't get taken place. I think that's the biggest challenge we face—manager, hostel 4.

High caseloads and pressures meant hostel staff did not have sufficient time to spend with residents to build trust. Without the development of trust, the sharing of information relating to health between residents and staff was limited and challenging.

I'm still finding I'm having to learn to trust people. I don't always trust people now, and my confidence is not brilliant. Once I know someone [this is different]...., but I'm not very good coming forward at the beginning—resident, hostel 1.

Assumptions regarding mental capacity

When residents are self-neglecting or refusing to see a healthcare professional, this can be distressing for staff, as they are left feeling responsible. Concerns were raised by staff about the assumptions of external services regarding the capacity of residents to refuse treatment, often without assessing them. This means that hostel staff are often left to support people alone. Staff described the assessment of mental capacity as complex when people were self-neglecting or had significant health problems, on a background of substances misuse.

The other thing is they feel that the Resident is able to make that judgment for themselves. That could be difficult even though we've said actually, "Please don't leave without even assessing them," because that would be a concern for us—manager, hostel 3.

Impact of lack of health and social care support on hostel staff

Going above and beyond

Staff describe how the activities they undertake to support residents' health and well-being far exceed their job roles, which are to support people to move out of homelessness and engage with services. They often ended up taking responsibility for medicines management and supporting people who are self-neglecting with multiple and complex needs. This was usually in the absence of sufficient training or support.

That was always my grind that we are not trained but they expect you and the expectation is there for us to give them the support—support worker, hostel 1.

We also have to go and collect people's medications. We don't have to but we're doing that as well and liaising with GPs to put [medication] in dosette boxes and things like that—manager, hostel 3.

Staff acknowledged that they all worked differently with some providing more support than others. Nonetheless, it was agreed that theirs was a demanding role and staff need to be robust, resilient and dedicated.

For one to be able to do a good job, you need to be robust, you need to be resilient—support worker, hostel 4.

Burnout

Due to the challenging nature of their role, the demands placed on them and low pay, turnover among hostel staff is high, often resulting in staff shortages. This places staff under further strain, which can impact on their well-being.

I don't really switch off. Even on my week on annual leave—support worker, hostel 4.

Staff shortages can also negatively affect residents.

Because of how understaffed we are at the moment, we're stretched. Things are getting missed that wouldn't have been missed a few months ago. Checks aren't getting done as often. Just because there's no staff and it's one of the biggest issues here at the minute—manager, hostel 5.

It can be extremely traumatic for staff when a resident dies, as highlighted by this quote following a sudden unexpected death of a resident.

When he was standing along the walls and he was saying, "I'm feeling pain," and he just slid into the floor. It was during the night, early morning so there were only two staff. Staff were running up and down. It was quite a traumatic experience—manager, hostel 2.

Continuous support given to residents

The residents were overwhelmingly positive about hostel staff partly due to the support they gave them when other services failed to. Residents described how the staff would be the first person they would talk to if they were concerned about something. The staff then listened to them in a non-judgemental way and provided continuous care and support.

It's pretty supportive. My key worker is great. They're people that don't come across as judgmental—resident, hostel 1.

Yes. I think she does care about me. I've never actually asked her, does she care? The staff here are alright, I

like them. I like the staff here. I ain't got a bad word to say about them—resident, hostel 3.

Here the staff are brilliant. They're actually brilliant. They're available 24/7 which is good because sometimes I do feel that I do need to talk to someone, I need to get things out. They work with anyone outside that I want them to work with—Resident, hostel 5.

Potential facilitators to health and social care access Support from those that understand this population

Staff reported feeling powerless. Their expertise and understanding of the population were often not appreciated, and they wanted and needed support from other agencies that understand this population. In the hostels with significant barriers in accessing primary care, when there is a health problem, all staff feel they can do is advise their residents to use emergency services. Staff felt they needed assistance and advice regarding how to get better support for their residents and how to build, maintain and benefit from relationships with other agencies.

Sometimes it's about just general advice.... Say, "Okay, in future try and do X,Y,Z." Sometimes you're just trying to learn as new things happen and it's not a professional way of learning it's just your learning—manager, hostel 1.

In-reach

In the hostels where it was in place, in-reach from GPs or nurses was felt to be extremely useful. Providing consistent support within the hostel eliminated key barriers to access and provided the opportunity for trusting relationships to be built.

It's really invaluable because it then allows Residents to bypass the process of having to get past the gatekeeper or the receptionist. It takes away, in effect what is happening in that there are barriers being put in place between being able to access the services they want to access. If you take away that barrier, so the Residents know that a healthcare professional is coming here on a certain date, then they don't have to fight the system as it were, having to jump through hoops to get an appointment—support worker, hostel 6.

Residents also felt that in-reach into hostels might improve engagement with other services. The following quotation came from a resident in a hostel where there was no primary care in-reach.

I sometimes wonder. Again, it's so expensive to do it. Like if we had a doctor come on a regular basis. If someone from those services come, but it's not likely to happen, which I think it would help a lot of people, because they would then go in and talk to them. It might take a while initially—resident, hostel 5.

One hostel described a good relationship with a specialist homelessness GP practice. Staff at the hostel

with an in-reach GP also felt well supported. When talking about a particular resident of concern:

We would raise the risk to the GP and other relevant bodies, people who are dealing with this particular individual...We are well supported in that area when it comes to the health care—support worker, hostel 1.

More staff training

To be more equipped both in terms of knowledge and emotional capacity to support residents, staff highlighted training as something that would be useful. Training around recognising signs of deteriorating health, building and maintaining useful relationships with other local services and engaging residents that currently are not accessing support were identified as key topics to be considered.

It's the training that we lack on that side. Our resources don't stretch that far as to be trained in the physical side of things—support worker, hostel 4.

DISCUSSION

This paper has explored the experiences of hostel staff and residents in relation to accessing health and social care support. We identified three themes that summarised staff and residents' experiences and challenges. These included managing the barriers of access to internal and external services, the impact of lack of external support on hostel staff and potential facilitators in supporting hostel staff and residents to access health and social care support.

Experiencing stigma from health and social care services has been identified in previous research and has been recognised as a significant barrier for people experiencing homelessness.⁹ However, this paper identified that staff themselves can also become stigmatised and not believed. Many of the barriers that staff described were related to fragmentation and a lack of support from outside agencies, disagreements over whether residents have capacity or not (often resulting in a reason for not providing support) and a lack of information sharing. Previous research identified the need for multidisciplinary, joined up care in which services communicate effectively with each other for people experiencing homelessness.²¹ This paper has also illuminated the pressure hostel staff face from commissioners to ensure residents move on, out of the hostel, within a specified time, irrespective of their needs. The barriers to health and social care combined with the stigma and lack of understanding around the needs of people experiencing homelessness highlight an urgent need for more training, support and dedicated funded inclusion health in this area for more equitable access.

Experiences of trauma are common among people experiencing homelessness, and homelessness itself is traumatic.²² Within this study, previous traumas and

negative experiences adversely influenced the development of trusting relationships with services. Issues relating to a lack of trust did not extend to hostel staff, with whom residents reported caring and supportive relationships. People experiencing homelessness often have a limited social network with many estranged from their family.²³ This social isolation can lead to the hostel staff taking on a more familial role by emotionally supporting residents and visiting them in hospital in their free time as well as even arranging funerals and vigils.^{14 17} This study echoes those findings by highlighting how the hostel staff go above and beyond their job role consistently to try to meet the residents' needs. This sense of responsibility and isolation in combination with the complex needs of residents can contribute to staff burnout. Previous research identified how burnout can create a vicious cycle in which staff are too unwell to work, putting pressure on remaining staff, leading to further burnout.²⁴

Hostel staff wanted to be supported and believed by services that understand the population and with whom they could build a relationship. In the absence of specialist inclusion health services, in-reach by GPs or nurses could help remove barriers and enable residents to build trusting relationships and access services. Hostel staff requested more resources and training for themselves to increase their knowledge and confidence in supporting and advocating for residents. Training for hostel staff has been found to be beneficial, but multidisciplinary care is also necessary for lasting change and empowerment to take effect.²⁵ Ongoing support and training for staff should, therefore, be a priority for future research and service development.

Strengths and limitations

This study has explored the experiences of hostel staff, managers and hostel residents in relation to accessing health and social care support and has captured a range of challenges and areas of need. The people experiencing homelessness recruited were suggested by staff or self-selected, so there was likely to have been bias towards including residents who were more positive about hostel staff or hostel life. Another limitation is that hostels vary greatly in terms of the support available to them (eg, mental health services, in-reach primary care, in-reach addiction services, etc). We explored six hostels here, but we cannot conclude that the experiences would be the same in hostels with a higher level of support in place.

Implications for research and clinical practice

This research has highlighted how previous traumatic or negative experiences can influence how a person relates to others and accesses services and support. There is a recognition of the need for 'psychologically informed environments', in which the psychological and emotional needs, of people experiencing homelessness and the needs of people who are supporting them, are met.²⁶ Some research have shown that this can be challenging to embed in practice but is broadly meeting the aim of



creating an improved environment.²⁷ The lack of understanding from some other agencies described by both staff and residents in this study posed additional barriers to accessing person-centred care and support. There is growing recognition of the value and need to include people with lived experience (experts by experience or peers) in the development and delivery of services, to ensure that they are accessible, inclusive and designed with those with experience at their heart. *Groundswell* runs a homeless health peer advocacy programme across several areas in England, whereby people with lived experience of homelessness are trained to support others to address barriers to accessing health services and support them to attend appointment and to address their physical and mental health needs.²⁸ Further work exploring the impact of peer navigators working within services in a psychological trauma informed framework on harm reduction is also currently underway in Stirling, Scotland.²⁹ The focus of this project will be to facilitate the development of trusting, supportive relationships and providing practical elements of support such as access to primary care, treatment and housing options.

Both staff and residents in this study are called for greater in-reach from health and social care services into homeless hostels. GP practices in England are now grouped into primary care networks, which are expected to appoint an inclusion health lead. Hopefully, this will result in more provision of in-reach support into complex need hostels.³⁰ A recently developed self-assessment tool can support primary care networks around how to best meet the needs of inclusion health groups and interventions that may be helpful to consider.³¹ Creating mechanisms for identifying and sharing examples of good practice would be helpful to share learning from services that are able to work in a holistic, multidisciplinary way to support people experiencing homelessness.

CONCLUSION

This paper explored the experiences of accessing health and social care support from the perspectives of staff and residents. Significant barriers were faced, which increase the inequity experienced by some of the most marginalised and unwell people in society, and contribute to staff burnout. Hostels urgently need additional support from health and social care providers, including in-reach to deliver care to people in an environment in which they feel comfortable. Support and services need to be psychologically and trauma informed and could gain valuable insights and input from people with lived experience.

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Contributors CS is the principal investigator of this project and accepts full responsibility for the work and conduct of the study. CS and MA carried out the data collection and alongside BH analysed the data. MA drafted the first version of the paper. MA, CS, BH, PS and NH contributed to the interpretation of the data and the final draft.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval Ethical approval for this research was provided by UCL Research Ethics Committee on 8 February 2019 (project ID: 6927/002). Written consent was given from all participants. CS and MA are both trained in accessing capacity to ensure that informed consent was given.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request.

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