

Guidelines for health related street outreach to people experiencing homelessness



Introduction

Street outreach is an assertive strategy that aims to bring services directly to people who are sleeping rough and can provide an approachable face of healthcare (Dorney-Smith et al., 2018).

Standards published by the Faculty for Homeless and Inclusion Health (2018) state that specialist primary care services should provide street outreach. Although many homeless health services around the UK are providing street outreach, there has previously been no guidance detailing how to deliver it.

The aim of these guidelines is to assist services to plan new health related street outreach projects, or to review their existing outreach. Homeless health services cover a range of locations and the demographics of the people sleeping rough in these areas may differ widely. Therefore this document is designed as a flexible tool for sharing best practice and innovative ideas, allowing services to use them as appropriate to their areas.

Process

These guidelines have been developed with input from experts by experience and healthcare workers around the UK, and have also involved the following pieces of work:

- A qualitative research project exploring how people with experience of sleeping rough perceive health related street outreach (Ungpakorn and Rae, 2019);
- A workshop involving 25 healthcare workers, housing outreach workers and peer advocates at the London Network of Nurses and Midwives Homelessness Group (LNNM) Conference in October 2018;
- 30 questionnaires sent to healthcare workers and housing outreach workers in locations around the UK including several boroughs of London, Edinburgh, Glasgow, Leeds, Bradford, Swansea and Bournemouth.

The scope of these guidelines only includes service provision to people who are 18 years old and over.

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Why?

Reasons to provide health related street outreach

Socially excluded people, including people experiencing homelessness, are 10 times more likely to die early than the general population (Aldridge et al., 2018). There are multiple barriers that prevent people experiencing homelessness from accessing the healthcare they need, including inflexible registration and appointment rules, negative attitudes of staff and competing priorities while surviving on the street (Burrows et al., 2016; Rae and Rees, 2015). Of the 800 homeless deaths recorded in the United Kingdom (UK) between October 2017 and March 2019, one third were caused by treatable conditions (Bureau of Investigative Journalism, 2019).

The National Health Service (NHS) Long Term Plan (NHS England, 2019) recognises that the numbers of people sleeping rough has increased over recent years, and identifies providing outreach services as an important intervention to tackle these stark health inequalities. People with lived experience of homelessness state that extra effort is needed to identify people who are excluded and meet them where they are at (Luchenski et al., 2018). The aim of health related street outreach is to bring healthcare directly to the most underserved people, i.e those that other services fail to reach, and to connect with hidden populations (Zlotnick et al., 2013; Szeintuch, 2015). It is an assertive strategy to build relationships with people in their environment and has been shown to increase engagement with sexual health, substance misuse and psychological services (Dorney-Smith et al., 2018; Connolly and Joly, 2012).



Perceptions of people with experience of sleeping rough

A recent Qualitative Description study used semi-structured interviews with a purposive sample of 10 participants and Braun and Clarke's (2006) thematic analysis to explore perceptions of health related street outreach (Ungpakorn and Rae, 2019). The findings of this study were that people with experience of sleeping rough felt it could provide:

- **A human connection that makes people feel cared for and included**

A 56 year old Latvian woman, who had been homeless on two occasions, was asked how she would feel about a healthcare worker visiting her on the street. She said:

"I would feel very good, I would feel someone was seeing me, that someone cares for me"

A 41 year old Cuban man, who had been homeless for 5 months, was asked what he thought about health related street outreach. He said:

"to think about them like as part of society, that homeless people are potentially patients or potentially people that need the service, this is just amazing"

- **A bridge to healthcare services that can overcome access barriers**

People with experience of sleeping rough gave many examples of access barriers, including fatigue, heavy baggage, shame about being unable to keep clean and a lack of knowledge about available services or rights to healthcare. Health related street outreach was perceived as a way to build rapport and encourage people to use other healthcare services in future.

A 44 year old British man, who had been homeless for 1 month, said he thought health related street outreach is:

"useful to try and encourage people to use what is available as a bridge. I mean as in explaining to people that services actually exist and they can access them"

A 26 year old British man, who had been homeless for 7 years, said:

"if I met another person from the team I think I'd be still comfortable, because I know they're from the team that I get along with"

A 44 year old British man, who had been homeless on two occasions, said:

"people maybe see it as a good thing, if they start seeing more doctors and nurses around, are willing to go see a nurse or a doctor at a walk in centre"



“The nurses were fantastic, they came and dressed my hands and my head on the streets, the care put in to that really saved my life. The fact they always came to find me, it really surprised me. They looked at the complex life I was living and tried to meet my needs. I was using so much heroin and crack I often felt invincible. They never came to force me off the streets; they never pushed me into doing anything I didn’t feel comfortable with. I knew when I was ready they would be there. They became a stable element in my life when my life was unstable”

Who?

Healthcare workers providing street outreach and partnership working

Healthcare workers who currently provide street outreach in the UK include:

- Nurses
- Pharmacists
- Health visitors
- General Practitioners (GPs)
- Substance misuse workers
- Social workers

Although their professional backgrounds vary, these common skills are recommended:

Expert engagement skills to build rapport and trust with people who may have had negative experiences of healthcare, who may not speak English as a first language, or may have learning disabilities, a history of brain injury or complex trauma, or be experiencing acute mental illness;

Specialist knowledge of homelessness and its impact on health, and of local services and referral pathways, to provide realistic and appropriate advice;

Advanced clinical practice to offer complete episodes of care on the street through autonomous assessment, diagnosis and management of a range of conditions, to recognise serious illness and to think creatively in complex and unpredictable situations.

Education and training for health related street outreach

Advanced clinical practice

Advanced clinical practice is delivered by experienced practitioners, is characterised by a high degree of autonomy and complex decision making, and is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research (Health Education England, 2017).

Accredited programmes of study for advanced clinical practice must map to the multi-professional framework published by Health Education England. Teaching content is at level 7 and will include:

- Physiology and pathophysiology
- History taking and clinical examination skills
- Clinical reasoning and diagnostic skills
- Managing complexity
- Leadership and management
- Research
- Independent prescribing

Any nurse who works at an advanced level of clinical practice and has independent prescribing rights can apply to the Royal College of Nursing (RCN) for credentialing, if they can demonstrate the relevant qualifications, experience and competence (RCN, 2020).

Other training

Other training subjects relevant to health related street outreach include:

- Inclusion health
- Refugees, asylum seekers and migrants: legal rights, no recourse to public funds, NHS charging
- Housing law
- Welfare benefits
- Mental Capacity Act and assessment
- Mental health: severe and enduring mental illness, drug induced psychosis, personality disorder and Mental Health Act assessment
- Care Act assessment
- Safeguarding children and adults
- Modern slavery
- Domestic abuse
- Equality and diversity
- Trauma-informed communication skills
- Motivational interviewing
- Alcohol and substance misuse: harm reduction, naloxone
- Lone worker
- Conflict resolution
- Basic / immediate life support
- Information governance and data protection
- Clinical topics including: infectious diseases, sexual health, wound care, minor injuries
- Reflective practice
- Professional boundaries
- Self-care and wellbeing

In addition to NHS based learning opportunities, training is also offered by charities including Shelter, Crisis and Homeless Link, and professional networks such as the Faculty of Homeless and Inclusion Health, the Queen's Nursing Institute (QNI) and the London Network of Nurses and Midwives Homelessness Group (LNNM).

Link to RCN homelessness resource page:

<https://www.rcn.org.uk/clinical-topics/public-health/inclusion-health-care/homelessness>

Partnership working

Integrated multi-component care is the best healthcare response for excluded groups (Luchenski et al., 2018). Collaborative working can address the range of complex problems that often affect people experiencing homelessness; it involves organisations coming together with a common purpose and clear goals (QNI, 2017).

Health related street outreach relies on partnership working and is often provided jointly by a healthcare service and another agency, or by multi-disciplinary teams. Scoping of local services and building links with them is essential when planning or developing health related street outreach. The following exemplars illustrate successful partnership models.

Doctors of the World

In response to a health needs assessment, Doctors of the World delivered a 6-month pilot of multi-disciplinary team outreach to rough sleeping clients in the City of London. Between December 2019 and June 2020, a GP, nurse practitioner and mental health nurse visited the streets on Tuesday evenings, accompanied by the local housing outreach team. A mobile clinic van was used when necessary, but most street outreach was undertaken on foot. The clinicians carried medical kits, personal protective equipment and basic dressings. The team was also able to provide food, clothing, mobile phones and nicotine replacement therapy, which they found helpful to encourage client engagement.

The multi-disciplinary approach enabled immediate on-the-street holistic assessment, encompassing physical health, mental health and substance misuse. The GP prescribed urgent medications if needed, with a private prescription sent to a local pharmacist. The mental health nurse supported clients with severe and enduring mental health issues and psychosis, facilitating treatment and admissions in some cases. The nurse practitioner escorted clients with severe acute symptoms to Accident and Emergency (A&E), advocating for thorough assessment prior to discharge and linked other clients with nurse-led clinics in day centres. The team also made referrals into, and visits to, emergency accommodation provided during the COVID-19 pandemic; and supported clients without a GP through registration. Weekly case discussion meetings involving the GP, other health partners, housing outreach, addiction support and social care also improved continuity of care. This successful multi-disciplinary approach achieved positive outcomes for several clients, and Doctors of the World aim to continue and expand the service.

Multidisciplinary partnership

West Suffolk Council's Multi-Disciplinary Rough Sleeper Team

The team includes Hannah Lawson, rough sleeper co-ordinator, who is responsible for creating multi-agency links, allocating referrals, and collation and reporting of data including bi-monthly street counts; Phil Owen, specialist substance misuse outreach worker, who has created pathways into community and residential treatment for people who have found these hard to access, and provides ongoing support with substance misuse including harm reduction; and Paul Warden, specialist mental health outreach worker, who has bridged the gap between the local authority and NHS Trust, facilitates mental health diagnoses and care and case management from the appropriate service.

The in-reach and floating support section of the service also includes Sophia Stennett, a rough sleeping support worker, and three outreach and resettlement workers: Linda Smith, Billie-Jean Croll and Karen Young.

The service continues to expand, aiming to recruit a social worker, to allow in-house Care Act assessments and improved access to social services support for eligible clients; and to add a navigator role to work with chronically excluded clients who have recurrent experience of the criminal justice system.

Hannah Lawson says: *"We have been extremely fortunate to have an in-house multidisciplinary team within West Suffolk Council. This has allowed us to offer wrap-around support to our clients, covering most of their needs or being able to access services much faster. The expertise, knowledge and experience of the team as a whole has attributed to the deeper understanding of the issues faced by rough sleepers and how to work with them."*



Partnership with housing outreach teams

Health and social care outreach can work synergistically, increasing engagement with both elements. In situations where people may be reluctant to discuss housing, health can provide an alternative route into a conversation:

“Having the nurse on outreach with us is really helpful to use health as an engagement tool; it helps build rapport and encourages clients to eventually engage with a route away from the street.” – Claire Hopkins, Manager of Westminster Street Outreach Service, St Mungo’s

HITPlus and St Mungos

The HITPlus service, part of Guy’s & St Thomas’ NHS Foundation Trust, provides a specialist nurse from the Health Inclusion Team to join St Mungo’s Street Population Outreach Team (SPOT) in Southwark, London two days a week.

HITPlus offers a wraparound service for people experiencing homelessness. The nurse can provide immediate access to holistic healthcare that is flexible and responsive to the individual's needs.

The St Mungo's outreach worker can provide assistance to access emergency accommodation and advice around employment, benefits and routes out of homelessness. The nurse can also support housing applications by providing relevant information about the health of an individual with the client’s written consent.

This partnership working has created closer links between the Health Inclusion Team and the SPOT Team and improved sharing of knowledge and skills.



Partnership with experts by experience

Service user involvement in interventions for marginalised and excluded populations is essential to ensure equity, acceptability and relevance of services. Peer worker programmes are an effective method to involve service users, and peer workers might be best suited for outreach and engagement (Luchenski et al., 2018). Peer advocates have been described as having a “phenomenal power” that helps people to recognise they are not alone, to build trust and to gain a sense of control over their health needs (Burrows et al., 2016 p.20).

Find and Treat

The Find and Treat Service at University College London Hospital NHS Trust has a mobile health unit which visits hostels, soup kitchens and drug or alcohol services across London. Screening for tuberculosis and blood borne viruses, and vaccinations are provided on the van.

Outreach Specialist Bean Noctor’s role is to persuade clients to get on the van and have a chest X-ray. He completes a clinical interview with each client, makes chest clinic referrals as necessary and escorts clients to their appointments. Bean says:

“In my experience of working with medical professionals in an outreach setting it is simply down to the individuals you employ. Of course having people with lived experience that can directly relate to the life experiences of the client group does help but if I had never been on the street I think I could still empathise with what that lifestyle is like and how soul destroying it can be. The subtleties of addiction are a much bigger hurdle because it’s not how people imagine it would be. An awareness that this group of people are not just those that have fallen through the social safety net but are part of a subculture to which they are fiercely loyal is something that anybody working in this sector should be taught. As with an anthropological analysis of any culture it takes a long time to become an expert, which is why using experts by experience is invaluable”



Partnership with meal services / soup kitchens

People with experience of sleeping rough recommend providing health related street outreach in the same locations where people come to collect food donations (Ungpakorn and Rae, 2019).

Homeless Health Service

Community Table is run by Steve, Sara and Annette and provides a hot lunch at Icthus Southcroft Church for approximately 40 people experiencing homelessness or food poverty.

Dianne Vigilance is a Specialist Health Visitor for the Homeless, Refugees and Asylum Seekers in Wandsworth, part of Central London Community Healthcare NHS Trust. Dianne visits Icthus Southcroft Church every fortnight during the lunch service to provide health advice and support with GP registration. Emmanuel Munyambuga, Health Advocate, offers assistance with benefit applications. Community Table is also visited by the SPEAR outreach team, citizens advice, the drug and alcohol service, and the Find and Treat Service.



Joint working with enforcement agencies

Joint work with any enforcement agencies, including the police, security services or immigration teams is not recommended by people with experience of sleeping rough (Ungpakorn and Rae, 2019). A 30 year old British man who had been homeless on two occasions described his experience:

“I was quite concerned that healthcare workers were in tandem with the Home Office and the police, their approach was almost like totalitarian, to say ‘documents’ and you were told you would be took to the police station to put your hand on live scanning unless you told them your name”

However some interaction with the police in a welfare role may be necessary for safeguarding, for example during a Multi Agency Risk Assessment Conference (MARAC) to reduce the risk of domestic abuse.

Written agreements

Written agreements between partnership agencies are helpful to define the aims, expectations and limitations of health related street outreach. A suggested framework for a Standard Operating Procedure would include:

- Aims and objectives
- Staff allocation, rota and timetable
- Referral pathway
- Daily planning and preparation
- Actions on the street
- Equipment
- Record keeping, data collection and analysis
- Training requirements

When and where?

Timings and locations of health related street outreach

Variety and flexibility are the most important aspects of the timing and location of health related street outreach. A balance of regular shifts at different times of the day and ad-hoc visits to individuals is ideal to reach as many people as possible. Flexibility in timing can allow immediate responses to referrals and the ability to cater to people's individual routines or preferences.

Waking people should be avoided. People with experience of sleeping rough feel this is inappropriate due to the challenge of getting adequate sleep on the street (Ungpakorn and Rae, 2019).

Healthcare workers and outreach workers report less meaningful interactions with people in the early mornings or late at night. It is also helpful for shifts to be scheduled during the opening hours of other services, to seek advice or make referrals to them e.g. GP practices, pharmacies, mental health teams.

Health related street outreach should be provided at locations where people experiencing homelessness may be present, including: city centre streets, parks, subway tunnels, bus and train stations, and graveyards. Timings and locations for health related street outreach should be responsive to the changing local environment or situation. Extremes of hot or cold weather may require additional shifts. Partnership agencies may be able to provide information about new locations where people are living.

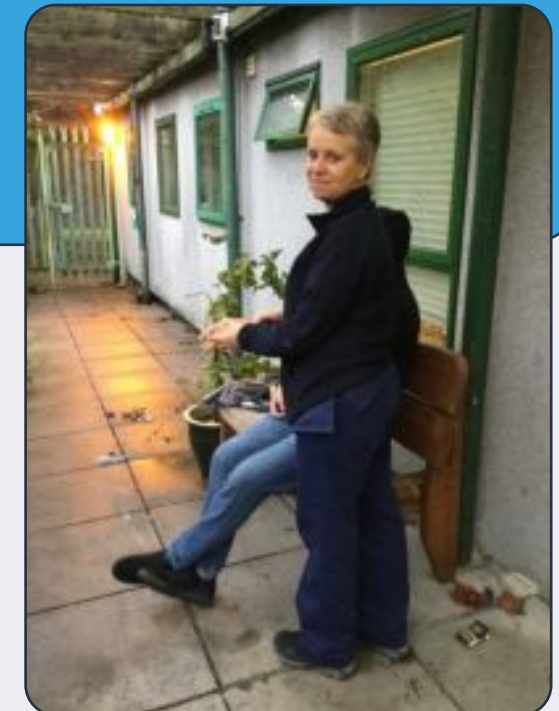
Healthcare for Homeless People

Healthcare for Homeless People in Swansea, part of Abertawe Medical Partnership, provides nurse-led street outreach. Breakfast Outreach starts at 7am and the nurses take hot drinks and rolls to the places where they know people who are rough sleeping can be found. At 8am more coffee and food is served at Zac's Place, a community venue where dry clothing is also provided. The nurses go there to offer advice and support on physical and mental health issues, substance misuse, benefits and housing.

In summer the nurses provide Street Clinics at a fountain at the centre of the city where people experiencing homelessness congregate in good weather. Individual targeted visits can also be arranged to any location where the nurses are needed.

"Some people find it too difficult to verbalise their thoughts, fears and anxieties in a formal GP or nurse appointment. For many the informal approach of street outreach is a useful first step to talking about their problems and a valuable way of working with people who feel disengaged from care and support. Today in my street clinic I referred a young man with a tooth abscess to dental services. I had a coffee with a patient to check on their wellbeing—they have fixed delusions and have been refusing mental health care. They are as well as they can be but importantly they are beginning to trust us. A young heroin user stopped me in the street and asked if I could refer them for a methadone prescription. Their friend asked what they could do about opiate related constipation and ended up being referred too. I telephoned the drug outreach team and as they were close by, they were available within a few minutes"

Jan Keauffling,
Clinical Nurse Specialist for
Homeless and Vulnerable Adults



How?

The approach of health related street outreach

People with experience of sleeping rough feel that a positive or negative response to health related street outreach will be determined by its approach. They feel that the wrong approach is likely to result in emotional distress and avoidance of healthcare services (Ungpakorn and Rae, 2019).

Interpersonal approach

The following recommendations are based on the views of people with experience of sleeping rough, healthcare workers and housing outreach workers.

Recommended	Not recommended
<p>Friendly, compassionate and respectful</p> <p>A 44 year old British man who had been homeless for a month said <i>“showing respect is the basis of any decent interaction”</i> (Ungpakorn and Rae, 2019)</p>	<p>Patronising, judgemental or dismissive</p>
<p>Human connection based on sharing mutual personal information and informal chatting</p> <p>A 44 year old British man who had been homeless on two occasions said <i>“nurses talking about their day and what they’re doing helped me to feel a bit more relaxed”</i> (Ungpakorn and Rae, 2019)</p>	<p>Hierarchy or social gulf between healthcare workers and people experiencing homelessness</p>
<p>Honest, genuine and reliable</p>	<p>Unreliable or false promises</p>

Recommended	Not recommended
<p>Gentle, gradual approach and person-led agenda</p> <p>Respect for a person's choices and their welfare</p> <p>Respect for the needs of a person related to their ethnicity, culture, language, gender identity, sexuality, and religion</p> <p>Asking people what they want (Luchenski et al., 2018)</p> <p>Let people decide if they want to accept help or not</p>	<p>Task-orientated, pushy or dictatorial</p> <p>Overloading people with information</p> <p>A 52 year old British man who had been homeless on two occasions said: <i>“explain that you’re only there for their help but they don’t have to accept it if they don’t want to”</i> (Ungpakorn and Rae, 2019)</p>
<p>Respect personal space and physically come down to the same level by sitting or squatting</p> <p>A 44 year old British man who had been homeless for a month said <i>“go down on to your haunches, to be at a more equivalent level rather than standing over someone”</i> (Ungpakorn and Rae, 2019)</p>	<p>Invading personal space or standing over people</p> <p>Too many people approaching at once</p>
<p>Show identification and explain that care is free</p>	<p>Wearing a uniform</p> <p>A 30 year old British man who had been homeless for 2 months said <i>“don’t come dressed as a nurse, it’s a uniform and to a lot of people it’s authority and they’d back away from it, it can create a barrier”</i> (Ungpakorn and Rae, 2019)</p>
<p>Consider possible history of trauma or violence</p>	<p>Don’t address sensitive subjects too soon</p>

Communication

Good communication is essential to reduce barriers between healthcare workers and patients, and to ensure safe consultations. Professional interpreters should be used rather than friends or family, to maintain confidentiality and a neutral perspective (Public Health England, 2018). A mobile phone and a telephone interpreting service are vital tools for health related street outreach, as many people experiencing homelessness in the UK are migrants. The use of telephone interpreting should be offered to any patient who is unable to understand or communicate fluently in English. An opportunity to speak to the healthcare worker privately should also be given.

To reduce the risk of transmission of COVID19 mobile phones can be used on loud speaker in quieter environments, or placed in a single use plastic bag while in use by the patient and removed from the bag while in use by the healthcare worker. To support communication with other services while on street outreach mobile phones should be pre-set with relevant numbers including local GP practices, pharmacies, outreach teams, and drug and alcohol support services.



Leigh Andrews, a speech and language therapist for Change Communication provided the following simple techniques to support communication on the street:

Setting

- Try to find a quieter area to communicate.
- Have as few people present as possible.
- Obtain the person's attention by using their name if known.

Literacy

- Do not make assumptions about reading and writing ability.
- Some people can read the words, but not understand them.
- If possible tactfully check literacy before providing written notes.

Language

- Use everyday words likely to be familiar to the person.
- Keep your sentences short.
- Be direct.
- Give space for a person to process your talk AND plan their reply before you talk more.

Example: *"Your ankle looks swollen."* Pause, wait, observe any reaction, stay silent, then *"Can I check your ankle?"*

- Questions starting with what / where / when may be easier to answer than how / why questions.

Example: *"What happened to your ankle?"* rather than *"Oh your ankle looks swollen, how did that happen?"*

- Talk about one idea at a time.
- Signpost where the conversation has been and is going.

Example: *"Thanks for telling me about the ankle. Next, I want to check your pulse."*

- Try not to interrupt other staff unless essential.

Visual support

Using simple large pictures to support your talk can be very helpful because:

- It keeps attention on the subject.
- It provides more clues to help a person understand the words.
- A picture helps a person remember the subject.

Gestures can help understanding so:

- Point to the relevant area.
- Use fingers to show numbers e.g. 1, 2, 3 etc.
- Replicate actions such as sleeping with a suitable gesture.

When writing a note:

- Date it in a format familiar to the person.
- Use short bullet points using relevant words.
- Put your name and contact details on it.

Shift planning and transport

A targeted approach involves looking for specific individuals with health concerns, who are already known to the healthcare worker or who have been referred by housing outreach teams, hospital A&E departments or homeless discharge teams, or other healthcare services. An opportunistic approach involves approaching anyone who appears to be experiencing homelessness. The advantage of a targeted approach is the ability to review medical records prior to visiting people and therefore to be able to give individualised advice and follow up information. However it may not be possible to find people on a target list and the shift time may be taken up with searching rather than patient contact. An opportunistic approach reaches more people, but the disadvantage is the inability to prepare individualised advice. Therefore a balance of a targeted and opportunistic approach is ideal.

Health related street outreach is often undertaken on foot, which allows more flexibility in the locations that can be visited and enables more opportunistic work. The use of bicycles can allow larger areas to be covered more efficiently. A mobile clinic space in a van provides the opportunity for assessment and treatment in a quiet, clean environment and enables more healthcare supplies to be transported. However finding free parking in convenient locations may be challenging in big cities.



Westminster Street Nurse

Westminster Street Nurse (Homeless Health Service, Central London Community Healthcare NHS Trust) provides joint shifts weekly with two housing outreach teams: St Mungo's Street Outreach Service and The Connection at St Martin's Street Engagement Team.

Before each shift the nurse and outreach worker meet to discuss a plan. Both services bring a target list of patients / clients who are sleeping rough and have health issues. The nurses check electronic medical records for people on these lists, and the housing outreach workers refer to the Combined Homelessness and Information Network (CHAIN) database. This pre-shift meeting allows: the most urgent cases to be prioritised; the most effective route to be planned; necessary information to be gathered and any sensitive patient issues to be discussed, in order to offer the best advice and management plan. While walking this planned route the nurse and outreach worker look for the people on the target list and also approach anyone who appears homeless or who is begging on the street.

During the COVID19 pandemic Westminster Street Nurse used bicycles to cover the large borough more quickly and to follow government guidance to avoid public transport. Nurses without their own bicycle used the Transport for London Cycle Hire Scheme.



Hastings Homeless Service

Just prior to the COVID19 pandemic Hastings Homeless Service (St John Ambulance) was given a mobile treatment centre to develop a pilot outreach project. During lockdown the service was unable to use any of its usual premises, so the vehicle was mobilised and parked twice a week outside the day centre where their treatment room was previously located. A wound care clinic was provided for existing patients with leg ulcers.

Numbers of people rough sleeping in Hastings started to increase (as the emergency accommodation provided was not suitable for everyone) and access to primary care became even more challenging due to COVID19 restrictions. The Hastings Homeless Service received a growing number of referrals from the hospital's A&E department, and from various community agencies, for people with leg ulcers, abscesses and other health conditions.

“The vehicle has allowed our healthcare clinic to become mobile, travelling across different areas of the town to see people on the street, and to visit those with complex needs who are in accommodation but not linked in to mainstream services. We have been able to reach vulnerable individuals that we would not have seen otherwise, to build therapeutic relationships with them and to start to see real health improvements.” Roger Nuttall, Nurse Co-ordinator



Personal safety and wellbeing

Health related street outreach should be done in pairs, or a maximum group of three, as larger groups can be intimidating or overwhelming for people on the street. Electronic medical records and databases used by housing outreach teams should be checked for any security alerts about the people on the target list for each shift. Healthcare workers should carry a fully charged mobile phone and a security alarm if available, and should check in with a nominated colleague before and after completing street outreach. Before entering an enclosed space the exit route and mobile phone reception coverage must be considered and a sensible approach should be taken to prioritise welfare in any situations that feel unsafe. Safety advice from other agencies involved with individuals should be followed, and employer lone worker policies should be adhered to.

Street outreach is very different from delivering healthcare in other clinical settings, and can be physically tiring, stressful and emotionally distressing. It is important for healthcare workers to prioritise their own wellbeing: take regular breaks, wear comfortable clothing that is appropriate for extremes of weather, and avoid carrying equipment above a safe moving and handling weight for them. Reflective practice or clinical supervision sessions can support mental wellbeing and enable solutions to complex issues to be worked out as a team. Joining homeless health networks - including the LNNM, the QNI and the Faculty of Homeless and Inclusion Health – can provide opportunities for mutual support and sharing best practice with other health professionals working in similar roles across the UK.

Links to homeless health networks:

<https://homeleshealthnetwork.net/>

<https://www.qni.org.uk/nursing-in-the-community/homeless-health-programme/>

<https://www.pathway.org.uk/faculty/>

Interventions

Best practice is to perform clinical interventions in a mobile clinic space or to accompany the person to a fixed-site clinical room. However this may not be possible or preferred by the person seen on the street. Therefore risk assessments should be made in order to offer complete episodes of care while maintaining dignity and privacy and infection prevention measures.

Information and relationship building	<ul style="list-style-type: none"> • Introduce yourself and explain why you are there • Ask general questions about the person's health and housing situation • Give information about rights to healthcare • Give information about own service • Signpost to other health services, including GPs, dentists, sexual health clinics, opticians, podiatry • Signpost to day centres, soup kitchens, women's refuges • Offer assistance to attend appointments e.g. referrals to peer advocacy service • Allow the person to use the outreach team mobile phone if necessary
Health promotion	<ul style="list-style-type: none"> • Offer health advice related to: extremes of weather, or current health risks including COVID19 • Share information and harm-minimisation advice from national or local drug alerts • Prescribe or facilitate prescribing of opiate substitute therapy • Offer and administer vaccinations • Offer and administer chest X-rays (in mobile digital x-ray unit)
Health checks	<ul style="list-style-type: none"> • Basic screening tests, including: blood pressure, oxygen saturations, blood glucose • COVID19 symptom screening • Urinalysis • Pregnancy tests • Sexually transmitted infections screening tests • Blood tests including blood-borne virus screening • New screening technology, e.g. "COPD-6" device or "Kardia" ECG app

Assessment and management of specific health concerns	<ul style="list-style-type: none"> • Ask if the person has any specific health concerns • Take an initial history on the street to assess the urgency of the situation and measure vital signs as appropriate • Use National Early Warning Score (NEWS) 2 and Sepsis Decision Support Tool if the person is unwell (Royal College of Physicians, 2017; Sepsis Trust, 2019) • Offer review in clinical room / mobile clinic space • Provide wound care on the street if necessary with simple dressings • Prescribe medication as appropriate and assist with collection from pharmacy • Make referrals to / appointments at dentists, opticians, sexual health clinics, other healthcare services • Complete HC1 forms to enable free prescriptions and dental care
Advocacy	Use frontline role and direct relationships with patients to feedback issues experienced by people sleeping rough and advocate for solutions with senior managers, and commissioners if possible

Example of outreach bag



Prescribing

A pharmacist-led service in Glasgow and Edinburgh (NHS Glasgow and Clyde and NHS Lothian) provides health related street outreach for people experiencing homelessness, in conjunction with the charity The Simon Community. Lauren Gibson, an advanced clinical pharmacist, provided the following advice about prescribing on the street.

Prescribing medication can enable immediate management of a range of conditions and complete episodes of care to be provided to people sleeping rough. Independent prescribing pharmacists providing health related street outreach in Glasgow and Edinburgh prescribe new medications for patients, and change doses or formulations of their current medications. Topical medications are commonly prescribed for dermatological conditions including skin infections, rashes and insect bites. Other medications for acute conditions include analgesia for musculoskeletal pain and oral antibiotics for infections. Pharmacists also prescribe on the street for chronic conditions including hypertension, diabetes, asthma and chronic obstructive pulmonary disease.

Independent prescribers with a background in substance misuse may consider prescribing opioid substitute therapy on street outreach. Alternatively partnerships with drug support services can be established to enable remote assessments and prescribing, while healthcare workers providing street outreach carry out urine drug screens and observations for a baseline and as part of the clinical opiate withdrawal scale. Naloxone and clean works kits can also be provided on the street.

Prescription pads should be stored safely while on street outreach in an inside pocket or closed bag worn closely at the front of the body. Community pharmacies in Glasgow and Edinburgh allow the street outreach pharmacists to use their consultation rooms for private assessments with patients, or as a safe, quiet place to write prescriptions.

Community pharmacists can also provide advice to independent prescribers from other professional backgrounds. If possible patients' notes should be checked before a street outreach visit for past medical and medication history, and allergy information. For opportunistic street outreach, prescribers should call their colleagues or GP practices with access to a patient's record and ask for this information. Useful resources also include The British National Formulary (BNF) mobile app and websites such as the Electronic Medicines Compendium, National Institute for Health and Care Excellence antimicrobial prescribing guidance and RCN prescribing guidance.

Links to prescribing resources:

<https://bnf.nice.org.uk/>

<https://www.nice.org.uk/Media/Default/About/what-we-do/NICE-guidance/antimicrobial%20guidance/summary-antimicrobial-prescribing-guidance.pdf>

<https://www.medicines.org.uk/emc/>

<https://www.rcn.org.uk/professional-development/publications/pub-009013>

Safeguarding

As in all homeless and inclusion health settings, safeguarding is a high priority during health related street outreach. Practitioners providing street outreach may be the only healthcare workers who have contact with a patient and therefore have an essential safeguarding role to fulfil. In safeguarding terms an adult at risk is someone with care and support needs, who is at risk of, or experiencing abuse and neglect and as a result of their care and support needs is unable to protect themselves (Homeless Link, 2014).

Nurses providing care for people experiencing homelessness must be confident in assessing mental capacity (Dorney-Smith et al., 2018). The Mental Capacity Act (2007) ensures that appropriate substitute decision making processes are used when someone is temporarily or permanently unable to make a particular decision for themselves at a particular time, due to an impairment or disturbance of the mind or brain (Homeless Link, 2018). Several factors may affect the mental capacity of people sleeping rough including diagnosed or undiagnosed mental health issues, alcohol and drug dependency, and brain injury (Dorney-Smith et al., 2018).

Other safeguarding issues for people sleeping rough include domestic abuse, exploitation and modern slavery, and pregnancy. Healthcare workers providing street outreach should work in partnership with local social care teams to implement safeguarding measures including: referrals to adult or child social services, safeguarding teams, emergency night shelters or women's refuges, multi-agency risk assessment conferences (MARAC), domestic abuse advocacy charities, safeguarding midwives and anti-slavery services.

Links to safeguarding resources:

- https://www.mungos.org/app/uploads/2017/11/StM_Pregnancy_Toolkit_Final.pdf
- <https://www.homeless.org.uk/sites/default/files/site-attachments/Using%20the%20Mental%20Capacity%20Act%202018.pdf>
- https://www.antislaverycommissioner.co.uk/media/1282/the-passage-modern-slavery-handbook_v3.pdf
- <https://www.rcn.org.uk/clinical-topics/modern-slavery>

Record keeping and data

Recording street outreach work can be challenging as people sleeping rough may be reluctant to give their personal details in a public space. However keeping accurate records is essential to enable continuity of care for patients, and producing data is vital for evaluation and demonstrating benefits for future commissioning and sustainability of health related street outreach. Tips to improve record keeping are:

- Only ask for a person's name and date of birth after having a conversation with them
- Offer to register people with the service - filling out a registration form on the street can demonstrate the purpose of asking for personal details
- If the person consents to registration, record the street outreach contact on an electronic medical records system (e.g. EmisWeb or SystemOne)
- If the person does not wish to give their personal details, record the contact on a spreadsheet with a description of the person's appearance and their location
- If possible carry a tablet or small laptop to access electronic medical records on the street – this will also reduce the information governance risk of transporting patient-identifiable data on paper
- It is preferable to use electronic medical records systems to collect and report data; alternatively a spreadsheet can be used, see example below:

Description	Possible name / DOB	Location seen	Registered with GP?	Actions (signposting / advice / clinical intervention)	Plan	Date 1 st seen	Number of times seen	Date last seen

Key Performance Indicators (KPIs) which can be measured for a health related street outreach service include:

- GP registration for those without a GP
- Completion of health checks
- Completion of blood borne virus screening
- Administration of vaccinations
- Referrals to other services (e.g. dentists, opticians, tuberculosis, HIV and hepatology clinics, substance misuse services)
- Mental health reviews and referrals
- Women's health interventions including contraception, cervical and breast screening (Examples contributed by Health Inclusion Team, Guy's and St Thomas' NHS Foundation Trust).

Starting a new health related street outreach service

Samantha Dorney-Smith (*Nursing Fellow, Pathway / Homeless Health Programme Lead, Queen's Nursing Institute*), and Jane Cook (*Health and Homelessness Adviser, Rough Sleepers Initiative, Ministry of Housing, Communities and Local Government*) provided the following advice.

If you are not currently providing street outreach, but would like to get such a service commissioned, you could consider arguing for a pilot or proof of concept project.

Establish the initial need

It will be helpful if you some have initial information available that demonstrates need.

This might include:

- Numbers of rough sleepers in your area.
- Numbers of rough sleepers attending A&E, or being admitted to hospital locally. It would also be useful to know how many have arrived by ambulance.
- Any information about deaths on the streets.
- Any safeguarding adult reviews that have been undertaken in your area.
- Any evidence of difficulty registering with primary care in your area.
- Key stakeholder opinions - in particular talking with local outreach and voluntary sector services will help to establish and evidence whether there is a local need. It would also be useful to talk to walk-in or primary care services in your area.
- Any information available about the health needs of local rough sleepers.
- Any direct information available from rough sleepers. If possible talk to rough sleepers in your area about their health needs, or see if any other work like this has been done before e.g. by voluntary sector services or your local [Healthwatch](#).
- Any information on health related street outreach services being delivered in areas similar to yours for comparison.

You may wish to consider undertaking a formal and thorough Health Needs Assessment at this point, and guidance and templates developed by the [London Homeless Health Programme](#) on how to do this can be found on the Healthy London Partnership website: <https://www.healthylondon.org/resource/london-homeless-health-needs-assessment-toolkit/>. This includes a template developed by [Groundswell](#) to assist with engaging effectively and meaningfully with rough sleepers.

However, do not worry if you do not have extensive information at this point. The purpose of a proof of concept project can be to fully demonstrate local need, and the initial work can be argued for using a summary of existing national evidence on Government and health improvement websites e.g. [Homelessness: Applying all our health](#), [Health Matters: Rough Sleeping](#), [Healthcare Improvement Scotland](#).

It will also be useful to reference the '[Guidance for NHS commissioners on equality and health inequalities legal duties](#)' (December, 2015) and to undertake an [Equality and Health Inequalities Impact Assessment](#) focused on the provision of primary care to rough sleepers in your area. Your Health Board, Local Health Board, Local Commissioning Group or Clinical Commissioning Group (CCG) should have a template for this.

Source funding for the pilot if needed

The first question to ask is whether you actually need new funding, and if so, how much? For example, is it possible to reorganise your service for a specified time as the pilot? Or are there quality initiative or innovation funds that you could apply to for support that might perhaps purchase equipment, or packs for outreach, or even just a few extra nurse hours a week? Applying to Health and Social Care Trust / NHS Trust / Health Board / Local Health Board quality initiative or innovation funds can help to promote the likelihood of the reorganisation getting funded long term.

Otherwise you could consider approaching any of the following:

- Health Board, Local Health Board, CCG or Local Commissioning Leads
- GP Clusters
- Local Authority Leads
- Local Alcohol and Drug Partnership
- Better Care Fund
- NHS Charities
- Other charities or organisations e.g. QNI innovation funds, Corra Foundation, Scottish Drug Deaths Taskforce (QNI Homeless Health Programme has a list of other grant- making charities that could be considered).

Try to be aware of funding cycles. For example, most NHS Trusts make full year funding decisions during the October of the prior financial year (which runs from April – March). Conversely small amounts of pilot funding may be available at year end. Lots of charities also have specific grant making windows.

Do not be put off by grant application forms. Find someone else who has done one, who is likely to be happy to share their expertise!

If it seems appropriate think about inviting your commissioner, health inequality lead, or Chief Executive Officer to shadow you so that they get can a better understanding of what you want to do, and why you want to do it. You may need to discuss this with your direct line manager first, but this can be a powerful tool for getting support for pilot funding.

Collect the right information during the pilot

When you are collecting information during your pilot, ensure you have thought about how to record all the contacts, and attempted contacts. Information gathering should focus on demonstrating the level of health needs, and in particular unmet needs in terms of e.g. primary care, mental health, addictions access, dental care. It should also aim to demonstrate how this need can be met by street outreach in a sustainable way, with a view to engaging clients in mainstream care long term. The Health Needs Assessment provided by the Healthy London Partnership can also be a good framework to think about useful information to collect during a pilot. An important tip is to try not to get drawn into a dialogue about reducing A&E attendance or secondary care usage. Although evidence of hospital visits is a demonstration of high morbidity, the reduction of secondary care usage should not be seen as a target for any pilot. It is quite likely that clients will be encouraged to attend A&E more as a result of your intervention. Focus primarily on inequalities in healthcare access, and how you have resolved this.

Communications

If you do undertake a pilot ensure that your project receives as much communications support and interest as is possible. A successfully promoted project that gives a Health and Social Care Trust / NHS Trust / Health Board / Local Health Board a positive profile in the community will be difficult not to support going forward.

What?

Items to provide on health related street outreach

People with experience of sleeping rough feel that providing items on health related street outreach can improve an interaction and encourage people to use healthcare services in future. Presenting items as an attractive gift is also recommended (Ungpakorn and Rae, 2019).

The following items are recommended by people with experience of sleeping rough, healthcare workers and housing outreach workers:

Written Information	<ul style="list-style-type: none"> Local health service leaflets (GP/dentist/optician/podiatrist) Local drop-in centres / soup kitchens leaflets Maps Pictorial health advice e.g. COVID19 transmission prevention
Toiletries (travel sized)	<ul style="list-style-type: none"> Toothbrush Toothpaste Wet wipes Soap Tissues Lip balm
First aid kits	<ul style="list-style-type: none"> Small dressings Alcohol wipes
Clothing	<ul style="list-style-type: none"> Socks Hats Gloves Underwear
	<ul style="list-style-type: none"> Sanitary products
	<ul style="list-style-type: none"> Condoms
Food and drink	<ul style="list-style-type: none"> Tea and coffee Water Cereal bars Chocolate bars
Bedding	<ul style="list-style-type: none"> Space blankets
	<ul style="list-style-type: none"> Sunscreen
Needle exchange	<ul style="list-style-type: none"> Clean works kits Sharps bin Naloxone
	<ul style="list-style-type: none"> Bus tickets
	<ul style="list-style-type: none"> Pen and notebook

Example of a 'Health Pack' to give to people seen on street outreach



'Gold Card' given to people sleeping rough in Edinburgh and Glasgow, which they can use to claim a priority GP appointment



Case studies

Case study 1

Maria*, a 28 year old woman from the Roma community, was 2 months pregnant and begging daily on Shaftsbury Avenue. Her husband was working cash in hand and they were staying in an illegal dosshouse, where their bed was used by another person during the daytime. Maria was seen on the street by a nurse practitioner and housing outreach worker. She spoke no English so a telephone interpreting service was used on a mobile phone. Maria was initially reluctant to give much information but said she had not had any antenatal care and was planning to return to Romania.

During several visits over the next few weeks the nurses gave Maria hot drinks, prescribed folic acid and offered to refer her to maternity care. The nurses also sent a safeguarding referral to social services. Eventually Maria disclosed her fear that her baby would be removed if it was born in the UK. The nurses were able to clarify social services' role and Maria eventually accepted a referral to the maternity service, where she was seen by the safeguarding midwives. Her husband was assisted to get a national insurance number so his work contributions could be recorded, providing security for their future. Social services provided temporary accommodation and Maria's baby was born safely and healthy in hospital. Once her husband found work they moved into private rented accommodation and chose to name their baby after their social worker.

(Westminster Street Nurse, Homeless Health Service, Central London Community Healthcare NHS Trust)

Case study 2

Louise*, a 25 year old woman from the UK, was living in crack houses and on the streets of Southwark. She was brought up in the care system, and had no contact with her family including her two children. Louise was a victim of sexual assault and had a history of drug dependence and chronic hepatitis C infection.

Louise was seen on the street by a nurse practitioner and housing outreach worker. The nurse referred her to a drug support service and completed a full health assessment, including blood borne virus and sexual health screening. She was assisted to register with a local GP, given health education about cervical cytology and long acting reversible contraception. Flu, pneumococcal and hepatitis B vaccinations were also administered. The nurse also made referrals to a domestic violence charity and the safeguarding team, and provided a letter to support her housing application.

Louise declined a women's refuge placement but is now in temporary accommodation. She is on a methadone script and is due to start treatment for hepatitis C.

(HITplus, Health Inclusion Team, Guy's & St Thomas' NHS Foundation Trust)

Case study 3

Mrs Smith*, a 40 year old from the UK, was referred by the housing outreach service, who reported she had a painful wound on her abdomen but did not want to go to the GP or day centre clinic. She was located by the clinical nurse specialist in a busy London station underpass and asked to accompany the nurse to a quieter area. She disclosed a fear of hospitals that was related to knowing several people who had died during admissions. The nurse was able to build a good rapport with Mrs Smith, who agreed to allow her to assess her wound. She declined to go to a GP surgery or day centre clinic room, as she needed alcohol and was at risk of withdrawal.

The nurse asked station staff for permission to use their first aid room, where she was able to do a more in depth consultation. On examination Mrs Smith had widespread erythema bilaterally to her upper thighs from her midline abdomen, with multiple ulcerations, which appeared to be cellulitis caused by infected intertrigo. As some of her vital signs were abnormal, the nurse discussed the risk of sepsis and advised that treatment in hospital would be most appropriate. However Mrs Smith declined to attend hospital and demonstrated the mental capacity to make this decision. The nurse consulted Mrs Smith's GP practice in Newcastle over the phone and confirmed she had a history of recurrent infected intertrigo and an allergy to penicillin. The nurse prescribed a course of clarithromycin, escorted Mrs Smith to the pharmacy to collect the antibiotics and observed her take the first dose.

The nurse made a referral to the emergency night shelter, with a plan for review the following day by the nurses and housing support workers who are based in the same building. She was given details to register at the GP surgery.

Mrs Smith did not attend for review in the nurse-led clinic the following day but the housing support workers reported that she looked well and was not complaining of any abdominal discomfort. Her name was added to the street outreach target list for further attempts to review her.

(Great Chapel Street Medical Centre, London)

Case study 4

Gerard*, a 59 year old British veteran, had a history of post-traumatic stress disorder and dependent drinking. He had been rough sleeping and in and out of accommodation for many years. He arrived back in Bury St Edmunds following an admission to rehab, was given a bed in a night shelter but was evicted two months later due to intoxication. He collapsed in a park and was referred to the West Suffolk rough sleeper outreach team, who attempted to visit him in hospital but found he had been discharged. Another referral was received via Streetlink and staff found Gerard sleeping rough in wet bedding. They booked a bed and breakfast (B&B) for him but Gerard collapsed again and was admitted to A&E overnight. He was deemed by hospital staff to have mental capacity to self-discharge and left the following day wearing slippers as his shoes had been lost. The rough sleeper outreach team arranged another B&B room and Gerard stayed there for a few weeks, but when staff visited him they found him living in unsanitary conditions, due to double incontinence, intoxication and disorientation. Staff assisted him with personal care, cleaned the room, and referred him for a Care Act assessment. However the adult social care department found that Gerard did not qualify for any funding towards residential care.

The rough sleeper outreach team continued to have serious concerns as Gerard regularly lost money, was not eating and having to shoplift alcohol. Staff made a referral to alcohol support services and fought for Gerard to be admitted to hospital for a detox. During this admission, they independently arranged for a specialist to assess Gerard and he was diagnosed with vascular dementia. A multi-agency meeting was arranged and the local council agreed to send Gerard to rehab with joint funding from other agencies to enable a longer admission. Gerard stayed in rehab for several months, but was evicted from a move on property as he started drinking again. He had several further admissions to hospital with intoxication and hypothermia. Eventually a senior social worker re-assessed him and found that Gerard lacked capacity to care for himself and made a decision that support would be required. Following several short accommodation placements, he was housed in an adult social care facility, where he was able to reduce his drinking and volunteer on a farm.

(West Suffolk Multi-Disciplinary Rough Sleeper Team)

Case study 5

Alan*, a 44 year old Scottish man, was found by the advanced clinical pharmacist openly groin injecting in a graveyard. He was visibly in poor health, emaciated and sleeping rough on a dirty mattress. The pharmacist discovered that Alan was fleeing violence, had no GP registration or any support with his drug use. He also had a history of hepatitis C, rheumatoid arthritis, Chronic Obstructive Pulmonary Disorder (COPD) and had no medication for these chronic conditions. His mobility was very poor.

The pharmacist arranged same day GP registration and prescribed medication for COPD. Due to partnership work with Streetworks, a social support team, Alan was given rapid access to an emergency bed with a plan for long-term supported accommodation following this. His welfare benefits were organised and a wheelchair was sourced to enable Alan to attend the GP practice. At the practice Alan was started on a methadone script - which helped to reduce his intravenous use of drugs - and on treatment for hepatitis C. His stable accommodation allowed him to engage with his medical treatment and opiate substitute therapy; and for significant improvements in his health to be achieved.

(Pharmacist-led outreach service, NHS Glasgow & Clyde and NHS Lothian)

*All names have been changed to protect patient confidentiality



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