

COMMUNITY HEALTHCARE

An integrated approach to nursing care for homeless people

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Rosa Ungpakorn

Specialist nurse, Homeless Health Service, Central London Community Healthcare NHS Trust, London

Correspondence

rosa.ungpakorn@nhs.net

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Abstract

Homeless people face huge health inequalities. The life expectancy of someone who sleeps rough is 30 years lower than the national average, and there are significant barriers to accessing healthcare. Homeless people are much less likely to be registered with a GP and poor links to primary care leads to higher use of emergency services. To reduce these stark inequalities, a different approach to healthcare is necessary, especially in major cities. In this article a specialist nurse working in London outlines the services her team provide, how the nursing role has developed, and how the London Network of Nurses and Midwives (LNNM) Homelessness Group provides support and networking opportunities for nurses in these challenging roles.

Keywords

health inequalities, homeless people, life expectancy, London Network of Nurses and Midwives Homeless Group

Introduction

Imagine life without a home. Imagine a daily struggle to feed yourself, keep yourself clean and find a safe place to rest at night. Many of us take these basic needs for granted, but every year, more people are forced to live on the streets of London – between 2010-11 and 2015-16, the number of rough sleepers in the capital increased by 103% (St Mungo's 2011, Greater London Authority 2016).

Homelessness can affect anyone and everyone's story is unique. People or families living in bed and breakfast accommodation, 'sofa surfing', living in hostels or sleeping on buses, in parks or on the street are all experiencing homelessness. Multiple individual or structural factors can lead to homelessness. Personal circumstances, such as the breakdown of a relationship or bereavement, are often traumatic and it is vulnerable groups, including refugees and people with learning disabilities or a history of abuse, who are commonly affected by homelessness (Homeless Link 2011, 2014).

The UK's systems are failing to protect everyone from slipping through the safety net. Rising rents compound low pay and caps on housing benefit; a revolving door persists between prison and rough sleeping; and asylum seekers are left destitute on the street as the state neither deports nor supports them (Bubb-McGhee and Rhodes 2013, Butler 2016, McVeigh 2016).

Homeless people face huge health inequalities. Homeless Link (2014) reported that 73% have a physical health problem, 80% a mental health issue and one third a high use of alcohol and drugs. Homeless people are two and a half times more likely to have asthma, five times more likely to have a stroke, six times more likely to have heart disease and 12 times more likely to have epilepsy than the general population (Story 2013). The life expectancy of someone who sleeps rough is 30 years lower than the national average, with an average age of death of 47 for men and 43 for women (Thomas 2012).

There are also significant barriers to accessing healthcare. Homeless people are much less likely to be registered with a GP and poor links to primary care leads to higher use of emergency services (Brown 2011, Homeless Link 2014). Contrary to NHS guidance, GP surgeries frequently refuse to register patients who lack identification or proof of address (Doctors of the World 2015). Mainstream NHS services can be dehumanising and stigmatising for homeless people, and their unmet basic needs may mean health becomes a lesser priority for them than survival (Brown 2011, Rae and Rees 2015).

Our healthcare system excludes the very people who need it most, preventing them from improving their health, which is often a vital step in accessing routes out of homelessness.

A new approach

To reduce these stark inequalities, a different approach to healthcare is necessary (Seiler and Moss 2012). Specialist services exist in many parts of the UK, aiming to assist with fair access to healthcare, improve health outcomes and prevent early deaths. The large number of homeless people in the capital means London has five specialist GP practices, nurse-led outreach teams in several boroughs, discharge teams in some of the largest hospitals, and a citywide tuberculosis prevention and treatment service, as well as specialist sexual health nurses, midwives, health visitors and counsellors.

I am a specialist nurse at the Homeless Health Service, which is provided by Central London Community Healthcare NHS Trust. Six nurses cover Westminster, which is the borough with the most people sleeping rough (Greater London Authority 2016). As a street-facing outreach team, we provide nurse-led clinics in three of the busiest day centres in the capital. We work closely with a team of counsellors, a podiatrist and the two specialist GP practices in the area. Our aim is to bring healthcare to our patients in a convenient location where they can shower, get cheap food, and access housing, benefits and job-seeking advice. Once a week, we also accompany housing outreach workers to meet people sleeping on the street, to talk about their health and offer information about our service.

The clinics are walk-in with no time limits for consultations, which increases the flexibility of access and allows patients to discuss multiple health problems and their living situation. We see an average of 12 people a day in a four-hour clinic at each day centre (Box 1).

There are three main elements to our work:

- » We assess and manage health problems that are priorities for our patients, and offer immediate treatment if possible. Several of our nurses are prescribers and we also issue medication under patient group directions. If necessary, we can refer onwards to the specialist GP practices or other services.
- » We build relationships between patients and the NHS. By using an inclusive and non-judgmental approach, we aim to provide a positive experience of healthcare and empower our patients by informing them of their right to register with a GP and to receive free prescriptions and dental care if they have no income. We can also act as advocates, liaising with mainstream services to manage appointments and, if necessary, arranging a peer volunteer – managed by the award-winning charity Groundswell – to provide extra support.

- » We promote health and prevent disease, offering all our patients a general health check and appropriate vaccinations, as well as screening for substance misuse and blood-borne viruses.

An integral role

Nurses have an integral role in homeless healthcare, leading many of the specialist services and often working autonomously at an advanced clinical level. The nursing approach, with its emphasis on holistic, patient-centred care, is ideal for addressing the complex interplay between the physical and mental health problems and social issues with which many homeless patients present (Seiler and Moss 2012).

Studies of homeless people's perceptions of healthcare have shown that an understanding of the context of their lives is essential to provide personalised and realistic advice, and that investing time to gain trust and listen to their stories has a significant effect (Williams and Stickley 2011, Rae and Rees 2015).

Historically, nurses have had a breadth of responsibilities in their practice. This enables those working in homeless healthcare to embrace duties ranging from advocacy work across multiple agencies, through wound care, to advanced assessment and diagnosis.

Although nursing in homeless healthcare can be extremely rewarding, with opportunities to develop a wide range of knowledge and skills, it can also be challenging and stressful. Many clinicians are lone workers, and services are run by a variety of NHS and voluntary sector agencies. Regular exposure to suffering can also increase the risk of vicarious trauma among staff (Seiler and Moss 2012).

The LNNM Homelessness Group

The London Network of Nurses and Midwives (LNNM) Homelessness Group (homeleshealthnetwork.net) was set up in

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BOX 1. Homeless case studies

We met Caroline*, a 40-year-old British woman, on a street outreach shift. She was sleeping under a bridge by a busy road. She had been homeless for more than ten years, in several different UK cities. She was asthmatic, with a six-week history of a cough, haemoptysis and weight loss. We invited her to attend our clinic in the day centre, where she was seen later that morning and given a course of antibiotics for her chest infection. We were also able to help her register with the specialist GP for ongoing care of her asthma, arrange for screening by the TB service and discuss further support for her alcohol dependency. Mariusz*, a 35-year-old from Poland, attended the clinic with a painful ankle. He was working full-time as a chef but was forced to sleep in a local park until he could save enough money to rent a room. He had been on his feet for ten-hour shifts in the kitchen and was also walking long distances with all his belongings. We were able to diagnose a sprain, provide free pain relief, and arrange for him to spend four nights in a temporary shelter to rest and elevate his legs.

*Names changed to maintain confidentiality

FAST FACTS

Homeless people are
2 1/2
more likely to have asthma

5
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6
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12
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have epilepsy

1999, as part of larger network that included 15 working groups for different specialties. The aim was to bring nurses, midwives and health visitors together across London to share their experiences and innovations. Although most of the LNNM groups have since disbanded, the homelessness group is still going strong.

Run entirely by the voluntary efforts of its members – most of whom work full-time in clinics – the longevity of the group demonstrates its importance on many levels. Bimonthly meetings offer a vital support network, allowing nurses to meet colleagues with similar experiences and to work in partnership to ensure continuity of care for patients who are often transient across the city. The lack of specialist training available in this emerging healthcare area is also being addressed, with teaching sessions and clinical workshops at the meetings and an annual conference. The latter has been running for the past three years and has hosted keynote speakers from NHS England, the Queen's Nursing Institute and the Care Quality Commission. It has also arranged focus groups for front-line workers to share their opinions and ideas. Visual and audio resources are available to a wider audience on a website created and maintained by the group.

Conclusion

Homelessness is disempowering, and the needs of patients are often ignored, despite their significant health problems and the expense caused to the NHS by leaving these

untreated. The LNNM Homelessness Group aims to represent the needs of homeless people at a higher level, to positively influence commissioning of NHS services and health policy. The group has a member on the board of the London Homeless Health Programme – which is developing a citywide commissioning strategy – and has recently issued a briefing to the shadow health secretary.

I became involved with the LNNM Homelessness Group four years ago when I joined the Homeless Health Service. The group gave me the support and advice I needed to manage the steep learning curve of my new role, and the opportunity to work closely with many dynamic and inspiring nurses. This has encouraged me to be passionate and ambitious in my career and the improvements that can be achieved for my patients. I believe that the positive aspects of a nursing network – peer support, sharing knowledge and skills, and promoting nurse leadership and influence in the upper structures of the NHS – would be replicable in any specialism or setting.

The focus on social justice in healthcare is also applicable on a wider scale: people experiencing homelessness are at the sharp end of inequality and deprivation. If nurses can improve services for them, hopefully we can improve them for all.

Most importantly I hope that nurses working in any area, who meet homeless people in their clinics, hospital departments or on the street, will strive to have greater empathy and to be as inclusive and flexible as possible.

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