



**Street Healthcare – Test and Learn  
Croydon November 2025**



**Change  
Grow  
Live**

# Nursing in Outreach Teams

<b>Delivery partner</b>	Change Grow Live
<b>Evaluation partner</b>	Cardiff University
<b>Funder</b>	Ministry of Housing, Communities and Local Government

Oldham  
Watford  
Peterborough  
Ealing  
Greenwich  
Kingston Upon  
Thames  
Croydon  
Harringay

Solihull  
Tameside  
Bournemouth  
Christchurch and  
Poole  
Waltham Forest  
Hounslow  
Preston  
Liverpool



**Oldham (Lauren Pollitt) April**

**Peterborough (Ali Wagg) March**

**Watford (Rachiel Shito) Jan**

**Ealing (Niki Kakora-Shiner) Jan**

**Kingston (Christine Mohan) Jan**

**Croydon (Rosie Bridger) Feb**

**Greenwich (Oli Cawthorne) Jan**



# The project – Research questions

What are the potential impacts of the intervention on the housing situation of service users?

What are the potential impacts of the intervention on the health of service users?

## Delivery Update

So far, we have:

7 Nurses in place (1 vacant post, Haringey)  
Collected surveys across 15 boroughs (8 Test, 7 Control)

### Emerging trends/themes:

Patterns of specific care needs in certain areas, etc leg wounds, mental health needs and substance misuse - usually class A drugs.



## Delivery

Practical support to people experiencing street homelessness:

- Going out with the outreach team twice a week.
- Accessing mainstream services such as GPs, attending A&E with clients, supporting hospital admissions.
- Referrals to appropriate services where needed etc mental health teams.



# Croydon Implementation

Thames reach – outreach rough sleeper team

Partnerships – CGL, SLAM mental health team,  
CRISIS, ASB, Local council.

Health teams – Rainbow Clinic



# Croydon Homelessness

Croydon has a high population of people sleeping rough. Mental health need dominates in the client group.

Most of the clients are very complex, experiencing high mental health needs, high physical health needs, challenging behaviour, lack of trust in services and willingness to engage with services & substance misuse.



**Based on the latest available data from the Combined Homelessness and Information Network (CHAIN), 469 people were recorded sleeping rough in the London Borough of Croydon during the 2024/25 financial year (April 2024 to March 2025).**

**This figure places Croydon as having one of the highest numbers of rough sleepers among outer London borough**



## Outer Boroughs: Distribution

Table 5: People seen rough sleeping in 2025-26 Q2, by borough

BOROUGH	New RS with no second night out	New RS with a second night out but not living on the streets	New RS joining living on the streets population	LOS - Known	Intermittent rough sleeper	TOTAL
Barking & Dagenham	16	4	1	5	25	51
Barnet	21	6	4	5	26	62
Bexley	23	14	1	10	10	58
Bromley	17	9	0	7	8	41
Croydon	70	8	0	3	72	153
Enfield	34	4	0	2	16	56
Greenwich	54	18	4	40	51	167
Hackney	41	19	2	12	31	105
Harrow	18	0	0	0	3	21
Havering	12	2	0	0	7	21
Heathrow	33	4	0	0	5	42
Hillingdon	44	11	1	17	59	132
Hounslow	50	14	1	8	53	126
Kingston upon Thames	11	8	0	5	33	57
Lewisham	38	8	2	10	48	106
Merton	14	2	0	0	7	23
Redbridge	26	14	0	21	45	106
Richmond	10	1	1	9	16	37
Sutton	12	0	0	0	2	14
Waltham Forest	17	8	0	28	32	85
Wandsworth	25	0	0	13	37	75
Bus route	6	0	0	0	6	12
Tube line	2	0	0	0	2	4
<b>UNIQUE TOTAL</b>	<b>504</b>	<b>150</b>	<b>11</b>	<b>107</b>	<b>599</b>	<b>1371</b>



# Interventions across the project

SWEP

Wound Care

Mental health support

Safeguarding

Addiction support

MDT

GP referrals

Support to attend appts

Health bus

Support for vulnerable migrants



36yr old man, sleeping rough in bus station.

-Poor eyesight, due to being assaulted while sleeping rough.

-Cognitive issues

-Alcohol dependent.

-Chronic leg ulcers with occasional maggots & uses Zimmer frames

-Poor personal hygiene. “smelt like rotten flesh”.

## Case study

### CHALLENGES

-Lack of wanting to engage with services for support and difficult making decisions regarding health

-Language barrier

### ACTIONS

-Referral to MH team.

-GP referral – support to appointments and health advocacy

-Support with alcohol dependency through CGL.

-Care act assessment.

### OUTCOME

Health got worse as difficulty to get client to engage at times, ambulance was called. Kept under Dols, received treatment in hospital. Placed in accommodation to support needs upon discharge. Update - recently back on streets following eviction from accommodation after he abandoned. MDT meeting to be confirmed.

# Challenges

- High demand on me being the only nurse
- Suffered an assault
- Revolving door especially people with MH needs
- Lonely at times, not having another nurse with me
- High needs not being met
- High case load

## Examples:

Trying to navigate rough sleepers into accommodation that is appropriate to their needs, with support in place. High mental health needs and confounding drug or alcohol use can create multiple barriers into accommodation. Quick fixes, lack of support or long-term solutions.

Coordinating the communication between health, social care, and outreach services can be a difficult task. MDT meetings were frequently set up to link everyone together involved in client's case, but hard to get a good outcome sometimes due to lack of agreement and right people not there.



# What has worked well?

## **Methods of surveying:**

- 1) Linking in questionnaire with building-based services or existing interventions helps data collection processes
- 2) Eligibility analysis – reviewing databases to focus survey work
- 3) Liaison with other professionals – verification not required.

## **Street-based nursing outcomes:**

- Early clinical narrative shows that early intervention has prevented clinical deterioration.
- In many cases the nursing team have recognised when somebody is not presenting clinically well, and they have subsequently been admitted to hospital and then accommodated.



# Healthcare usage capture on questionnaire

**healthcare usage**  
In the last 3 months, has the person...

Visited the GP?	Yes	If <u>Yes</u> , how many times? (min.1 - max 10)	
	No		
Had a mental health appointment?	Yes	If <u>Yes</u> , how many times? (min.1 - max 10)	
	No		
Had a hospital appointment?	Yes	If <u>Yes</u> , how many times? (min.1 - max 10)	
	No		
Visited A&E?	Yes	If <u>Yes</u> , how many times? (min.1 - max 10)	
	No		
Had an ambulance called for you?	Yes	If <u>Yes</u> , how many times? (min.1 - max 10)	
	No		
Had a hospital admission?	Yes	If <u>Yes</u> , how many times? (min.1 - max 10)	
	No		
		How many of these were for mental health?	
Used any substance use services?	Yes	If <u>Yes</u> , how many times? (min.1 - max 10)	
	No		
		Which services did they access?	Drug
			Alcohol
			Other
Had contact with other healthcare?	Yes	If <u>Yes</u> , how many times? (min.1 - max 10)	
	No		

**PLEASE ALSO COMPLETE THE EQ ED EL HEALTH QUESTIONNAIRE ON**



**90 clients were surveyed in Croydon since February. This included doing EQ-5D-5L.**

**I am currently completing the 3 month, and 6 month follow ups.**



## Feedback from partners

Thamesreach - The time that Rosie has been in the team feels impactful. Really good interventions delivered, and a skill set for delivering on health processes and procedures. Outreach workers feel able to approach Rosie for advice and support, with clients with complex needs.

CRISIS service has appreciated my help and seen a difference.



## Next steps

End of baseline survey collection = 31<sup>st</sup> October 2025

Follow-up surveys completed with clients at 3- and 6-month intervals.

Nursing:

- Support with cold-weather SWEP and winter provision
- Work with boroughs to explore continuity of service after Test and Learn program ends

Analysis and publication of results by Cardiff University



# Any questions?

