Taking advanced clinical practice to the streets: an evaluation of the benefits and challenges in homeless health care

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ABSTRACT

Homelessness in the UK continues to rise. People who are homeless are more likely to have poor health and die early, and face multiple barriers to accessing health care. Ten years have passed since the Marmot review recommended action on these disparities. In the context of significant health inequalities, advanced clinical practitioners (ACPs) offer a different approach to homeless health care, providing complete episodes of care in complex situations and leading in integrating multiple agencies, service development and strategic advocacy. ACPs can use their expertise in this specialty to deliver education that raises awareness and reduces prejudice. Their research skills can identify gaps and expand the evidence base to improve practice at local and national levels. However, ACPs must promote their own roles, work closely with people with lived experience and be supported by their employers to embrace all four pillars of advanced clinical practice for the full benefits to be realised.

Key words: Homeless ■ Inclusion ■ Advanced clinical practice ■ Leadership ■ Research ■ Education

It is well documented that a person's socioeconomic position in society dictates their quality of life, including health outcomes (Mackenbach et al, 2008; Stringhini et al, 2017; Kivimäki et al, 2020). In the last 10 years, the number of people sleeping rough in England has increased by 165% (Crisis, 2019). The impact of COVID-19 seen in unemployment, rent arrears and evictions of sofa-surfers has led to even more people living on the street and compounded inequalities (Boobis, 2020).

The *NHS Long Term Plan* recognises England's homelessness problem, identifying that new service models are needed to tackle health inequalities in this population. It also recommends expanding traditional roles to meet changing workforce demands (NHS England/NHS Improvement, 2019). This would include advanced clinical practitioners (ACPs), who demonstrate high levels of autonomy and clinical decision-making informed by the four pillars of: clinical practice; leadership and management; education; and research (Health Education England (HEE), 2017).

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Accepted for publication: August 2021

Homelessness and health inequalities

The definition of homelessness includes people sleeping rough, sofa-surfing or living in squats, emergency shelters or hostels (Homeless Link, 2014). Socially excluded people are 10 times more likely to die early than the general population (Aldridge et al, 2018). For people experiencing homelessness, the average age of death is 45 for men and 43 for women (Office for National Statistics, 2020). There is a higher prevalence of chronic disease (Story, 2013) and tri-morbidity (coexisting physical and mental ill-health with substance use) (Ministry of Housing, Communities and Local Government, 2020), with frailty at a much younger age (Rogans-Watson et al, 2020).

In 2010, epidemiology professor Michael Marmot detailed determinants of health inequalities in the UK and stated these issues must be addressed for the whole of society to benefit (Marmot, 2010). Unfortunately, a decade later, disparities in access to health care still exist (Marmot, 2020).

Against NHS England guidance, many GP practices still deny registration based on a lack of address or identification (Doctors of the World, 2018). Rigid systems stop people without a phone from booking appointments and short time slots prevent complex needs from being addressed (Burrows et al, 2016). With the switch to remote working because of COVID-19, people who are homeless have further struggled to access information and care.

Basic survival needs are also difficult to meet while homeless and competing priorities can lead to delays in seeking medical help (Burrows et al, 2016). Poor access to primary care results in increased use of emergency services (Poduval et al, 2015; Rae and Rees, 2015). Follow-up or referral appointments are equally hard to access, with did-not-attend rates seven times higher than the general population (NHS North West London, 2013).

Recent extensions to NHS charging for overseas patients have exacerbated barriers for homeless migrants, deterring people from seeking essential treatment for fear of deportation, detention

or accruing bills they cannot pay (Equalities and Human Rights Commission, 2018; Docs Not Cops, 2021).

Four pillars of advanced clinical practice in homeless health care

Clinical practice

Universal action is needed to reduce the social gradient of health inequalities but the scale and intensity should be proportionate to the level of disadvantage (Marmot, 2020). For homeless patients who experience severe disadvantage, a different approach to health care is necessary (Seiler and Moss, 2012).

A peer-led study found people experiencing homelessness value health professionals actively seeking them out to offer flexible care in convenient locations, feeling this helped to overcome barriers to improving their health (Burrows et al, 2016). To optimise this opportunistic approach and ensure patients receive a service from specialist outreach care that is equitable to mainstream services for the general population, an expanded scope of practice is required.

ACPs use diagnostic skills, including history-taking and physical examination techniques, and can order investigations and interpret their results (HEE, 2017). Higher-level clinical knowledge and reasoning skills allow ACPs to assess patients with undifferentiated and undiagnosed conditions, and independent prescribing facilitates immediate pharmacological treatment if necessary (Royal College of Nursing, 2018). An ACP working within homeless health care uses their full autonomy and generalist expertise to diagnose and manage a wide range of health problems. This ability to provide complete episodes of care reduces the need to make onward referrals, which people experiencing homelessness are less likely to attend. This approach enables new models of care to be established, including street outreach to the most vulnerable and underserved (Ungpakorn and Torry, 2021).

It could be argued that substituting medical staff with professionals from other disciplines may compromise care quality. However, studies across a variety of settings, including high-quality evidence from systematic reviews, have confirmed that ACPs can achieve comparable health outcomes to those of GPs or secondary care doctors (Jennings et al, 2015; Martin-Misener et al, 2015; Evans et al, 2020). A critical understanding of the increased responsibility and the limits of competence are fundamental for ACP accountability, so they recognise when to seek help (HEE, 2017). The capacity to function autonomously is influenced by the context in which ACPs work and their relationships with the multidisciplinary team (MDT) (Cole et al, 2014). For example, supportive infrastructure, such as pathways to request diagnostic tests, must be established to reduce barriers (Torrens et al, 2020).

The prevalence of complex needs in homeless health care also presents a challenge. Tri-morbidity and a history of poor access to health care cause patients to present intoxicated and with multiple problems at once (Burrows et al, 2016). Substance use has safeguarding implications because it can lead to psychotic symptoms, alcohol-related brain damage and self-neglect; and opiate and alcohol addiction affect prescribing practice. Overdose is common in homeless populations, who experience a higher rate of drug-related deaths (Advisory Council on the Misuse of Drugs, 2019). Socioeconomic factors add practical complications for people experiencing homelessness, making storing medication safely, following generic health advice and affording prescription charges in England problematic (Seiler and Moss, 2012).

This multifaceted complexity can result in patient consultations where even practitioners with advanced clinical skills may struggle to achieve a successful outcome. Clinical practice that is traditionally task oriented and protocol driven may be effective in stable environments with familiar problems but is too rigid to apply to complex, unpredictable clinical situations (O'Connell et al, 2014). However, the foundation of advanced clinical practice is the move beyond competency to achieve capability: it involves a creative, analytical approach that requires a high degree of self-efficacy. ACPs can synthesise data from multiple sources, working with the client to find a solution by considering the situation as a whole, including management of risk (Oliver and Leary, 2012; O'Connell et al, 2014). This flexible, problem-solving approach enables ACPs in homeless health care to manage increased levels of complexity, in unstable and chaotic situations, and to fulfil a unique requirement for expertise across physical and mental health and substance use.

People become homeless because of a mixture of individual and societal factors (Bramley and Fitzpatrick, 2018). Failures in the welfare system—including unaffordable housing, benefits caps and sanctions, and punitive immigration policies—cause people to distrust services that are in place to support them (Burrows et al, 2016). Shame about homelessness and a lack of knowledge about available services or rights to health care also create obstacles (Ungpakorn and Rae, 2020). Poor experiences of mainstream health care are common, with reports of feeling stigmatised, labelled or invisible (Seiler and Moss, 2012; Rae and Rees, 2015). Chronic shame—common among groups who face stigma—has close associations with mental ill health and substance use, and harmful physiological effects of increased levels of cortisol and inflammatory mediators (Dolezal and Lyons, 2017). Stigma can also have profound consequences for future health-seeking behaviour and engagement, increasing exclusion as people adopt strategies to avoid negative feelings of worthlessness (Campbell et al, 2015; Rae and Rees, 2015).

Advanced clinical practice has been described as a blended scientific and humanistic approach (Paniagua, 2011). Barratt (2016) described an increased rapport between ACPs and patients, developed through skilled communication techniques and using life-world experiences. Nurse practitioners in homeless health care in the USA have highlighted the importance of listening to a patient's story and acknowledging them as a person (Seiler and Moss, 2012). In the face of shame and loneliness on the street, this human connection can make people who are homeless feel cared for and included (Ungpakorn and Rae, 2020).

Health and social care can work synergistically to empower recovery from homelessness: in situations where people have become disillusioned with complex housing pathways, positive interactions about their health can provide an alternative starting point for engagement (Ungpakorn and Torry, 2021).

Leadership and management

Leadership is another core capability of advanced clinical practice. Heinen et al (2019) identified leadership skills ranging

from shaping direct patient care to strategic planning. ACPs participate in recruitment and retention (Evans et al, 2020), lobbying and strategic roles (Hall, 2016) and are described as a linchpin around which the MDT functions more cohesively (Williamson et al, 2012).

Swartwout (2016) argued that it is their leadership qualities that make ACPs ideal to address population health. Jezewski (1995) described their value as a link between the patient and the healthcare system, where culture-brokering enhances the co-ordination of work between various agencies. These agencies and their staff include specialist GP practices, secondary care and discharge teams, mental health and addiction services as well as housing, employment and immigration advisers. Examples of this linking work include joint street outreach work, case conferences, initiating and monitoring the progress of referrals and writing supporting letters for housing or benefits applications.

Advocacy is an important dimension of an ACP's multi-layered work (Oliver and Leary, 2012). ACPs aim to empower and enable their patients (HEE, 2017). Those working in homeless health care can inform patients of their right to register with a GP regardless of immigration status, or whether they can produce proof of address or ID, and assist them to claim free prescriptions and dental care in England if they have little or no income. Xue and Intrator (2016) also argued that caring for vulnerable populations provides a unique position to advocate for their patients at a political level, for example, to influence NHS commissioning and facilitate policy reform from the frontline.

ACPs in homeless health care can provide role models for the team and drive service improvement through evaluation and pioneering new ways of working (Dorney-Smith, 2007; Collinson and Ward, 2010; Schneller, 2012). Services must be especially responsive to changing situations in their local area, including fluctuations in the numbers of people sleeping rough or new trends in substance use or in immigration from certain areas. COVID-19 has shifted service needs dramatically, and ACPs have been involved in adapting quickly to work in temporary hotel accommodation and in redesigning street outreach for the pandemic (Ungpakorn and Torry, 2021).

However, a challenge to ACPs' ability to provide integration and leadership is a potential lack of understanding of their role by key stakeholders (Torrens et al, 2020). Historically, there has been inconsistent use of job titles and, in contrast to international norms, there is no register of ACPs in the UK (Leary et al, 2017). This has led to confusion over the scope and competence of ACPs and provoked scepticism among other professionals (Cowley et al, 2016).

Studies of ACP implementation in various settings have found that acceptance increases with exposure (Lawler et al, 2020). Therefore, an ACP working within homeless health care must act as a professional advocate, using their pioneering position to create and promote a clear vision to the wider MDT and management structure (Acton Shapiro, 2009).

Education

Effective leaders create a culture of learning and development (McKenzie and Manley, 2011) and promote evidence-based practice in an organisation (Stetler et al, 2014). ACPs can provide informal support and teaching for colleagues, as well as formal mentorship for individuals who wish to extend their own practice (Williamson et al, 2012; Kerr, 2016; Evans et al, 2020). ACPs have also been responsible for teaching other MDT members including junior doctors (Hooks and Walker, 2020). Beyond the clinical setting, ACPs teach in universities (Hooks and Walker, 2020) and are involved in regional training development (Evans et al, 2020).

These provide opportunities to raise awareness of the complex problems of homelessness and its impact on health, reducing prejudice and preventing negative patient experiences in future. One recent example is the Safer Surgeries campaign where frontline clinicians offered training and resources to GP practices across the UK. This led to successful implementation of inclusive

Case study

Miss S was a 36-year-old woman with a long history of homelessness and drug use. She had three children, all in care. She was a survivor of domestic abuse perpetrated by her long-term partner. He usually prevented Miss S from speaking to social or health workers, but was currently in prison. Previous attempts to engage with her had been difficult because of the chaotic cycle of her drug dependency, which meant she was often distracted or intoxicated. However, since her partner's arrest, Miss S's drug use had reduced.

Working in partnership with the housing outreach team, an advanced clinical practitioner (ACP) located Miss S on the street. She was sleeping on the pavement of a busy road in central London. The ACP introduced herself and offered to buy Miss S a hot meal to help build rapport. Miss S then agreed to an initial health assessment in the back of a car.

Her main concerns were the risk of unwanted pregnancy and drug use relapse. She also reported a painful wound to her arm, from a previous injecting site. The ACP was able to take a full history and clinically examine Miss S. As the wound appeared infected but Miss S was systemically well, the ACP prescribed antibiotics, which she collected from a nearby pharmacy to ensure Miss S was able to access the medication free of charge and start the course immediately. The ACP suggested Miss S use a café toilet to provide a urine sample and completed a pregnancy test, which was negative. Miss S also agreed to be referred to the local drug support service.

Following this consultation, the housing outreach team were able to secure accommodation for Miss S in a female-only hostel, and she began attending support groups at the drug support service. Having built some trust with the ACP on the street, Miss S agreed to attend her walk-in clinic at a day centre, where a full health check was completed. A long-acting reversible contraceptive implant was also inserted, giving Miss S control over her fertility and a 'sense of empowerment' as she put it. In the clinic, the ACP was able to review her wound, carry out screening for bloodborne viruses and sexually transmitted infections, arrange for overdue cervical cytology screening and provide a much-needed listening ear.

Working creatively and in partnership with another organisation with shared goals, the ACP was able to bring health care directly to Miss S and offer complete episodes of care opportunistically in non-conventional settings. Miss S was able to access a service that would otherwise have been difficult because of the barriers of appointment systems and long clinic waiting times. The ACP was able to offer her a positive experience that was non-judgemental, promoted her dignity and gave her the time she needed to engage with improving her health.

policies for patients experiencing homelessness and vulnerable migrants in 220 practices (Doctors of the World, 2019).

However, homeless and inclusive health are not widely covered in healthcare curricula, and even education programmes for professionals within the specialty are not well defined. There are moves in the USA to improve this, with the establishment of street medicine academic programmes and a student coalition (Street Medicine Institute, 2020). ACPs working in homeless health are in an ideal position to use their expertise to drive similar changes in the UK.

Research

More research is needed into effective models of health care for excluded groups (Luchenski et al, 2018). Collecting patient data and feedback can be difficult because of digital exclusion among people who are homeless (Dorney-Smith and Gill, 2017) and their understandable reluctance to give personal details (Ungpakorn and Torry, 2021).

Health problems experienced by these populations are embedded in complex cultural and contextual issues that healthcare providers need to understand (Sullivan-Bolyai et al, 2005). Researchers working with people who are homeless must be aware of specific ethical issues created by enhanced vulnerability and avoid making assumptions or stereotyping (Runnels et al, 2009).

The ACP scope includes identifying gaps in the evidence base, engaging in research activity, and using findings to underpin their own practice and inform that of others (HEE, 2017). Those working directly with people experiencing homelessness are well placed to identify areas for improvement and implement research designs. Their results can influence local service delivery and practice at a national level (Ungpakorn and Rae, 2020).

However, professional researchers may struggle to overcome the mistrust of authority figures that is common among this patient group. Peer researchers with lived experience of homelessness bring a shared connection and extra level of empathy that can enable participants to open up and share more information (Groundswell, 2020). Therefore, ACPs can work in partnership with peer researchers to improve the validity of their findings.

Many ACPs report difficulties undertaking research in their roles because they lack time (Hooks and Walker, 2020). Employers must play their part to value this aspect of their role.

Conclusion

Improving a person's health is often the first step towards recovery from homelessness. ACPs working in homeless health care combine generalist clinical knowledge with their specialist expertise at an individual and strategic levels. This is optimised by use of all four pillars. Employers should promote advanced practice education and establish the infrastructure to support leadership, research and education as well as clinical practice. ACPs must also promote themselves and aim for high-profile opportunities to publicise their benefits. This will foster greater acceptance and enable ACPs to have a seat at the table where they can affect change for this vulnerable and disadvantaged patient group. **BJN**

KEY POINTS

- Advanced clinical practice offers a different approach to care for people experiencing homelessness, who experience huge health inequalities
- Advanced clinical practitioners (ACPs) have the autonomy and advanced clinical skills to offer complete episodes of care to people with complex needs in non-conventional settings
- Multiple health and social care agencies are involved with people who are homeless and ACPs can co-ordinate work between them
- ACPs can use their expertise in this specialty to deliver education that raises awareness and reduces prejudice
- In this under-researched area, ACPs can identify gaps in the evidence base and use research findings to improve practice at local and national levels

Declaration of interest: none

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CPD reflective questions

- What barriers to health care are faced by people experiencing homelessness, and could anything be done to reduce such obstacles in your service or services you work with?
- How can communication skills help build rapport with people who have had negative experiences of health care?
- How can frontline experience be used to influence at strategic levels?
- Why is education about homelessness important in improving care, and what training opportunities on this subject could you access?
- Why is it important that people with lived experience of homelessness are involved in service design?