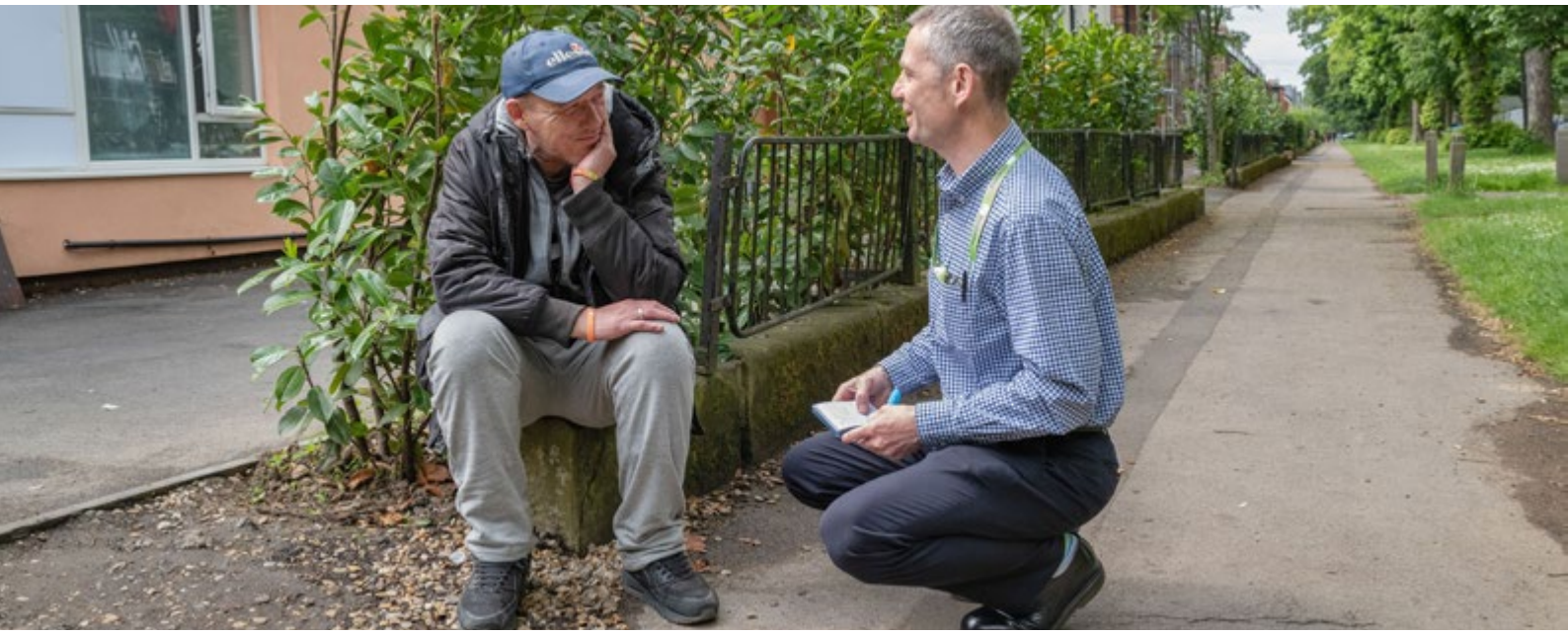
The Queen's Institute of Community Nursing

New to Inclusion Health Nursing

Guidance for Nurses

Contents



1. How to use this guide

This document has been written as a guide for any nurse looking to start working in the Inclusion Health field, or who is working in a service that assists those who fall into Inclusion Health populations and need some guidance.

While the fundamentals of nursing care and values don't change, there will be some skills and knowledge that will be useful to have when working with groups of people who have newly arrived in the country, who find themselves without a home, or have other additional needs.

Having worked in this sector for over 10 years now, I have seen first-hand the value that nursing brings, not only in direct clinical care, but in the spaces where they traditionally do not sit, e.g. influencing local policy, steering multi-disciplinary and multi-sector meetings, or changing the educational landscape to name a few.

We would like you to use this guide in a way that is useful to you. Whether that's as a reference document to look up useful agencies and articles, or using it as a workbook to inform your practice and development.

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2. Introduction - What is Inclusion Health Nursing and is it needed?

The NHS was built on the founding principles of:

- Universality
- Equity
- Providing a comprehensive and high-quality service
- Free at the point of access
- Funded through taxation

It was the first service of its kind in the Western world. However, despite having a system with such admirable values, we continue to see disparities in health status across socioeconomic lines. Years after the first Marmot report (2010), the newer Marmot review (2020) and the latest Darzi report (2024) both highlight gaps in access to healthcare services with varied outcomes for different populations.

Some examples of poor health disproportionately affecting those who are marginalised are:

+ Mortality rates are highest in the most deprived areas of England (ONS, 2023)
+ Living in temporary accommodation has been cited as a vulnerability factor in the death of children (APPG for Households in Temporary Accommodation, 2025)
+ People experiencing homelessness have higher rates of depression than the general population (Homeless Link, 2015) as well as other mental health problems (Groundswell, 2020; Milaney et al., 2020; Upshar et al., 2017)
+ People experiencing homelessness have higher proportion of learning disabilities when compared to the general population (Oakes and Davies, 2008; Van Straaten et al., 2017)
+ Chronic conditions (aside from diabetes) are disproportionately higher in people experiencing homelessness (Lewer et al., 2019)
+ Multi-morbidity is known to be higher in deprived populations (Barnett et al., 2012)
+ Many people facing homelessness and vulnerable migrants are not registered with a GP. Reasons vary from being refused by Practices to clients worrying they may be arrested (Doctors of the World, 2017). Studies looking at rough sleepers (Elwell-Sutton et al., 2017; Weber et al., 2013) and women experiencing homelessness (Wei Lim et al., 2002) echo this lack of GP registration.
+ Consequently, there is higher use of emergency services (Rae and Rees, 2015; Collinson and Ward, 2010; Quilty et al., 2012) with some saying they would wait until their symptoms worsen and then go to the emergency department (Poduval et al., 2015).
+ Violence is often both a factor in leading to homelessness and a consequence of homelessness for women (Scott and McManus, 2016) and is important to consider in their wider health and well-being as it could be a reason for them seeking health care.

"Despite having a system with such admirable values, we continue to see disparities in health status across socio-economic lines."

- Access to pandemic-related information was found to be difficult (language, digital poverty, support services closed to face-to-face contact); being able to follow national guidance was difficult (shared or overcrowded accommodation, needing to go out for work or essentials, managing addictions, little trust in authority); not having support to shield if clinically vulnerable; difficulty accessing appointments remotely for marginalised populations in the UK (Doctors of the World, 2020).

The sector of Inclusion Health refers to working with people who have difficulty accessing mainstream health services. This tends to be those who are generally marginalised in society and includes people experiencing homelessness, refugees, asylum seekers, undocumented migrants, sex workers, those from the Gypsy, Roma, Traveller, Boater and Showmen communities, veterans, prisoners and anyone else vulnerable to exclusion from health services such as care leavers, those with learning disabilities or who are neurodivergent.

Depending on the practitioner's role and location, you may come across clients from a variety of community groups and with a variety of needs. For example, if you are working with families, you may see more children, whereas if you are working with people experiencing street homelessness, or those with addictions, the needs may be different.

Important questions to ask:

1. Why are mainstream health services difficult to access?
2. Do we need separate health services for this cohort?
3. Isn't it everyone's responsibility to ensure services are easily accessible?
4. What do Inclusion Health nurses do?
5. What impact does terminology used have on the care given and received?

We often hear the term "hard-to-reach" groups. However, as service providers, it is important for us to reflect and consider whether it is the person who is hard to reach or the service that is difficult to access.

Both experience and research show us that barriers to accessing healthcare are many and can be due to the system and also due to personal circumstances. Themes that appear in multiple studies from around the world include:

- Competing priorities
- Cost
- Documentation
- Travel
- Knowledge of services & where to go
- Operational factors
- Perceived discrimination
- Language and literacy

The addition of a worldwide pandemic brought a whole new dimension to the barriers, with service closures and digitised appointments being cited as problematic in accessing care (digital exclusion).

Barriers in a bit more detail:

Competing priorities

These are needs that are equally important as a person's health and these may take priority over health, with the person directing their resources to meeting them (housing, food, hygiene facilities). Studies show that competing priorities have a significant impact when accessing healthcare (Baggett et al., 2010; Gelberg et al., 2004; Shah et al., 2019).
Figure 1 shows Dahlgren et al.'s (1991) determinants of health model describing the interacting factors leading to health inequalities, and we can see how health care can potentially compete with many other priorities.

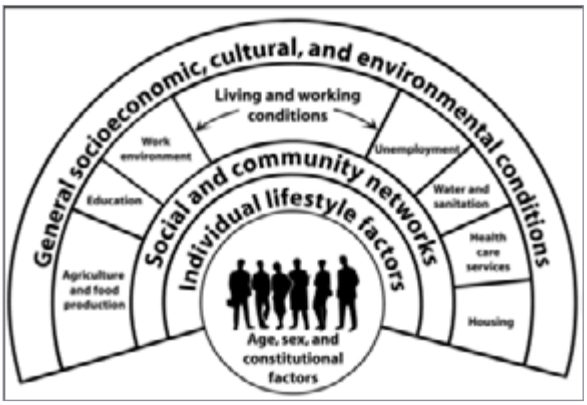

Figure 1. Dahlgren et al.'s (1991) determinants of health model

"The addition of a worldwide pandemic brought a whole new dimension to the barriers."

Cost

Studies conducted in the USA and Canada have reported cost being a deterrent to both accessing healthcare and being able to follow recommended medical guidance (Kertesz et al., 2014; Ramsay et al., 2019; Wadsworth et al., 2018). This is less the case in the UK and may well be because the healthcare system is set up differently with a national health service and no involvement from health insurance providers. However, this is still important to bear in mind because we often see people in the UK who are not yet familiar with the healthcare system here and may incorrectly assume that they need to pay for their healthcare, sometimes avoiding it because they do not have the funds. Insight from those working in the field shows that this has also been the case with antenatal care, with women avoiding approaching healthcare services because they are afraid that they will be charged. For those working in the UK, it is important to understand people's rights to access healthcare. Everyone, regardless of their immigration status can register with a GP and access Primary Care for free. This is the same for using Emergency services. However, if a person requires inpatient stay or secondary care, they may be charged by the hospital Overseas Team. To find out more on this, visit the Doctors of the World website.

Documentation

Despite NHS Guidance stating Primary Care is free to all, many people facing homelessness and vulnerable migrants are not registered with a GP, and lack of documentation seems to be a major barrier. In the UK, through interviewing professionals in the field, Doctors of the World (2020) found GP registration is difficult for people without proof of address or identification. Similar findings have been reported when patients themselves were interviewed (Rae and Rees, 2015), and when mystery shopper visits were made to GP practices (Verity & Tzortziou Brown, 2024). Certain people such as those from the Gypsy, Roma, Traveller, Boater and Showmen communities are likely to be transient or have a nomadic lifestyle. This can impact their ability to register with a GP and to receive postal correspondence. However, services can adapt and use other forms of communication if this is identified early on.

Travel

Transport costs and distance to the service have been cited in several studies across various countries as challenges to accessing care (Gelberg et al., 2004; Kertesz et al., 2014; Parker and Helmat, 2012; Ramsay et al., 2019; Reid, 2005; Salem et al., 2013; Shah et al., 2019; Wadsworth et al., 2018; Wentzel and Voce, 2012).

Knowledge of services and where to go

Lack of knowledge about where to go for health care, or being unable to navigate the system has been mentioned in several studies (Davis-Berman, 2011; Parker and Helmat, 2012). Anecdotal accounts from those working in the sector here in the UK, show worrying consequences of people not being aware of services and where to access them in a timely manner.

Operational factors

Once services are accessed, some studies show service operational factors as a deterrent to accessing health care. These included long waiting times (Gelberg et al., 2004; Kertesz et al.; Parker and Helmat, 2012; Salem et al., 2013; Shah et al., 2019; Wentzel and Voce, 2012), inconvenient hours (Kertesz et al., 2014), few available appointments (Salem et al., 2013), not enough time given, and difficulty getting an appointment (Ming et al., 2019). This highlights the importance of service flexibility and shaping the service to the population it serves. For example, some GP surgeries keep 1-2 appointment slots free each day for unexpected, on-the-day appointments for those without a fixed abode. Other services routinely offer longer appointment slots to give the person time and to be able to address several confounding concerns.

Perceived discrimination

While many people have voiced positive experiences in healthcare services, a dominant theme in literature has been perceived discrimination from health professionals, and a feeling of distrust of health professionals (Gelberg et al., 2004; Mago et al, 2018; Moura de Oliveira et al., 2018; O'Donnell et al., 2016; Paisi et al., 2020; Ramsay et al., 2019; Reid, 2005; Rodrigues do Prado et al., 2021; Shah et al., 2019).

Common sentiments described have included being patronised, dismissed, not believed, and having their problems trivialised. Harris and Fiske (2009) termed the concept of "dehumanised perception" to explain how marginalised people are treated by health care workers. Trivialising or downplaying a person's symptoms could be seen as a way of using language to oppress a person (Burr, 2015).

Language and literacy

Not being able to speak a common language and not having access to interpreters can be a frightening experience when you need healthcare. Yet, this is a commonly cited challenge (O'Donnell et al., 2016; Parker and Helmat, 2012; Ruiz and Contreras, 2020). Being able to

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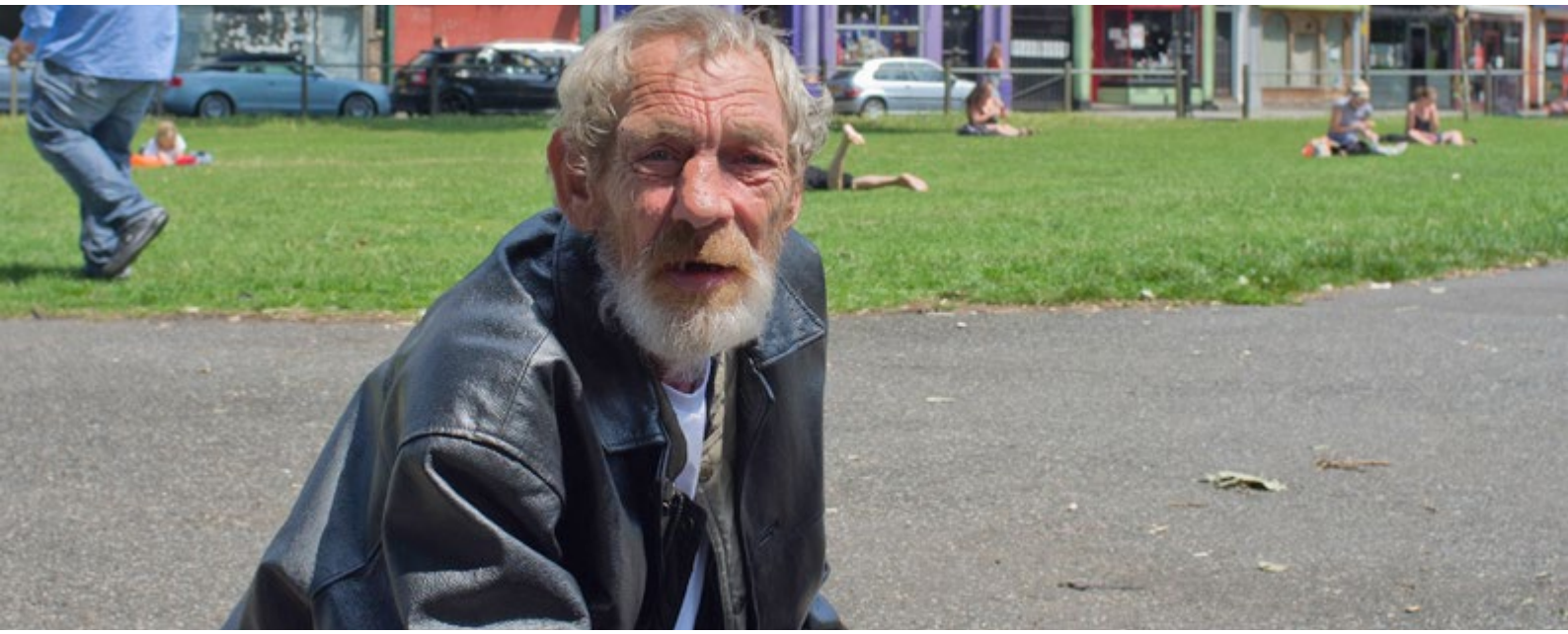

communicate clearly with your healthcare provider and understand the information they are giving you not only makes sense but makes for safe practice.

As we can see, many factors can be at play in an individual's life alongside their health concerns that will impact and shape their outlook. The fact that someone feels alone, is bereaved, feels discriminated against, perceives inequality and stigma or have language barriers will affect how they see, use and interact with primary health care services (Flood, 2010; Sullivan-Bolyai et al., 2005).

It is not enough to have a service that is open to all, but addressing the disproportionate factors affecting a person's ability to access care must be considered to bring everyone onto a level playing field. This is equity rather than equality.

Nurses have a long history of working with marginalised groups to improve access to health care worldwide (Duke, 2013; Ensign, 2021; Sheer and Yuet Wong, 2008) and studies globally support this (Poghosyan and Carthon, 2017; Savage et al., 2008; Seiler and Moss, 2012). In the UK, the birth of District Nursing in 1859 took nurses outside the hospital and clinic walls, and then in the 1960s, Barbara Stillwell pioneered the nurse practitioner role, reaching out to marginalised communities specifically.

A note on terminology

As healthcare services have moved from an authoritative model towards person-centred care, the language we use to refer to the people who use our services is important. This is because it will reflect our intention, our perceived roles and our respect for their autonomy and individuality.

Many services and teams have moved away from the term "patient" because it can signify a relationship whereby the person is in need of treatment. It comes from the Latin word "to suffer".

The term "client" can appear to be one that is more collaborative, and where the person's autonomy is recognised. However, the term "client" has also been questioned as it can appear

that the person is a paying customer of a service that is free to access.

Others use the term “service user” but this generates debate over the fact that the person’s identity is removed in this description, as it only relates to the service.

Research shows a mixed picture, with some people preferring the word patient.

What’s important here as a service or team is to get people’s feedback about how they prefer to be referred to. This can simply be done through a conversation, a feedback form or a focus group.

3. Developing knowledge

The best way to develop knowledge and understanding about your patients and community is to visit the places they visit and to get a feel for the local area.

When we are not using services or working in them ourselves, it is easy to miss them as we go about our day-to-day activities. But, if we look closely, there are many community assets that support neighbourhoods in various ways. Local knowledge is invaluable when giving care, especially in times of crisis.

Activity

Get to know your area activity:	What type of accommodation is available for people experiencing homelessness?
	What type of housing is in the area?
	What condition are the buildings in? Are there any derelict/disused buildings?
	Where is the local Housing Office?
	Does the local authority house people in temporary accommodation? (hotels, B&Bs)
	Where is the nearest Foodbank?
	Where is the nearest soup kitchen/day centre?
	What services are there to support specific groups such as refugees, single women, young carers etc?
	Register with Street Link to notify the local outreach teams if you notice someone street homeless.
	What street outreach team is operational in your area? (St Mungo’s, Thames Reach, etc.)

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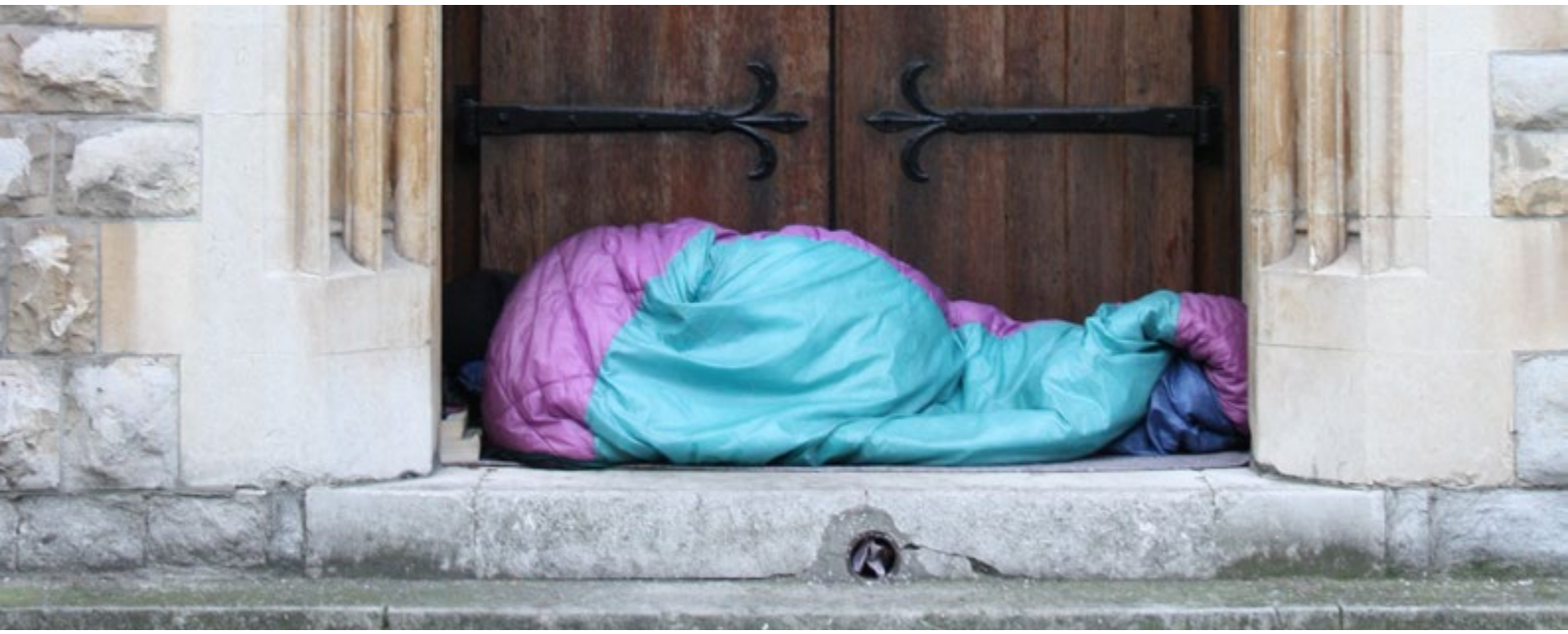

Get to know your area activity:	Do any of the local GP services offer enhanced services for people with no fixed abode?
	Where are the local pharmacies? What additional services do they provide e.g. Direct Observed Treatment (DOT) or Pharmacy First Scheme?
	Where are the local sexual health clinics?
	Where is the nearest Walk-in Centre or Urgent Treatment Centre?
	Where is the nearest A&E?
	Where are the local dental services and are they taking new NHS patients?
	Where is the local Drug & Alcohol treatment service?
	Think about the local amenities – are they nearby or in retail parks that are only easy to access by car? Where is the nearest supermarket, post office etc?
	Where is the nearest Job Centre?
	Where is the nearest police station?
	Think about transport – where is the nearest train station and bus stops?
	Is there a known red-light district?
	Are there any areas considered unsafe?
	Are there any encampments in the area?

Another way to develop knowledge and confidence in your practice is to keep up to date with relevant legislation, regulations and guidance affecting the people you work with. It is beyond the scope of this document to list all the legislation, and it is not likely that you will need to know the full Act of Parliament, but it may be useful to know certain sections of the law.

Here are a few that are relevant. Remember that legislation changes, so these were correct at the time that this document was published (2025). Click the title to be taken to the webpage.

The Housing Act (1988)

This Act explains that a person who has received notice to end their tenancy and where this notice period is within 56 days, is considered to be threatened with homelessness.

The Children Act (1989)
Section 17 of this Act states that the local authority has a responsibility towards children 'in need' in their locality. This support is available to everyone, including families who have no recourse to public funds (NRPF).

The Housing Act (1996)
This Act states that housing authorities must give proper consideration to all applications for housing assistance.

The Human Rights Act (1998)
This legislation outlines the basic human rights and principles of equality. All public authorities have a general duty to ensure that everyone is treated equally and with dignity. The Act has five main principles that people should be treated with: Fairness, Respect, Equality, Dignity and Autonomy.

Immigration and Asylum Act (1999)
Under section 95 of this Act, the Home Office can provide housing and financial support to people seeking asylum who are destitute or likely to become destitute. The support they provide will continue until a decision is made by the Home Office about the asylum claim.

Homelessness Act (2002)
Under this Act, all housing authorities must have a homelessness strategy in place which considers all forms of homelessness. The purpose of the strategy is to set out the authority's plans for the prevention of homelessness and for providing appropriate accommodation for those who become homeless. The strategy must be renewed every 5 years.

Homelessness (Suitability of Accommodation) (England) Order (2003)
This legislation states that bed and breakfast accommodation is not considered suitable for families with children and household that include pregnant women. The only exception is where there is no other accommodation available and then in this case, they can only house them there for a maximum of 6 weeks.

The Mental Capacity Act (2005)
This Act was designed to empower and protect vulnerable people who are not able to make decisions independently. It sets out who can take decisions, in what situations, and how they should do this. The Act outlines five key principles: the presumption of capacity; the right for individuals to be supported to make decisions on their own; the right to make an unwise decision; for any decision or act done for or on behalf of the person to be done in their best interest; to use the least restrictive intervention when anything is done for someone deemed not to have capacity.,

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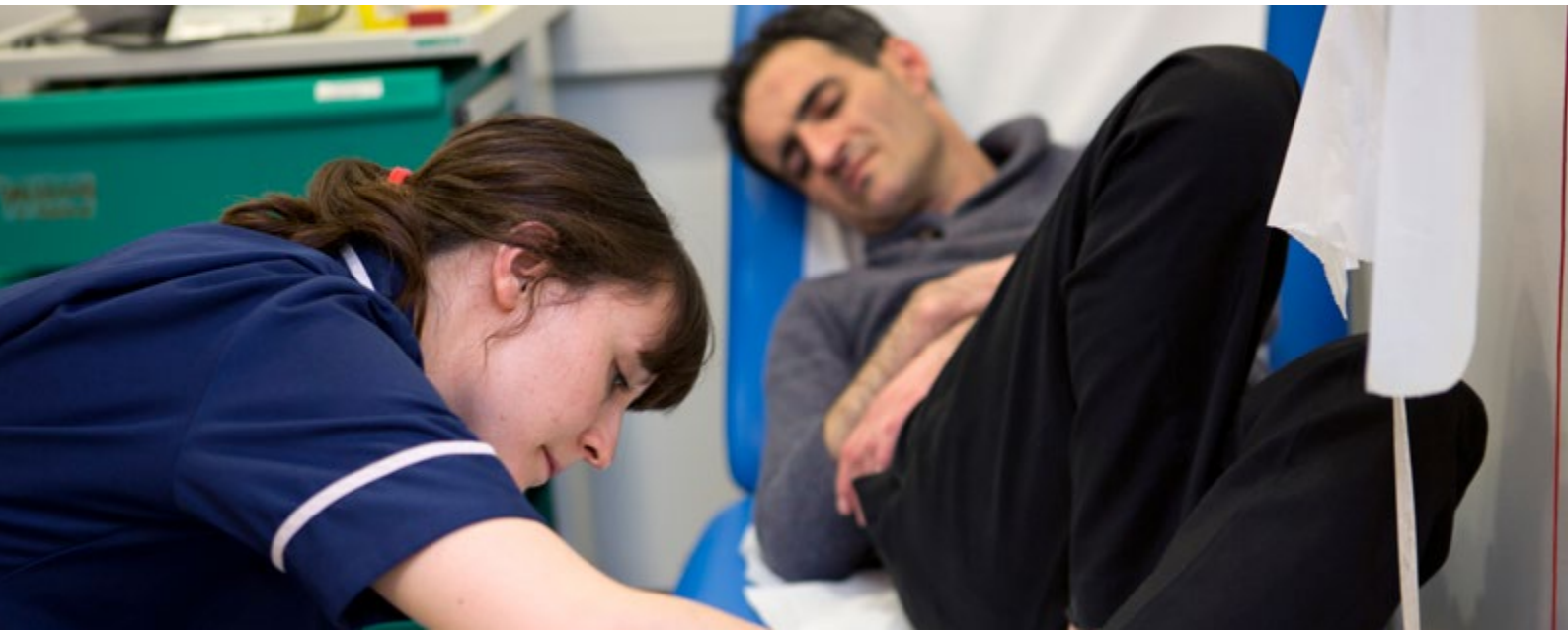

The Equality Act (2010)

This Act legally protects people from discrimination in all areas of society, including the workplace and in health and social care. It sets out nine personal characteristics that are protected by the law – age; disability; gender assignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

The Care Act (2014)

This law set requires that local authorities have a responsibility to provide care and support for adults. It sets out the local authority's duties when they make an assessment of a person's care needs to determine eligibility.

Homelessness Reduction Act (2017)

This legislation places a duty on certain public authorities to refer people who they think are experiencing homelessness or are at risk of homelessness (with their consent) to the housing authority. The local authority has a duty to intervene at an earlier stage to prevent homelessness. It also requires that local authorities provide homelessness services to everyone affected, not just those deemed to be 'priority'.

Data Protection Act (2018)

It is important to familiarise yourself with this legislation as well as your employer's own information governance policies because this role involves working with many different agencies, and although you may be able to advocate for a person with knowledge of their health needs, it is important this is done in the right way and with their consent. The Data Protection Act regulates how a business or organisation can use, store and share personal data.

Domestic Abuse Act (2021)

This Act requires that housing authorities prioritise those who are at risk of homelessness as a result being a victim of domestic abuse.

4. Multi-disciplinary working

People will be accessing a wide array of services and professionals in the community for their health and general social needs. Therefore, it is a good idea to understand and be familiar with these various roles, remits, and look at how partnership working can improve client care and outcomes.

Understanding clients' needs as well as the scope of practice is key to nursing. As discussed, there is an array of factors that impact a person's health and wellbeing. It is important to acknowledge that being an expert in all fields is not possible, but getting to know other specialists that can support people in different aspects of their health is key to offering a wrap-around service, and this can greatly improve outcomes for the client. For example, when trying to support someone to attend a clinic appointment, they may be hesitant because they do not have clean clothing or because they are managing with addictions. In this situation, it makes sense to link them in with a local clothes bank charity, and the local drug and alcohol service.

Nurses are often considered the "lynchpin" in the wider multi-disciplinary team, bringing together all the various professionals that are working to support an individual as a co-ordinator. However, it is important to recognise the roles, specialities and remits of each person in this wider team so that the co-ordination sits with the institution that carries the greatest responsibility.

In some areas, there will already be specific multi-agency forums and meetings set up. For example, many areas have a Violence against Women and Girls (VAWG) forum or panel which meet regularly to discuss high risk cases in the locality. These will often be attended by representatives from social services, the police, education, and healthcare bodies. This way of working can facilitate timely support. For example, if a person needs to be moved out of the area for their safety, a network or forum like this can speed up communication and action can be taken swiftly. Here are just some of the other services you will likely work alongside to provide a rounded service for clients:

Health-related services:

- District Nurse
- Community Matron
- Community Mental Health Team (CMHT)
- Podiatrist
- Dentist
- Paramedics
- Practice Nurse
- General Practitioner (GP)
- Rapid Response Team
- Speech & Language Therapist
- Sexual health Services
- At-home Team
- Learning Disability Nurse
- Maternity teams
- Health Visitor
- Palliative Care Team
- Specialist Nurses e.g. Hep C Nurse Specialist; Diabetes Nurse Specialist
- Occupational Therapist (OT)
- Physiotherapist

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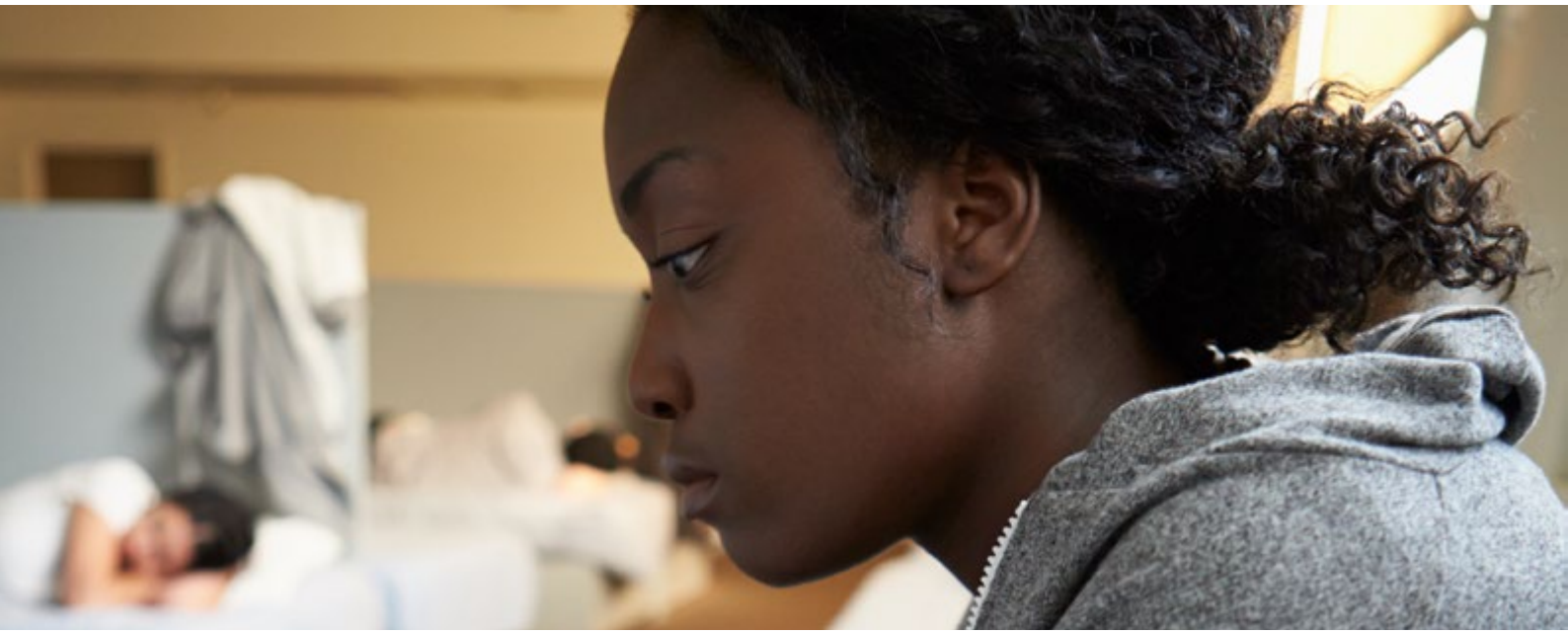

Non-health services:

- Hostels
- Day Centres
- Religious organisations
- Social services
- Housing departments
- Homelessness charities
- CHAIN (Combined Homelessness & Information Network) used in London
- Food banks
- Clothes banks
- Day centres/soup kitchens
- Drug & alcohol services
- Solicitors/Lawyers
- Job Centre
- Domestic violence support services

Building relationships with other agencies can be key to forging systems and pathways that work better for our client group. Here are some examples:

1. The nurse-led Health Inclusion service with the Guy's & St Thomas' NHS Foundation Trust negotiated access to the London Care Records that contain a person's relevant health and care information (Primary and Secondary care). This allowed nurses working in hostels and day centres to access the client's GP records in a timely manner for things such as blood results, medical history, medication list, etc. It helps avoid duplication of work, and promotes safe practice.

2. A Health Inclusion Team in Bolton developed a quick-access pathway to the local Anticoagulation clinic for clients at risk of DVT. This helped circumvent an often-longer pathway.

Think about your local services and how pathways into them are structured. Could these be negotiated to make them more accessible? Also, consider creating your own local directory of services.

5. Skills and experience

Are a separate set of skills required to work as an Inclusion Health Nurse?
Whilst individual behaviours and values remain the same regardless of who is treated, because of the higher prevalence of certain conditions seen in specific populations, such as blood-borne viruses or tuberculosis, it makes sense to be familiar with these topics and to become competent in certain skills, such as knowing what screening bloods to offer or which catch-up vaccines to offer. It is recognised that people experiencing homelessness are more likely to experience physical ill health, mental ill health as well as drug or alcohol misuse, a term known as tri-morbidity.

Some prevalent conditions seen in marginalised populations:

- Uncontrolled chronic conditions – Whether it's because a person has been travelling for many weeks or months and has run out of medication, or because their bag containing their medication has been stolen, the management of chronic conditions can be tricky when a person is more transient.
- Skin infections – abscesses and chronic wounds can be more common if a person is injecting drugs.
- Missed antenatal care – for various reasons, including fear of cost and not understanding the system, we can come across women who are not linked with antenatal services when pregnant.

Below are some skills and knowledge that are useful to be familiar with. However, these lists are not exhaustive, and the information you require will change according to the service you are working in, and the population needs.

Clinical skills and knowledge:

- Signs of infection
- Venepuncture
- Interpreting blood results
- Wound care (chronic and acute)
- Leg ulcer assessment and management, including use of Doppler
- Compression dressings
- Contraception + family planning
- Smoking cessation
- Dental hygiene + self-care
- Basic mental health assessment
- Management of long-term or sometimes poorly-controlled conditions (diabetes, hypertension, asthma, COPD, epilepsy)
- Minor injury and minor illness advice and management
- Medication – knowledge of local Patient Group Directives (PGDs) and the benefits of Non-medical Prescribing (NMP) if this is an option to study and qualify in
- Immunisations
- Dietary and nutrition advice
- Neurodiversity – knowledge of reasonable adjustments and the local Learning Disabilities Team

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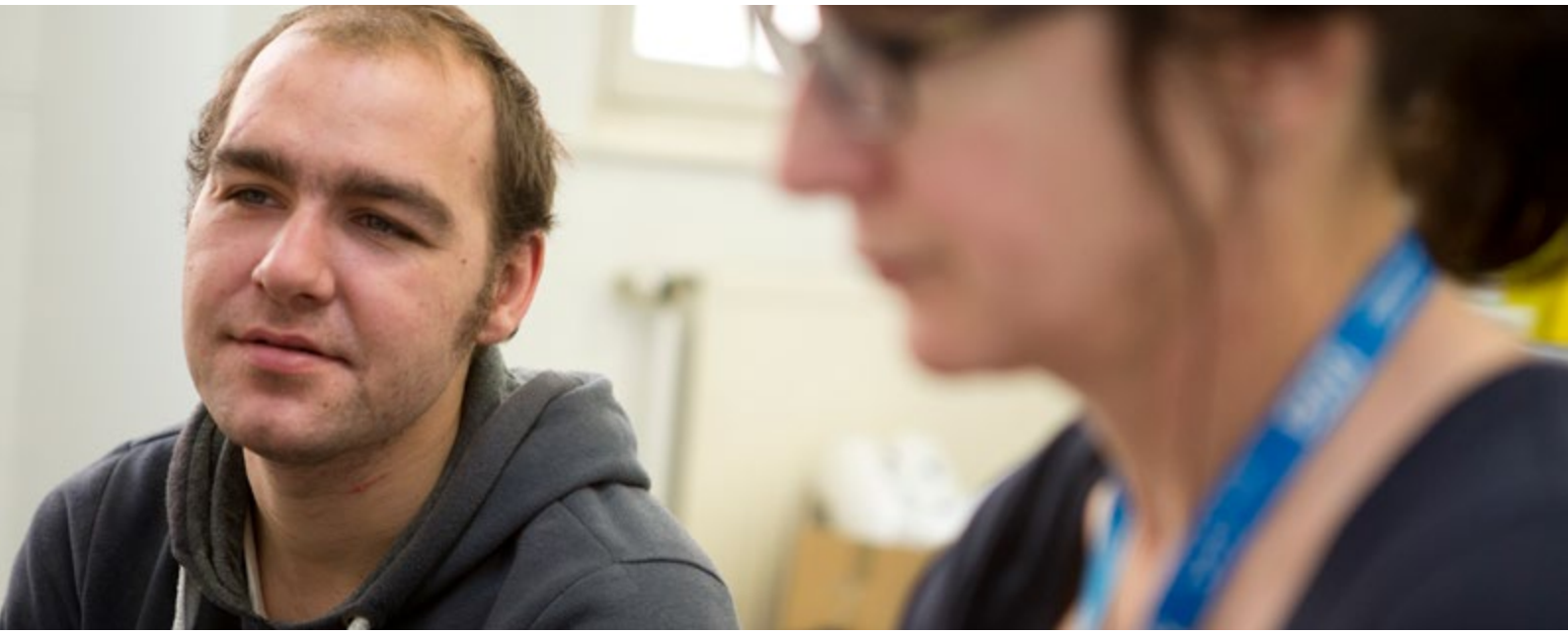


Other skills and knowledge:

- Relevant legislation
- Housing
- Consent
- Information sharing (working with many external agencies)
- Convening and chairing meetings
- Knowledge of drug + alcohol services to signpost/refer to
- Knowledge of local food banks and where to get food vouchers
- Knowledge of local soup kitchens, day centres and churches that offer support
- Knowledge of local libraries for those who may be digitally excluded
- Recognising young carers and knowledge of local support services
- Knowledge of local safeguarding pathways (MASH Teams, Early Help Teams)

You will encounter a wide range of health conditions across many specialties. Building links with local specialist teams can help improve patient access and outcomes. Here are some examples:

Case study 1

George was a 45-year-old male who had recurrent ascites due to alcohol consumption and chronic hepatitis C. He frequently needed treatment with an ascitic drain. The nurse working in this hostel understood the irregular nature of this person's day-to-day life and that having to go through layers of formal referrals to the local ambulatory care unit would take too long to arrange. So, the nurse built a relationship and agreement with the local ambulatory care unit that she could contact them a day before the person was ready to go in for the ascitic drain treatment and they would see the patient.

Case study 2

Caseload analysis by the Specialist Health Visitor Team in Southend highlighted that a high number of children living in temporary accommodation had speech delay. The team negotiated a fast-track referral pathway directly into Speech & Language services, bypassing the need for full assessments, instead just providing details of the child and the speech issue. Most children referred into this pathway are triaged within 2 weeks, as opposed to 2-3 month waiting time for routine referrals. The speech and language care plan is then added to the child's record and this is available for the new Health Visiting team to view and action. The Speech & Language service have also agreed to give a verbal handover of their care plan to the new area if the family moves.

6. Working with vulnerable people at risk of harm

Working in unconventional settings and with vulnerable people makes them more at-risk of being exploited.

Here is a reminder of the different types of possible abuse:

- Physical abuse
- Domestic violence or abuse
- Sexual abuse
- Psychological or emotional abuse
- Financial or material abuse
- Modern slavery
- Discriminatory abuse
- Organisational or institutional abuse
- Neglect or acts of omission
- Self-neglect

Mainstream safeguarding training is comprehensive. However, there are some other additional factors that can make a person vulnerable in the Inclusion Health population:

- Not speaking the local language
- Learning difficulties
- Increased stress
- Not knowing your rights or able to navigate the system means you may rely on others to support you (people being charged to register with a GP or to process their settled status.).

Some examples of safeguarding cases:

Case study 3

Frasier was a 54-year-old male recently moved into a hostel. He had never been diagnosed with a learning difficulty but tells the nurse that when he attended school as a child, it was a “special school”. Frasier is very friendly with everyone and can appear naïve. He appears excited that he is making friends easily in the hostel. Some months later, you notice Frasier’s personal appearance deteriorate, he is losing weight and has become a bit more withdrawn. It becomes clear that the people he considers friends are only friendly with him once a month when he gets paid his benefits money.
This is an example of financial abuse.

Case study 4

A gentleman from a particular community would often bring people newly arrived to the UK to the GP surgery to register. It appeared that they were a helpful member of the community, supporting people to navigate a system that was new to them. However, after some time, it was discovered that they had been charging people to get registered with a GP.
Unfortunately, this is not an isolated case and has been documented in various other locations too with other communities.
This is an example of financial exploitation.

“Working in unconventional settings and with vulnerable people makes them more at-risk of being exploited.”

Personal safety

Working as a nurse comes with its own risks and being able to confidently assess risks to the individual nurse, colleagues and patients is part and parcel of the nurse's skillset. Working in Inclusion Health often carriers the additional risk of lone working as the roles are frequently autonomous.

Formal risk assessments should be carried out when setting up clinics in new locations and environments. However, in-the-moment, dynamic risk assessments occur every day as each encounter will be a first. This could be managing a substance overdose to deciding how to manage the risk of discussing a person's health in a corridor or on a park bench. Being able to manage risk to work in a way that is both safe, yet effective, is a core duty of the nurse.

Activity

Questions to consider when putting together a risk assessment:	What personal protective equipment do you carry with you?
	Do you have access to a personal alarm or other means to access help urgently?
	How do your colleagues know your whereabouts? Does your team have a system in place such as calling into the office, a shared diary, a buddy system or something else? Do you have a specific word you use when calling the office for help?
	Does your team have information about your next of kin in case of an emergency?
	What emergency equipment do you have and how is it maintained?
	What is your workplace policy for needlestick injuries and body fluid splashes?
	What would you do if a patient collapsed whilst you were on outreach?

Questions to consider when putting together a risk assessment	Are you familiar with the emergency exits and fire safety procedures in the sites you work in?
	Have you undertaken relevant training e.g. Conflict Resolution, Breakaway techniques, Infection Prevention Control, Medicines management.
	Consider the risks in relation to a person using drugs or alcohol in your presence – are they presenting to the clinic under the influence of drugs or alcohol? How would this impact decision-making? Do you have access to Naloxone and the necessary training on when and how to administer it?
	What do you have in place to ensure there is no break in the cold chain for medications that needs to be kept refrigerated?
	Do you have an agreement in place with the hostel/day centre staff for chaperoning when necessary?
	Do you have access to equipment to support with manual handling e.g. adjustable height bed/couch, hoists.
	Do you have timely access to patient GP records?
	What system(s) are in place to report incidents?

7. Developing your career

Learning

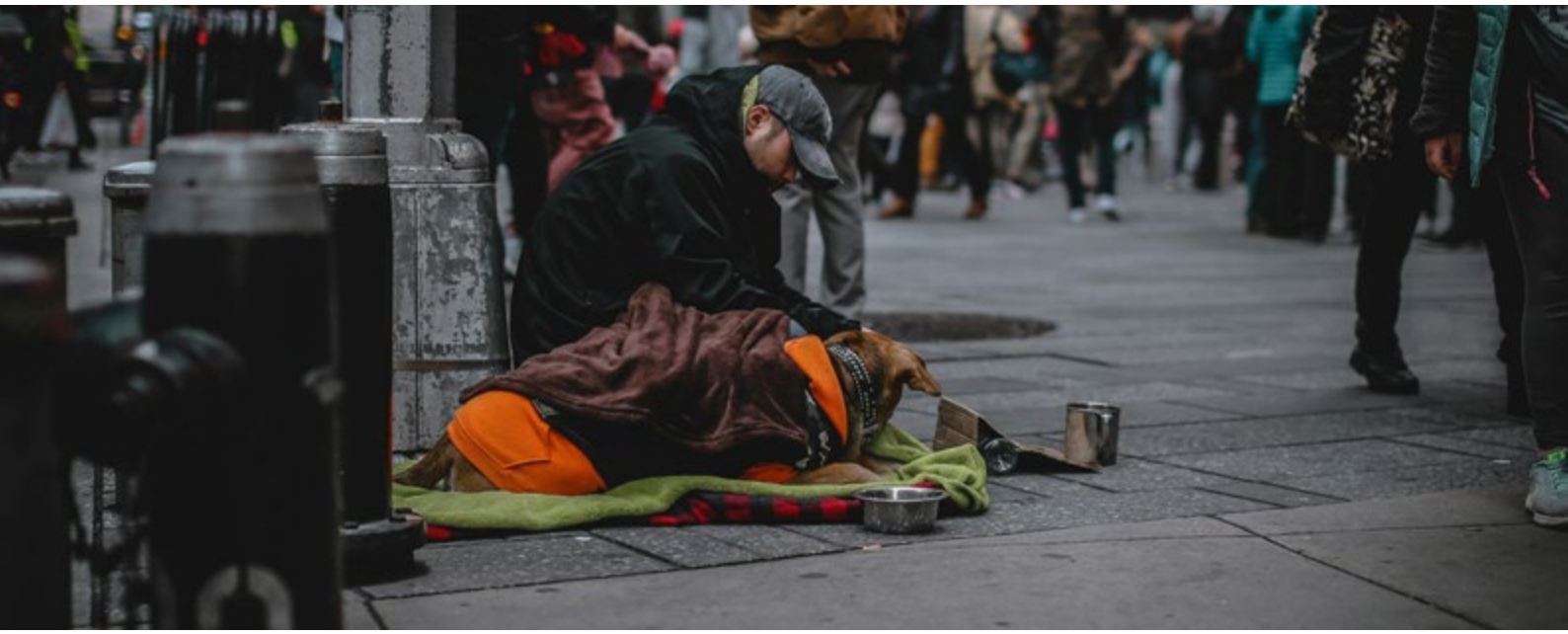
Shadowing colleagues and specialists in any field provides valuable, hands-on insight. Reaching out to professionals for an opportunity to see what a 'day-in-the-life' looks like, is highly recommended. Seeing first-hand the client presentations, interaction, assessments, coinciding issues, referrals processes, and on-the-spot creative thinking needed by different professionals is invaluable.

Another valuable learning opportunity is volunteering. There are many charities, community organisations, and even faith organisations that support those at the margins of society. Giving time to volunteer with them not only gives insight into the social aspects of life that are impacting a person's health and wellbeing but allows people to contribute and connect.

For more formal learning, there are plenty of regular webinars, report launches, conferences, and e-learning courses. Have a look at a few of these below:

- **Aneemo** – A staff training and development company that offer a range of module courses that help practitioners address health inequalities. Topics include: Trauma-informed approaches; Motivational interviewing; Working with women experiencing complex needs; Solution-focused therapy.

"Shadowing colleagues and specialists in any field provides valuable, hands-on insight."



- **E-Learning for Health** – This platform has a number of online training programmes that are relevant to Inclusion Health: Tackling Homelessness; Supporting GP registration for people experiencing homelessness; Trauma-informed care
- **Fairhealth** – A charity that offers free courses, e-learning, blogs, a podcast, and more, to support professionals in reducing health inequalities.
- **King's College London** – The Homelessness series is a series of webinars on different aspects of multiple exclusion homelessness.
- **LNNM** – A charity that works to support professionals working in inclusion health, promoting best practice. They hold regular monthly meetings to discuss current issues and clinical topics, as well as a yearly conference.
- **QICN** – The Homeless & Inclusion Health Network has been running since 2007 and runs regular monthly open meetings sharing best practice, innovative work, and the latest research.

Currently (2024/2025) there are only two institutions running higher education courses in inclusion health:

- London South Bank University – Level 7 module on homeless health
- University College Birmingham – Master's programme in Homeless & Inclusion Health Nursing
- University of Edinburgh- Undergraduate and Master's level

8. Your own wellbeing

Working in nursing can be both rewarding and challenging. Working in the Inclusion Health sector, can bring further exposure to difficult circumstances, hearing traumatising stories, and supporting vulnerable people.

Often, the mix of this and advocating for people within a system that can sometimes appear hostile or difficult to access and navigate, can sometimes leave nurses feeling worn out, frustrated, indifferent, or feeling that they can't make much difference.

Historically, the term vicarious trauma has been used, but more recently, the term 'moral injury' has been used to describe this feeling of harm to a person's values and moral conscience.

It is important that teams support each other, not just through structured and formal supervision sessions at specific intervals, but also through informal, day-to-day checking-in. This is particularly important with roles in the community which are more likely to be lone-working, isolated or in virtual teams.

On an individual level, it is important that we implement professional boundaries. This will look different for different practitioners but will include our attitudes, values and behaviours.

Healthy boundaries can include starting and finishing clinics on time so that everyone is clear on the operational hours and so that the practitioner does not get into the habit of staying late, which can have a downstream effect on their workload and personal life. Linked to this, it is important that we separate work from our personal life, whether this means we have a quick debrief with colleagues at the end of a shift, ensuring we book annual leave ahead so that we create time off to look forward to, or taking up hobbies outside of work.

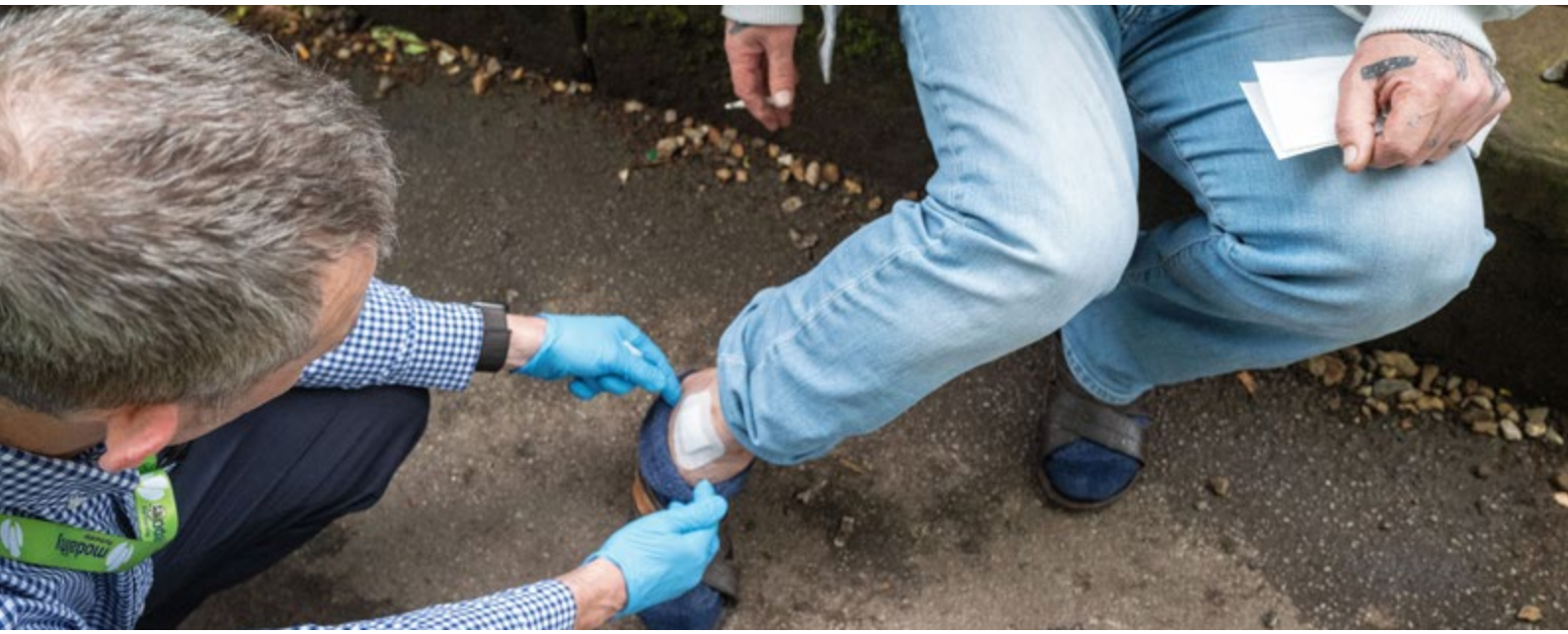
Our appearance can also play a role in boundaries. To foster trust and engagement in our relationships with clients, some workplaces adopt a more casual approach to their attire rather than wearing a uniform. This is understandable, as people from some communities have had negative experiences with organisations and uniform symbolises institutions. However, it is equally important to be aware that for some people, uniform provides clarity and reassurance of each person's role and responsibility.

Something to consider:

- Does my workplace have a regular clinical supervision or a Balint group?
- Is this in-house or delivered by an external facilitator or psychologist?
- Who do I call to discuss any cases on a day-to-day basis?
- Who can I call for support out-of-hours?
- What well-being initiatives does my employer offer?
- Are there communities of practice I can join to discuss similar wider issues in Inclusion Health, examples of best practice etc.?

An example of an initiative that supports practitioner wellbeing:
The Museum of Homelessness hosts a bi-monthly online session for practitioners to discuss and process death, grief and loss experienced at work.
You can register to attend the Breathing Room here.

"To foster trust and engagement in our relationships with clients, some workplaces adopt a more casual approach to their attire rather than wearing a uniform."



A final note – while initiatives like the example above and periodic supervision are invaluable, it is important to recognise the toll on professionals and to ensure adequate support is available on a daily basis. You should feel supported in raising this if this is something that is not already in place.

9. Resources

Local policies and SOPs will often be your first port of call for advice. However, there is a wealth of useful information available that can specifically support decision-making or improve health education when working in Inclusion Health.

General support:

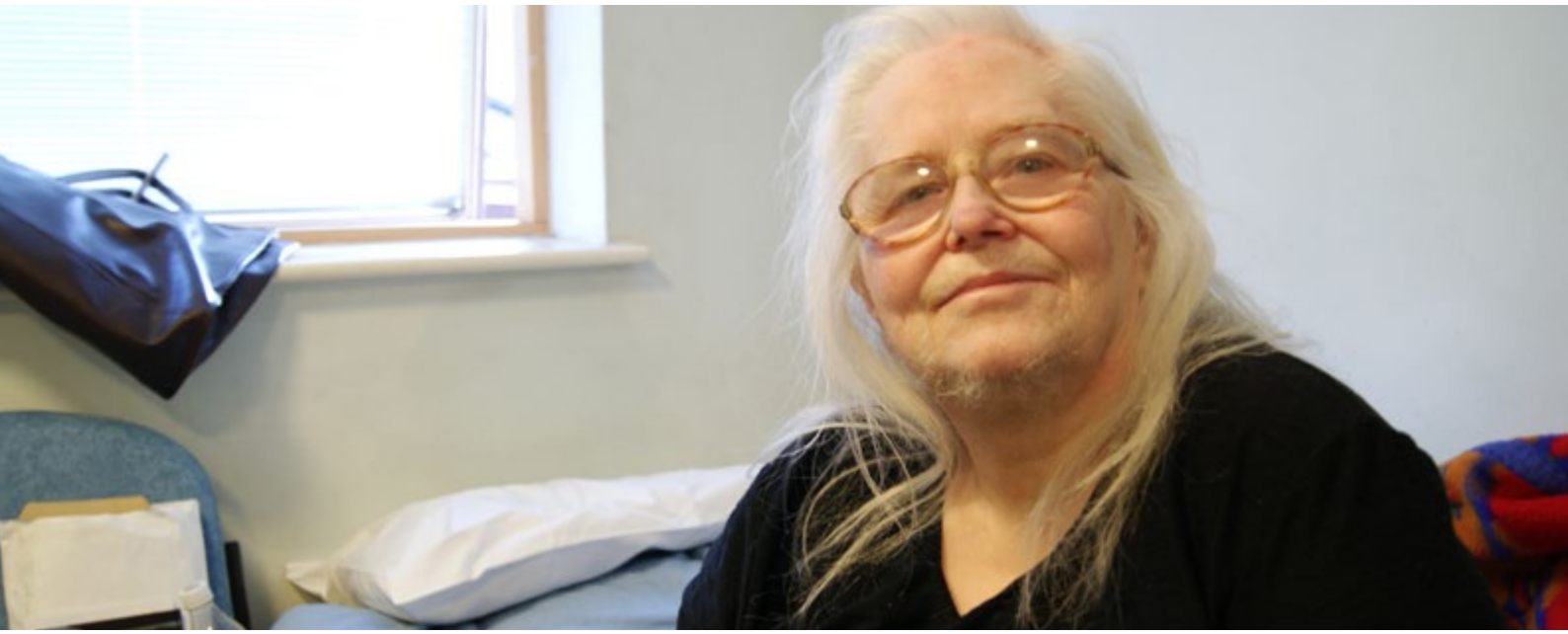
- **Doctors of the World** – Charity which advocates for access to healthcare. Plenty of resources for patients in different languages. An advice line for people who need support with registering with a GP. A Hospital Access Project which supports people with charges related to secondary care.
- **Project 17** – Charity providing advice for migrant families with no recourse to public funds.
- **No recourse to public funds network** – Charity that assists local councils to support families with no recourse to public funds in line with national guidance. Lots of information about the immigration law on their site.
- **Roma Support Group** – Charity that provides advice and advocacy for Roma people. Also provide training for organisations working with Roma people.
- **Friends, Families and Travellers** – A national charity that works on behalf of all Gypsies, Travellers and Roma. Run an advice line about various practical topics including how to set up council tax payments, evictions, and finding out about legal aid.
- **Showmen's Mental Health Awareness** – A charity founded and run by people from the showmen and fairground community to break the stigma around mental health in their community. Awareness raising as well as providing a mental health service that people can self-refer to.

- **London Housing Foundation** – This site contains an interactive map of services that support people experiencing homelessness across London, including specialist health services.
- **Refugee Action** – This organisation provides various services that support refugees in the UK. Currently have projects set up in several cities. Check the site for more information.
- **Shelter** – Housing and homelessness charity that offer one-to-one advice regarding housing problems, and campaign for housing justice.
- **Homeless Link** – A membership charity for organisations that work with people experiencing homelessness. Head here for research on homelessness and training for your team.
- **Migrants Organise** – Charity providing a platform for refugees and migrants to organise campaigns for a more just system. Provide advice on immigration, welfare benefits, and asylum support.
- **Groundswell** – A charity which carries out research and develops practical resources informed by people with lived experience of homelessness. They have produced very useful leaflets on various health conditions and screening programmes in user-friendly formats.
- **Pathways** – With health equity at its core, Pathways share best practice, develop training, and influence policy around inclusion health.
- **Children's Society** – National charity that supports young people struggling with mental health, or a history of or a risk of abuse. They have a postcode checker to find local services for young carers.
- **Women's Aid** – National charity that campaigns, delivers training, provides an emergency helpline, and carries out research.
- **IKWRO** – Organisation that provides a free counselling service to women who have experienced gender-based abuse. They offer services in English, Kurdish, Farsi, Arabic, Dari, Pashto, and Turkish languages.
- **Ashiana** – Organisation that provides safe housing, specialist counselling and professional training on domestic violence.
- **Veterans Covenant Healthcare Alliance** - Organisation that provides an accreditation programme designed to support healthcare providers understand and meet the needs of the Armed Forces community.

Clinical support

- **The Green Book** – Now an online document only, the Green Book is the go-to resource for all immunisations against infectious diseases. Each chapter is dedicated to a specific disease and gives you some history around it as well as information such as symptoms, incubation period, and immunisation schedule.

"Inclusion Health Nursing reminds us that nurses can be agents of change on a societal level."



- **Vaccination schedule** – The UK Health Security Agency publish a vaccination schedule that is updated yearly. There is a specific schedule for individuals with uncertain or incomplete immunisation status.
- **Zanzu** – A health education site website that explains anatomy, and also specifically sexually transmitted and different types of contraceptives in many different languages. Very helpful to give written information to people who speak and read a language other than English.
- **Freedom from Torture** – Therapy and support for survivors of torture. Requires referral from a professional.
- **Refugee Council** – Crisis advice, mental health counselling, and practical support for refugees in the UK. Specialists in working with unaccompanied minors.

10. Conclusion

Inclusion Health Nursing reminds us that nurses can be agents of change on a societal level. Whether you work in this specialty or not, this is a powerful reminder to all nurses that every person we advocate for, every person we listen to, and every person we care for can have the trajectory of their life changed as a result.

People's lives can be complex and bring unique challenges including addictions, mental illness, historical trauma and uncertain immigration status. Recognising that these varied elements will affect each participant's experiences differently, and that each person will experience their health and access to health care in distinct ways, we need to be adaptive in how we work. This knowledge isn't easy to square: we work for the wider healthcare service yet are seeing people facing barriers to it. However, it is very rewarding work.

Inclusion Health Nursing is holistic nursing at its best.

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