The Queen's Nursing Institute

Nurse-led Projects in the Community:

For people experiencing homelessness

Contents

‘Community nurses are at the forefront of delivering compassionate and effective healthcare to people who may otherwise simply be invisible to the system, with terrible costs to them as individuals and to society as a whole.’

Nurse-led projects are one of the most direct ways in which the Queen’s Nursing Institute (QNI) help nurses improve patient care. Since 1990 the QNI has funded over 200 innovative projects across the whole range of community nursing specialties. Sharing the results of these projects helps us to drive improvements in knowledge and practice. Often, these funded projects become part of mainstream services.

In 2018, the QNI announced ten local nurse-led projects that would benefit from a year long programme of financial and professional support. The projects were aimed at people who were experiencing homelessness or who were living in vulnerable or temporary housing, including recent migrants, street homeless, people in custody, and Gypsy, Romany and Traveller populations. All of these groups experience a range of health inequalities which can be severe and life threatening.

The ten projects were all led by community nurses working in different parts of England, with projects taking place in London and the Southeast, Midlands, the Northwest and Northeast.

This is the first time that the QNI’s Fund for Innovation and Leadership has focused specifically on projects that work with the homeless population. The QNI is currently working in partnership with funder, Oak Foundation, which is supporting its Homeless Health Programme for three years.

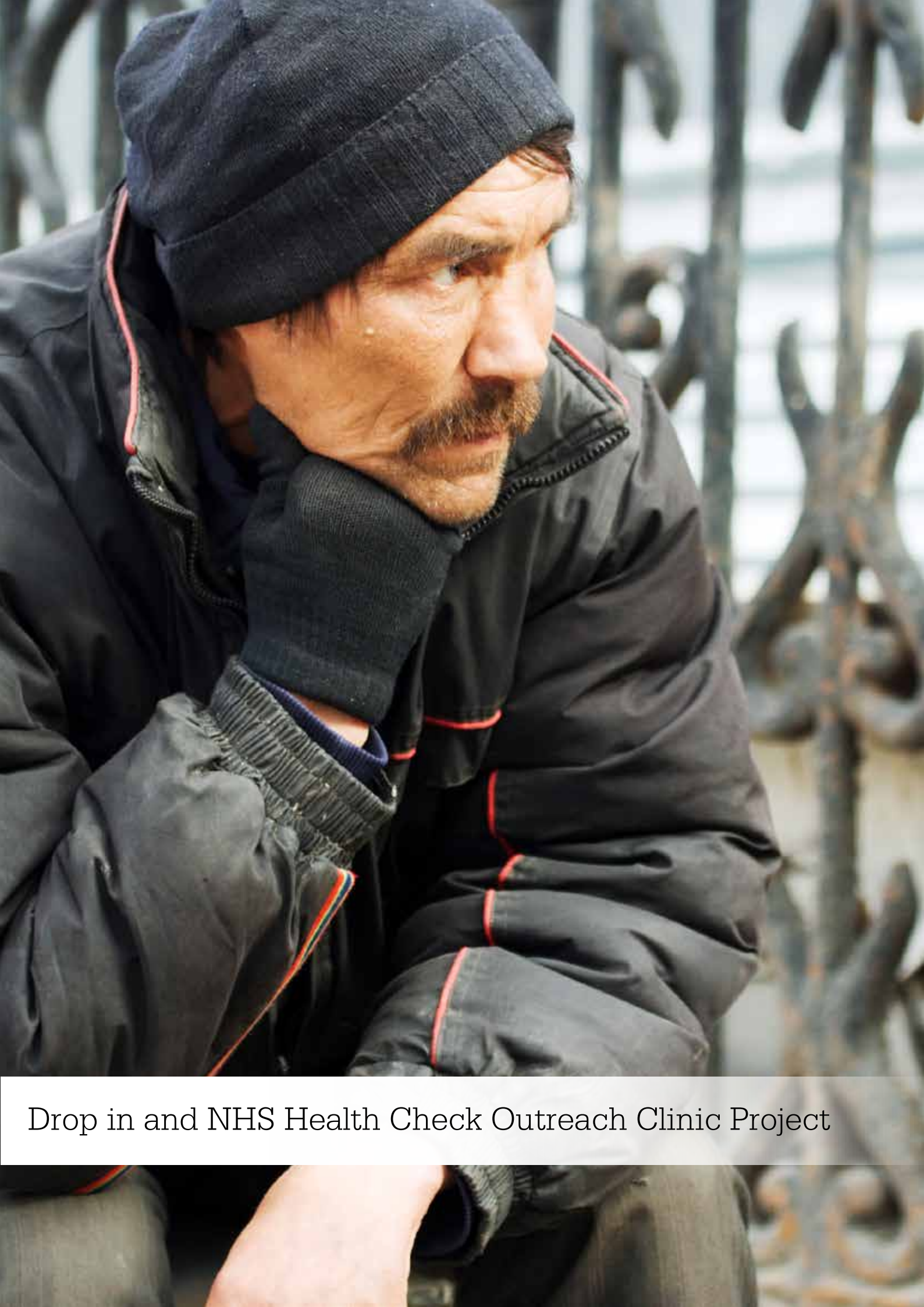
David Parker-Radford, the QNI’s Homeless Health Programme Manager said, ‘These projects represent the vital role that community nurses have to play in supporting some of the most vulnerable groups in society, by engaging with them on the streets through outreach and treatment work, where more traditional models of care are not effective.

‘The health and social problems related to homelessness are acute and the number of people who are street homeless has increased substantially in recent years in recent years. Community nurses are at the forefront of delivering compassionate and effective healthcare to people who may otherwise simply be invisible to the system, with terrible costs to them as individuals and to society as a whole.’

It is hoped that by supporting innovation in the field and measuring outcomes, positive benefits to patient care and service delivery will be identified. Following project completion, evaluation and reporting, this new learning will be shared with other practitioners.’

With thanks to

OAK FOUNDATION



Drop in and NHS Health Check Outreach Clinic Project

‘I was very much in a bad place, but Patsy and the other nurses were very caring. If the nurses weren’t at the Ark, I may not be writing this.’ Patient

Project team

Patsy Dodd, Advanced Nurse Practitioner; Charlotte Swan, Wirral Churches Ark Project, Birkenhead.

Project aim

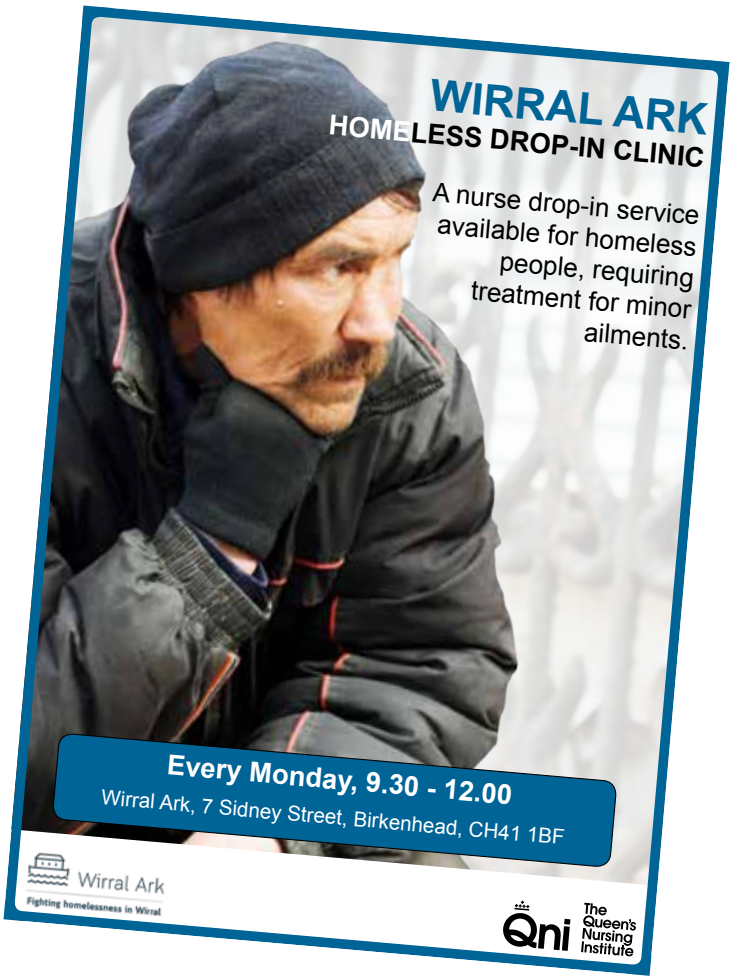
- deliver a nurse-led clinic to provide primary care to Wirral Ark residents and non-residents
- reduce inequality of access to health care for homeless people
- NHS Health checks to all Wirral Ark homeless hostel residents aged 40-75 years
- early identification of chronic disease, management of any disease identified, preventing secondary complications and avoiding hospitalisation.

Introduction to project

Research shows that people who are homeless are at higher risk of developing chronic diseases and experience higher morbidity.

One of the biggest difficulties they face is obtaining basic medical care. With no fixed abode, it is very difficult to register with a GP. Patients face stigma and are often turned away from walk-in clinics and A&E or discharged without patient care or follow up, often due to their challenging or chaotic behaviour.

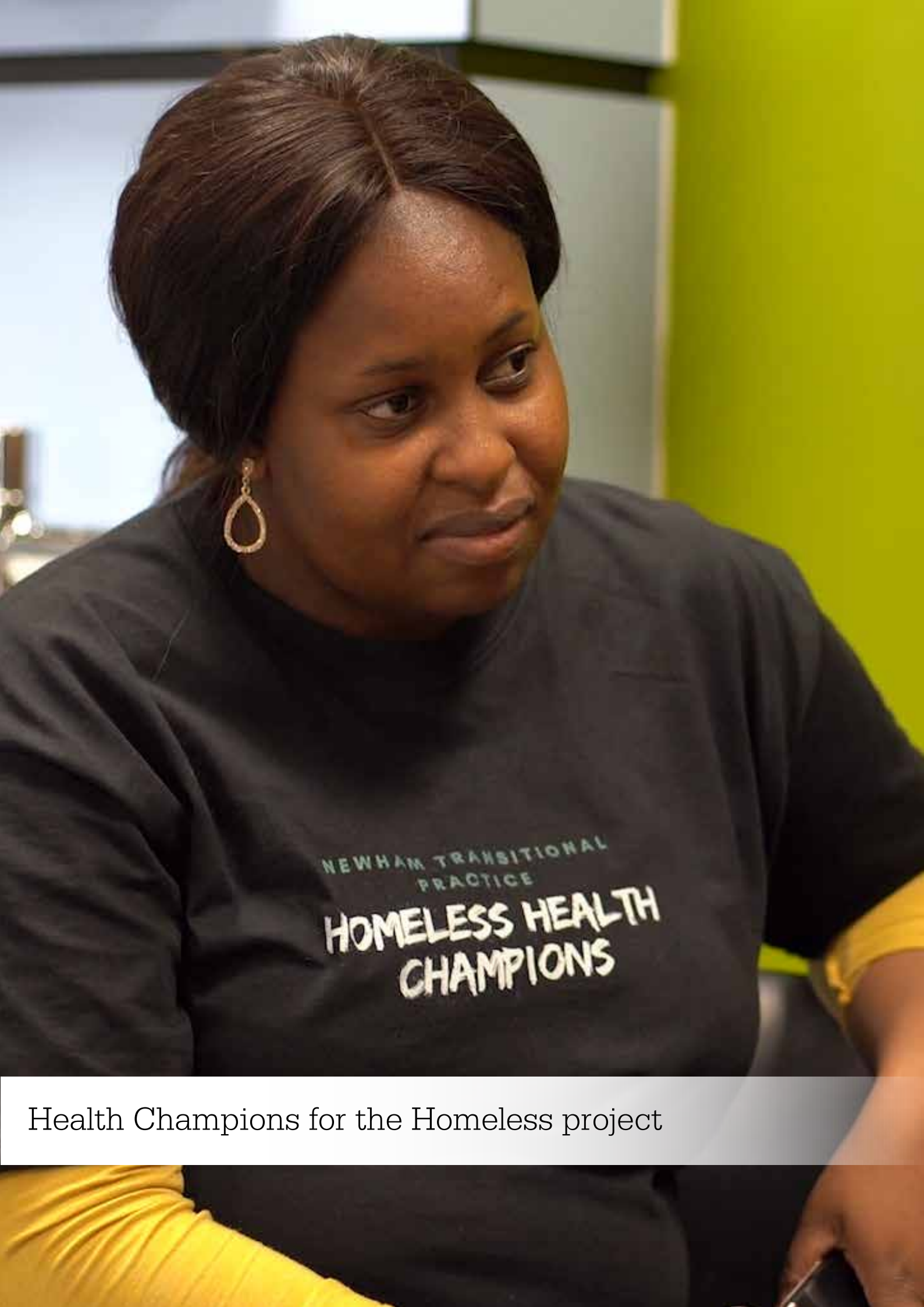
There is a real need to address these serious obstacles to health services that people who are homeless face in getting appropriate health care and to prevent and treat prevalent chronic health conditions.



Above: Project poster for patients.

Outcomes:

- **48** sessions delivered
- **117** residents attended and **62** non-residents
- **40%** who attended said they would have otherwise attended A&E
- **85%** had some form of chronic disease
- **96%** increase in healthchecks (aim was to increase by 20%)
- Implemented hepatitis tests and self-harm reduction kits as a result of hearing from other QNI Fund for Innovation projects.



Health Champions for the Homeless project

‘Before, you feel like you don’t exist... You always look down... You don’t meet people. When we got involved with this programme, you feel more human.’ Homeless Health Champion

Project team

Sihle Malapela, Nurse Practitioner; Abdul Rawkib, Commissioning Manager; Sultan Ahmed, Administrator; Newham, London

Project aim

- to improve the general health of people experiencing homelessness in Newham
- to identify undiagnosed long term conditions with a focus on diabetes, mental health and respiratory conditions
- to start patients on a treatment plan and social support.

Introduction to project

One in 25 people are currently homeless in the London Borough of Newham - the highest number in the capital. 13,607 people out of the population of 340,978, and an increase of almost 1,500 in the past year.

The figures do not include ‘hidden’ or unrecorded homelessness which “is very difficult to quantify, but known to be sizeable”. The health of people experiencing homelessness is known to be significantly worse than that of the general population.

This project tried to address this inequality and improve the health of people experiencing homelessness in Newham, in partnership with Newham Transitional Practice and Newham Clinical Commissioning Group.

Above: stills from the film featuring the project. To view it, please go to: www.qni.org.uk/explore-qni/nurse-led-projects/homeless-health/

Outcomes:

- 7 health champions recruited and 5 managed to complete the programme
- Predominantly user-led: health champions helped co-design the structured health programme
- 10 health education sessions completed and 2 evaluation sessions
- Successful and well-attended health event, arranged with health champions
- Health champions interacted with a number of different homeless peers and signposted to a range of services
- Very positive feedback from the health champions, who reported feeling more empowered to better manage their own health needs and have more awareness of local services.

HIT Plus project

‘Clients have reported a better quality of life and wellbeing as a result of the project. Some clients have become more self-aware about their own health needs and how and when to manage themselves or when to seek advice and support from those with specialist knowledge.’
Project lead

Project team

Kendra Schneller, Serina Aboim, Nurse Practitioners, Guy’s and St Thomas’ NHS Foundation Trust, Southwark, London

Project aim

- The Health Inclusion Team (HIT) Plus project aimed to ensure that rough sleeping clients have the same access to health care services as the population in general.

Introduction to project

There is currently a cohort of clients experiencing homelessness who are unable to access day centre services due to the restrictions in place with regards to substance/alcohol use. Therefore these clients are not seeking advice regarding their health. This will have an impact on hospital services as the clients are more likely to present to A+E in a state of crisis.

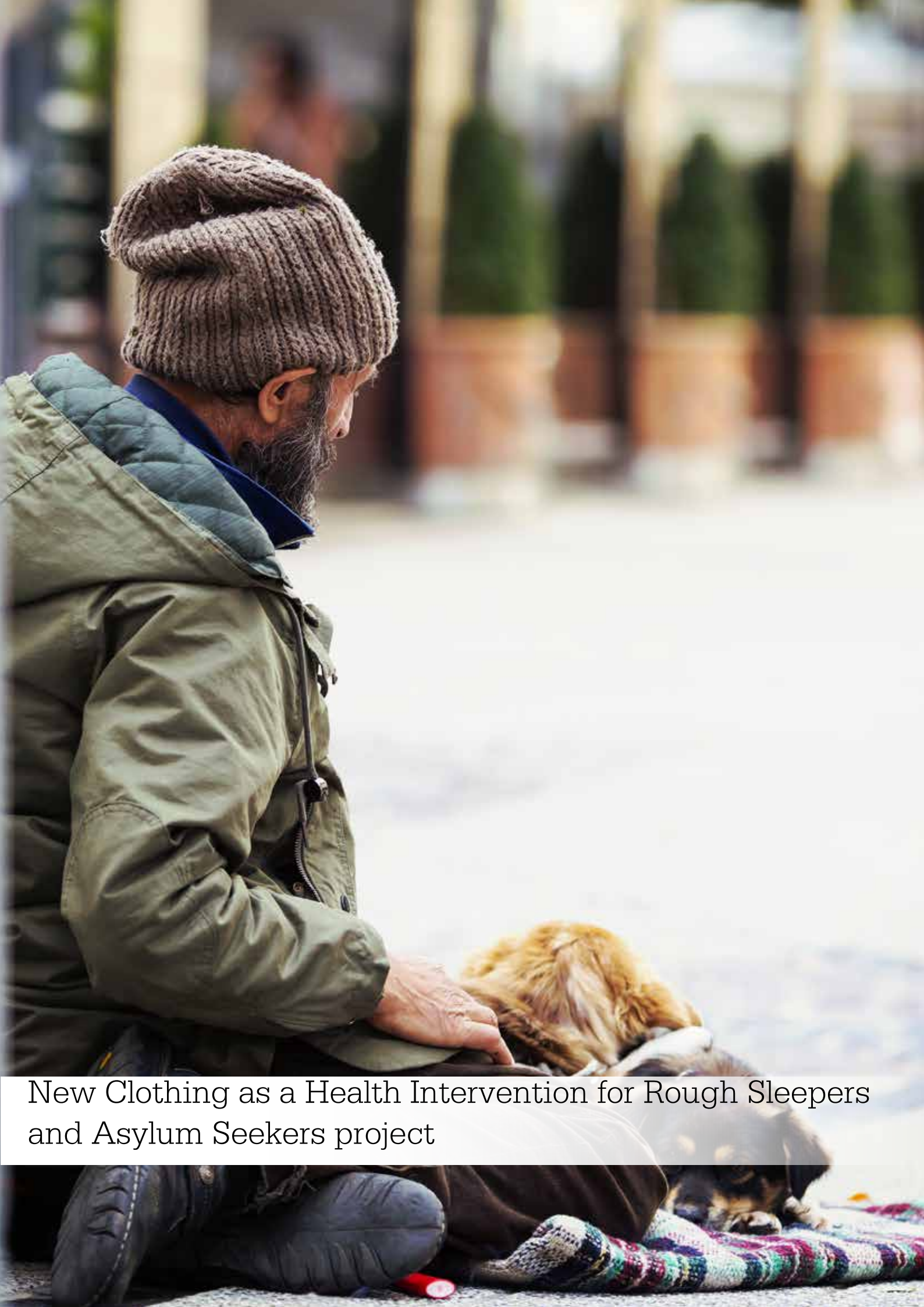
The project is also needed to help reduce the burden and costs to the NHS as a whole, by providing specific primary care advice and services, reducing A&E attendances.

It also helps with GP identification and proof of address issues, targeting a cohort of rough sleepers who do not access day centres for individual reasons and to respond to issues related to public health concerns.

Outcomes:

- **77** patients seen for same day healthchecks
- **109** clients seen on the street whilst on outreach
- **69** health interventions completed
- Interventions included: health assessments, immunisations, making successful housing applications for clients, supporting the addiction service, to ensure timely commencement of opiate replacement therapy (ORT), wound assessment and management
- HIT Plus model expanded into two other boroughs: Lambeth and Lewisham
- The service has also been profiled on **2** radio stations and was featured on BBC London news
- Project is sustainable and has secured funding from the Ministry of Housing, Communities and Local Government's Rough Sleepers Initiative and will continue to provide the service until 2020 when it will be reviewed
- Featured in the Time's Christmas Appeal in December 2018, with full article on the project.

Left: Kendra Schneller and Serina Aboim in London.



New Clothing as a Health Intervention for Rough Sleepers and Asylum Seekers project

'The itching [from scabies or other skin infestations] that prevents sleep can be very distressing to people who have already endured so much suffering prior to claiming asylum.' Project Lead

Project team

Paul Coleman, Consultant Nurse Homeless and Refugee Health Services; Jennifer Adu, Specialist Health Visitor, Croydon.

Project aim

- to reduce the spread of scabies, improve the outcome for patients who present with scabies and other infestations by offering timely treatment

- to reduce skin and respiratory infections by providing warm clothes, including coats and shoes to our rough sleepers

- develop a referral pathway to the dermatology nurse specialist for clients who meet referral criteria.

Introduction to project

People who are rough sleeping, particularly those with respiratory infections, find that the lack of new warm winter clothing is an issue that impacts directly on their health and quality of life. There is no new-clothes programme available by any of the charitable, voluntary or statutory sectors in Croydon.

Patients who contract scabies or other skin infestations also find it difficult to rid themselves of the infestation without new/clean clothes. For those patients who have had scabies for many weeks without treatment, they often end up with skin cysts which require onward referral to Dermatology. As a result this project also included creating a seamless pathway with the local Dermatology Department.

Outcomes:

- **3** patients seen with skin conditions that the service was able to treat who had not previously engaged with the health team
- Patients' engagement improved and compliance with the rest of the treatment seemed to improve in **4** cases
- An unexpected outcome was that a number of staff at Crisis reported psychological benefits including improved self–esteem and general wellbeing
- The CQC stated that The Homeless Health Team were a "stand out service"
- Offering new clothing (as part of a health intervention) had a very positive impact on the mental health of the patients who were homeless
- New care pathway for patients created
- Great inter-agency working (Crisis)
- One patient reported that access to new underwear as part of her treatment for urinary tract infection was an unexpected (positive) additional benefit. Because of this project she received treatment for her urinary tract infection and was referred to the No Recourse to Funds team who helped her to move into temporary accommodation.
- Secured **£6,000** further funding from NHS England to continue the project 2019/2020.

Leap Ahead project

‘I knew that it would be a difficult project but it resulted in me being more determined to make a difference and get further people on board.’ Project lead

Project team

Julia Mullaney and Ann Neville, Advanced Nurse Practitioners, Darwen, Lancashire.

Project aim

- to reduce inequalities and improve the access to general practice for individuals at a local hostel
- to increase uptake of flu, pneumococcal, MMR and meningitis immunisations, reduce smoking rates, and reduce the risk of diabetes and heart disease through targeted education.

Introduction to project

A recent Healthwatch Report that provided information on Darwen’s homeless population suggested that reaching vulnerable groups could improve health outcomes for the local population.

Evidence shows that 30-50% of people who are homeless have mental health problems, 45% have physical health problems and 60% have substance misuse issues, yet people who are homeless are 40 times less likely to be registered with a GP.

The project aimed to improve knowledge about health, encourage engagement and provide much easier access to medical care with hard-to-reach groups.

Outcomes:

- **31** residents given flu vaccination (0 given flu vaccine in hostel last year)
- **1** MMR vaccine delivered
- **1** Meningitis vaccine delivered
- **11** healthchecks carried out
- **1** life saved! On one initial routine health check a resident was found to be in acute kidney injury stage 3 and renal failure which required immediate hospital admission.

Left: project resources

Self Harm project

‘I had known Mark for around 5 years. I would treat his wounds and wonder what else we could do to help him. His arms always looked so sore, they would be dressed in toilet roll and tape. He would look ashamed of what he had done but would continue to cut himself on a daily basis.’ Project lead

Project team

Kelly Smith, Rebekah Jeavons, Community Matron Outreach Team, North Somerset.

Project aim

- to provide a regular self-harm support group, providing health education on self harm reduction and emergency first aid kits.

Introduction to project

People who are homeless are some of the most disadvantaged and socially excluded in our society. 1 in 10 young people self-harm; some eventually take their own lives. The risk increases with age and is much greater for men (RCPsych).

Within North Somerset there are no support groups available for individuals who are homeless that self-harm so the project aimed to provide this and in so doing, make a significant impact on both patients’ physical and mental health.

Outcomes:

- **50** clients helped
- decrease in self harm
- decrease in wound infections
- safer self-harm methods discussed
- group sessions were not popular, so one-to-one sessions were developed
- reduced number of visits to A&E because patients either looked after wounds themselves and then saw the project team or because they reduced the number of times they self-harmed
- **80** emergency first aid kits handed out
- identified **5** people a month on average who self-harmed.

Left: project resources

Latent TB Screening and Awareness at HMP Birmingham

'The prisoner was only discovered to have TB because of the QNI project. Had he not been tested, it would have led to a major public health incident and extensive screening at both the hospital and at the prison. He is now on treatment and doing well.' Project lead

Project team

Julie McLoughlin, TB Clinical Nurse Specialist; Hanna Kaur, TB Lead Nurse; Kim Bruton, TB Support Worker; University Hospitals Birmingham NHS Foundation Trust

Project aim

- to offer screening and treatment for latent Tuberculosis to prisoners at HMP Birmingham.

Introduction to project

People in prison are not routinely screened for latent Tuberculosis infection (LTBI) despite being at heightened risk. This project wanted to give people in prison the same access to LTBI screening as other high-risk groups in the community, to tackle an unmet health need and health inequality.
The project aimed to provide evidence for the need to fund routine LTBI screening to the whole prison population, in line with national guidance.

Outcomes:

- **7** TB awareness sessions were delivered - **35** attended
- **20** screening sessions held in prison in a 9 month period
- **100** screened for latent TB, **10%** tested positive
- Of those testing positive, **70%** completed latent TB treatment
- Better joint working between healthcare and prison staff around infection prevention and suspected referrals
- Better knowledge and awareness of TB
- Referral rate of TB symptomatic patients in prison to TB nurses by **52%**

Case Study

'Paul was a 63 year old white UK born gentleman who had been in and out of prison for most of his adult life. This was Paul's 20th custodial sentence for drug related offences. We met Paul at the beginning of our Latent TB screening project at the prison and when we visited his wing he told us "I'm fit and well and no one is sticking a needle in me." We met Paul several times over the following months and he always stopped for a chat and greeted us with the "vampires are back." We gave him advice about latent TB infection and raised awareness of potential symptoms of active TB disease with him.

Paul told us he had a difficult home life when he was a child and suffered physical and sexual abuse causing him to leave home at 15 years old. He has no contact with his birth family and hasn't seen his 2 adult children for 20 years. Paul was very open about his long history of intravenous drug use and alcohol dependency. He had experienced long periods of rough sleeping and had a 45 year history of smoking tobacco and cannabis. This has had a detrimental impact on Paul's physical and mental health. He had depression, type 2 diabetes, chronic obstructive pulmonary disease and coronary artery disease.

It was one of Paul's fellow inmates on the wing who finally persuaded him to take up the screening. His friend had a positive TB screening result and Paul was very worried that they may have been exposed to TB by the same person as they spent a lot of time together. Paul did have a positive TB blood test but said he fully understood the diagnosis because of the information we had given him and he subsequently told everyone on his wing that he had TB infection and used it to drum up business for the project.

Paul accepted a 3 month course of antibiotics taken once daily to eradicate the bacteria and reduce the risk of developing TB disease in the future. He has successfully completed the treatment and is very well. He has become a latent TB screening advocate and he has spread the word throughout his wing which has had the biggest uptake of TB screening tests. We are often greeted by Paul shouting to us "Miss I've got another one for you to test." The wing Paul is on has a stable population and it is a supportive and therapeutic environment where prisoner turnover is small. The officers have been very supportive of the project which has also had a positive impact on TB screening uptake.'

The Health Bus - Gypsy/Romany/Traveller Health Outreach project

‘Not addressing basic health needs causes a level of human suffering and misery which not only impacts mental health but is inequitable and unacceptable in 21st century British society.’ Project lead

Project team

Lisa Gavin, Homeless Health Lead Nurse, Mark Haythorne, Surrey County Council, Redhill, Surrey.

Project aim

- to improve the health of people living in the Gypsy, Romany and Traveller communities in East Surrey.

Introduction to project

Local and national evidence indicate stark differences between the health and life expectancy of people living in Gypsy, Romany or Traveller (GRT) communities and the wider population - addressing these health inequalities is a social, ethical and financial priority. In Surrey, people living in GRT communities make up the largest ethnic minority group. This project directly responded to Surrey GRT communities’ request for direct engagement with trusted health professionals. It took into account their specific cultural needs with a targeted health visiting service aimed at identifying and treating dental health problems in children, increasing the uptake of immunisation, and identifying and supporting the management of diabetes and heart disease.

Outcomes:

- **54** adults offered screening for blood pressure, weight and BMI
- **22** weighed, **8** blood pressures taken and **2** body mass index taken
- **26** children needed urgent treatment (including multiple extractions) which were completed with the fast tracking pathway developed by the project
- Worked with the community to build awareness about the need for immunisations. **42** discussions about immunisations and **3** delivered
- **16** referrals, **44** signposting, **40** direct advocacy
- Other issues picked up: hypertension, domestic violence, sexual health and contraception, mental health, safeguarding, child sexual exploitation, grooming
- Development of new Vulnerable Children’s Dental Pathway for Surrey.
- Subsequently successful bid for **£250,000** was obtained to expand project across Surrey. Project Team of 6 recruited and project went live on 1.4.19.
- NHS staff across Surrey will be offered Cultural Awareness Training to improve engagement with GRT communities and reduce the inequalities they face trying to access healthcare.

Case study

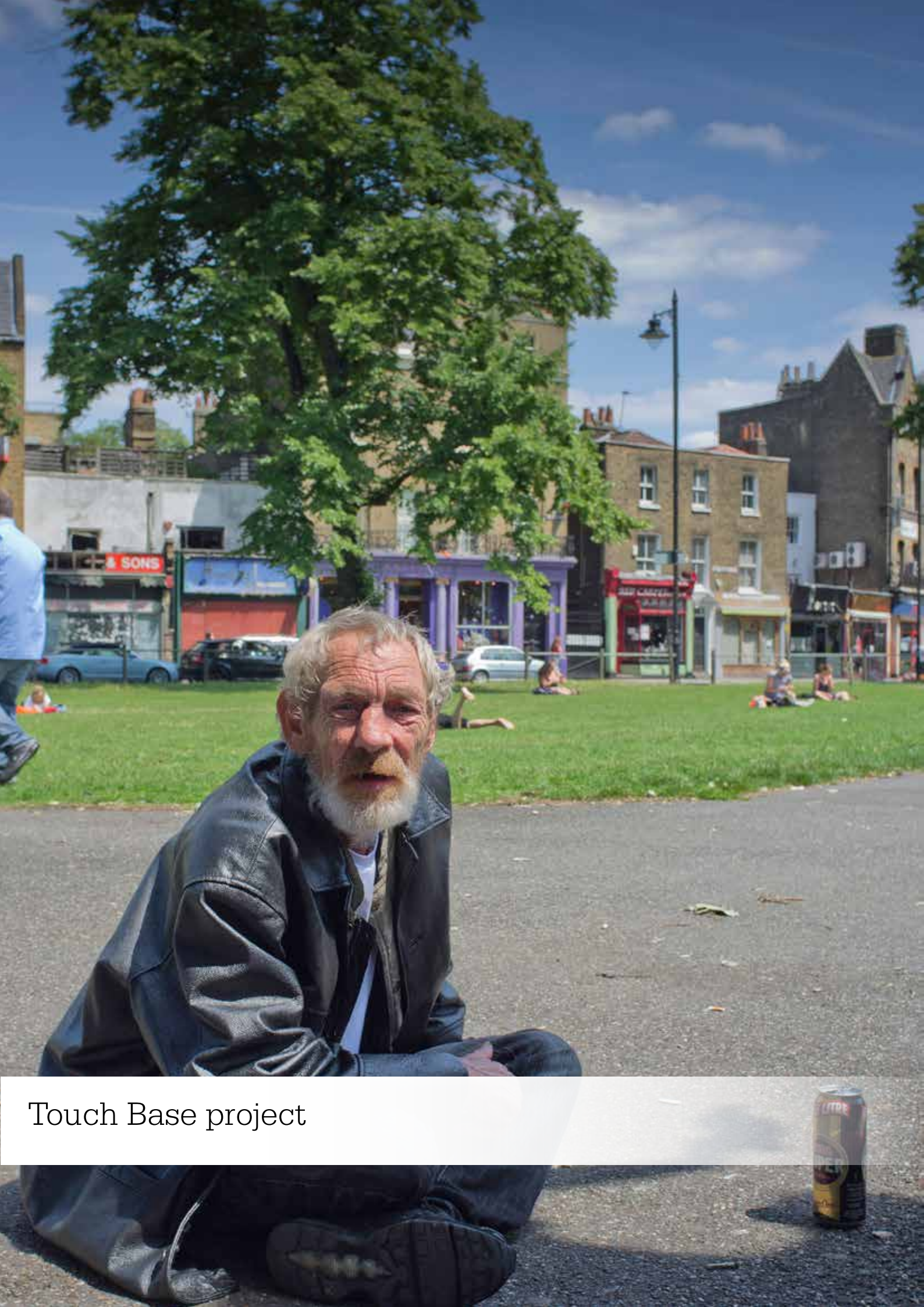
“Mary” was a little girl aged 2 and a half. Her parents did not report any concerns about her teeth, however, as she had never seen a dentist and her older siblings had poor dentition and had had multiple extractions, they agreed to get her checked out. The referral was made by the GRT nurse, according to the “Vulnerable Children’s Dental Pathway” that we had developed with the hospital team.

When examined by the dentist, it was found that she had not yet developed all of her deciduous (“baby teeth”) but all that were present in her mouth showed evidence of decay. Discussion with her mother established that her diet was poor and very high in sugar. Although eating solids, Mary still had several bottles a day, sometimes with Coca Cola in them.

The dentist explained that she would need to have all these teeth removed under a general anaesthetic and preventative treatment applied to protect the adult teeth. Her parents were upset about how she would look with her teeth removed. He suggested that they address her diet and dental hygiene, to prevent further deterioration. They agreed to come back in two weeks’ time to see the Consultant. However, they did not attend. Another appointment was made with the nurse texting the family on the morning of the appointment, urging them to attend. The dentist reported that she was still pain-free, with no signs of any abscesses or symptoms of pain but with the existing caries, as seen before. However, he was pleased to note that her mother reported that she was no longer having bottles and that they were brushing her teeth twice a day.

The dentist again explained the need for extractions under general anaesthesia and also follow ups every three months. Another appointment was made for three months’ time but again, the parents did not bring her. After hearing that she Was Not Brought (WNB) again the nurse made several attempts to contact her mother and discovered that the family had gone travelling. She liaised with the Traveller liaison outreach worker who agreed to inform the team as soon as the family was back in the area. We are hoping that, as Mary’s older siblings and cousins have had lots of teeth removed (one had 14) that they are aware of the risks of ignoring the decay.

This case highlights not only the poor dentition in GRT children but the additional barriers to treatment. These include poor literacy, forgetting appointments and cultural pressures, such as looks and attitudes to surgery and treatment. Proactive efforts to help parents engage is often required to enable GRT children to get access to routine and required health care.



Touch Base project

‘We have been able to prove that you can and should treat people with HCV who are homeless. There is a great sense of professional achievement as I truly believe that healthcare needs to be where the patient is.’ Project Lead

Project team

Margaret O’Sullivan, Community Viral Hepatitis Nurse Specialist, Brighton

Project aim

- to increase testing, diagnosis and treatment of Hepatitis C in the vulnerable homeless population.

Introduction to project

Liver disease is one of the five “big killers” in the UK and is the only one where mortality is rising. Hepatitis C is the third most common cause of liver disease which is catastrophic in terms of early mortality but also on NHS resources. Hepatitis C is preventable, treatable and now curable with the newer medications available. The majority (90%) of Hepatitis C virus (HCV) positive individuals in England are people who inject drugs who have suboptimal engagement with health services. The prevalence of Hepatitis C is four times higher in the homeless population, but they are far less likely to engage with health services. Hepatitis C is a public health concern that needs to be addressed to prevent onward transmission.

Outcomes:

- Staff trained to raise awareness around Hepatitis C.
- **60** clients tested with HCV saliva tests carried out by non nursing staff.
- Staff had a clear referral pathway. **24** were seen at follow up.
- **4** new HCV diagnosed, 1 was co-infected with active hepatitis B.
- All **4** diagnosed with cirrhosis with ongoing follow up with services as required.
- **2** of the 4 clients started and completed treatment, were street homeless and are now HCV negative.
- **1** new HIV diagnosis with supported engagement with HIV services and currently on treatment.
- **3** other known HCV clients regularly used the service and were also homeless. They have also completed treatment and are HCV negative.

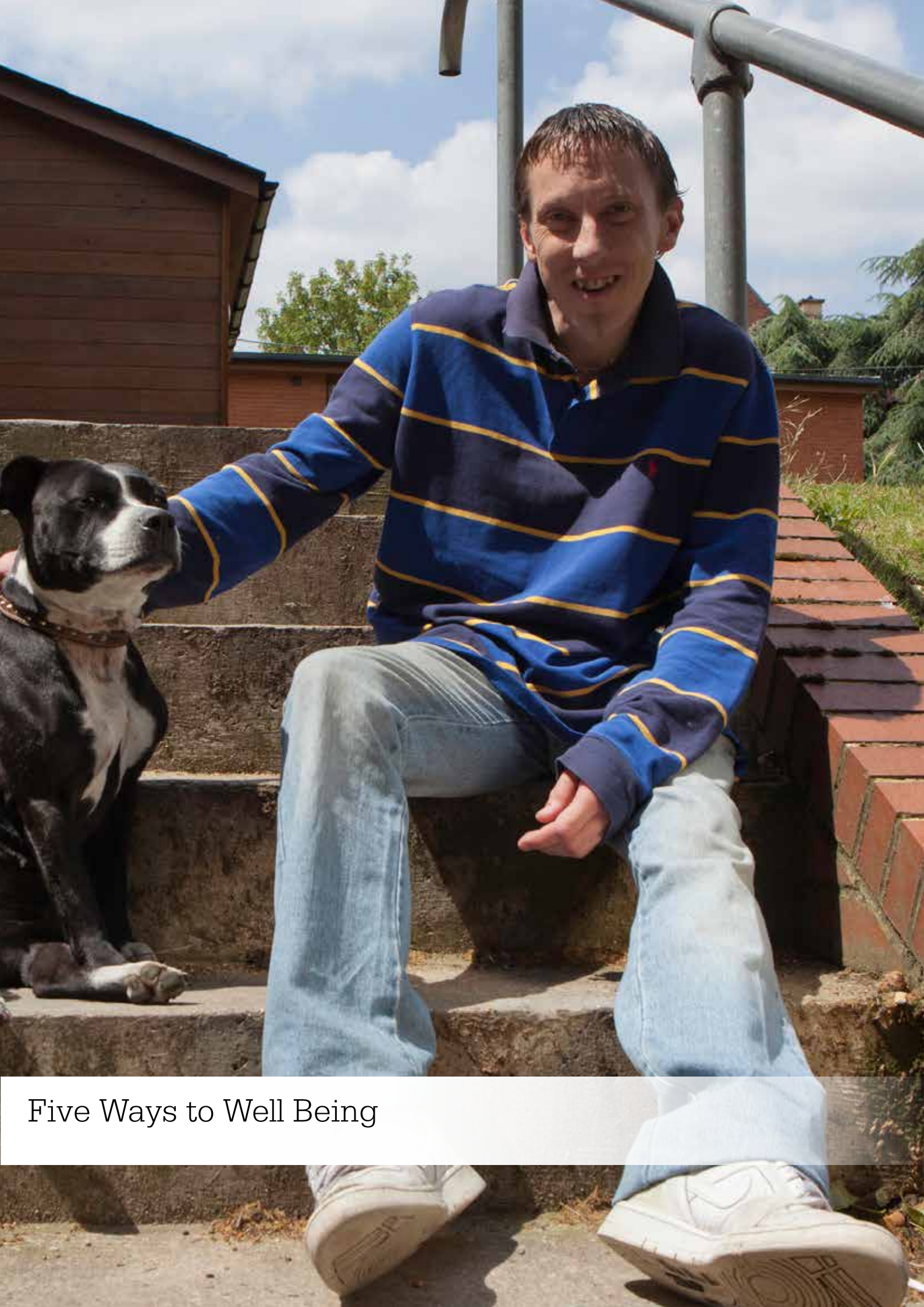
Case Study

Jack was a 38 year old man from the old USSR who came to find a new, better and happy life in the UK. He had minimal English so when I first met with him I used a telephone translator. When I asked Jack if he understood what Hepatitis C was he just shook his head. When I explained to him the highest risk factor to how you can contract it, he denied any drug use. He informed me that he drank alcohol, had been homeless for about three years in which time he had been involved in many altercations which he thinks could be how he contracted the virus. Jack was shocked when the bloods came back as positive.

When I performed a fibroscan it showed that he had advanced scarring. We discussed how much alcohol he was drinking which was over 40 iu a day. Jack explained to me that this was normal within his circle of friends and that it is part of his life and a coping strategy. I worked closely with the centre to provide Jack with a locker to store his medication. Few services across the UK actually treat street homeless due to the fear of medication being lost. Once Jack’s treatment was ready I collected this from the hospital and met him at the centre. I explained how important it was to be adherent to the medication for it to be successful. We spoke again about his levels of alcohol consumption and how important it was to try to reduce this. We agreed that I would leave his medication every month in his locker and that I would take a blood test at the end of treatment.

Though my face to face contact with Jack was minimal I kept in contact with him by text messages which he allowed me to do. He informed me that he was fine with no problems with the medication. He also informed me that he had found work and that he had reduced his alcohol consumption.

Just before Christmas at the end of Jack’s treatment I met him at the centre. When I saw Jack he looked so well and he informed me that he had met a partner and that he was now not living on the street. More importantly he informed me that he was happy. I obtained bloods and for Jack the news that the Hepatitis C virus was negative at the end of treatment was the “best news for Christmas”. I agreed with Jack to review him in nine months’ time to re check his fibroscan to see if the scarring on his liver had reduced. We know that 50% of people remain undiagnosed with Hepatitis C and this innovative service offering testing to all is a service that can be easily replicated. From this project we have now started to roll this screening service as a pilot project to the local rehab units and hostels services to try to diagnose the undiagnosed.



Five Ways to Well Being

Having the time and space to consider how to look after our emotional and mental wellbeing has shown to be a simple, cost effective intervention. Our homeless clients have rarely had the opportunity to consider these ideas and have enthusiastically taken part in the discussions and exercises. The atmosphere during the sessions has overwhelmingly been trusting and mutually supportive; it has been an honour to be part of these amazing people's journeys.
Project Lead

Project team
Claire O'Connell and Sheila Shatford, Primary Care Nurses, Homeless Health Service, Bristol.

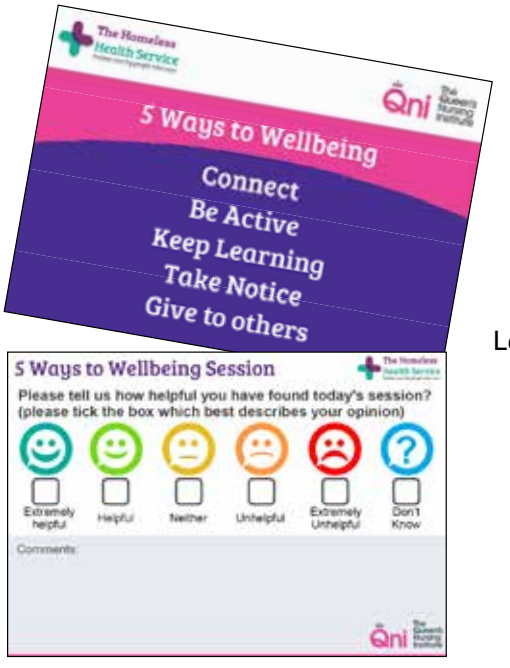
Project aim
- to improve the emotional wellbeing of people experiencing homelessness in Bristol, using the 'Five Ways of Wellbeing' approach.

Introduction to project
In 2015 Bristol had the second highest number of people rough sleeping in England, Wales & Northern Ireland. Homeless Link reports that over 70% of people using homelessness services experience mental distress and over 45% felt they needed more support to cope with their mental health needs.

Bristol Homeless Health Service predominantly provides physical health care and gives a significant amount of mental and emotional health support alongside this but without any specifically allocated time to do so. Much of this support is focussed on trying to help people find ways to raise their own self-esteem and manage anxiety so that they are better able to negotiate the systems on their path towards health and housing.

The project used the '5 Ways to Wellbeing' approach as a framework to help people look at their mental and emotional wellbeing in a positive way, in a non-judgemental environment.

Outcomes:
- **22** clients attended the wellbeing sessions in total
- **50%** got greater than 6 point increase in their Warwick Edinburgh Score and **38%** greater than 7 points increase (clinically significant)
- **100%** of clients rated the sessions as helpful, **59%** as extremely helpful
- Positive learning between clients
- Client involvement in running project and speaking at QNI events.
- Increase in confidence of group facilitators and co-facilitators.



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