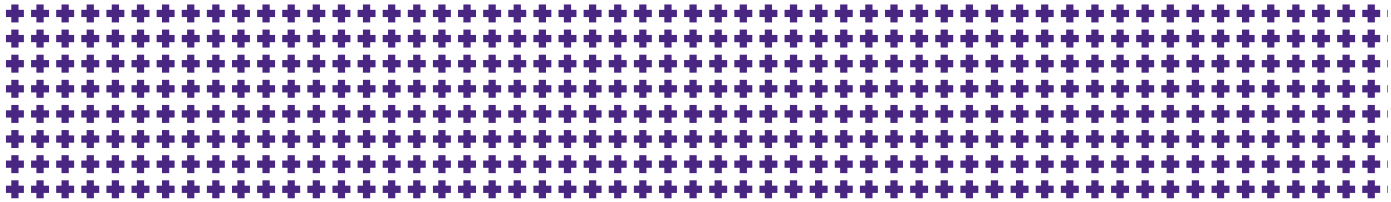
The Queen's Nursing Institute

Homeless Health Innovation Funding Programme
EVALUATION REPORT

Contents

Author: Professor Emerita Rosamund Bryar



Executive Summary

The QNI has developed expertise in the field of homeless healthcare over a number of years, through its pioneering Homeless Health Programme. This is a national network of nurses and allied health professionals focused on improving practice, developing guidance documents, and holding conferences and workshops.

External funding for the Homeless Health Programme has been provided by a number of organisations and during the period 2017-2020 this was provided by Oak Foundation. As part of the funding agreement with Oak Foundation, the QNI offered to support a number of nurse-led projects that would seek to improve the health of people experiencing homelessness or who were otherwise vulnerably housed.

The QNI has developed considerable expertise in supporting local projects since 1990 as part of its 'Fund for Innovation' work. Typically this involves a group of nurse-led projects sharing common characteristics that are supported with seed capital, workshops, site visits and advice from QNI staff and external specialists.

Ten nurse-led homeless health projects were therefore selected by the QNI in 2017 to receive funding of up to £5000 each and the projects ran from 2017-18.

The QNI commissioned this evaluation to describe and analyse some of the key outcomes of the projects, during and after the project year, and to evaluate the role and impact of the QNI in supporting them to deliver on their specific objectives. It also sought to identify areas that were particularly challenging for the project leaders and how the QNI may be able to develop its programme of support to benefit future cohorts of nurse leaders and, importantly, the individuals and communities that they serve.

This evaluation was carried out independently by Rosamund Bryar, a Fellow of the QNI, whose biography is provided in Appendix 7.

Summary Findings

Would the projects have happened without the QNI funding?

Apart from one project (Project 5) which had already started as a pilot, none of the projects would have happened without the QNI/Oak Foundation funding. Project leaders' comments included:

'When you have an idea of how to improve services sometimes you can't see how to achieve it. With the QNI support I was able to achieve so much in a short space of time.' (Project 10)

'The funding allowed us to try out a proactive service rather than just continuing with reactive services.' (Project 1)

'This was a project we would have liked to have done but it was not possible to do without extra funding which was provided by the QNI.' (Project 6)

How many of the projects have continued?

Seven of the ten projects have continued beyond the original funded year. Three have been extended to cover a whole county or have been extended into nearby boroughs (Projects 3, 5 and 10). Four have continued and been absorbed into the local service provision, two with additional funding (Projects 1, 6, 8 and 9). Two are currently suspended, one due to a lack of nurses to provide support at present and the other due to secondment of the project lead, but other local service providers are interested in continuing the project (Projects 4 and 9). One has been discontinued in its original format (Project 7).

What has been the spread of the projects' work?

Two of the projects were based in specialist health services, TB and liver services, and both of these have had significant impact in networks of these specialist services (Projects 6 and 10). One project (Project 5) has been widely distributed throughout London and has been commissioned in one borough with several more looking at implementing the project model. One project (Project 3) has been extended to the whole of Surrey. The project leader commented: 'The local

project… gave a platform for the issues faced by the Gypsy Roma Traveller (GRT) communities and I was able to align it with a current national and regional focus on reducing inequalities in these communities… to develop it into a much bigger project'. This project has been extended with £500k additional funding.

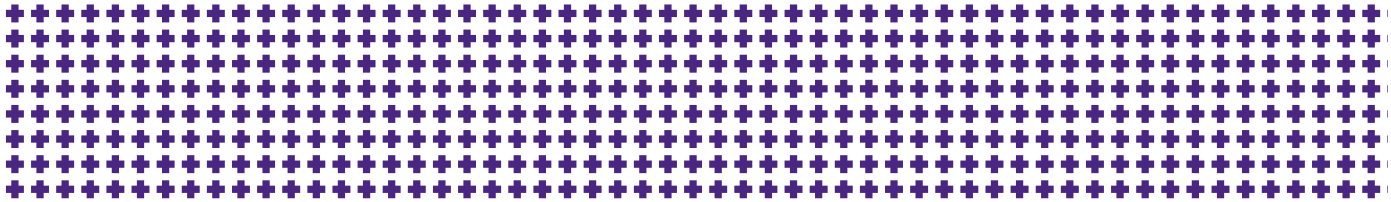
What is the potential for replication of the projects?
All the projects were set up to address a specific local issue and all projects may be seen as pilots that have generated outcomes and learning. There is learning from all projects, which could be widely disseminated and implemented in other areas. There is an informal system in place through the QNI to support project leads to publish papers in relevant journals (although none mentioned this during the evaluation visits). A co-ordinated formal mechanism for dissemination and/or replication of learning from the projects would be beneficial to this goal.

Learning for Future Development Projects
The projects provide evidence of a large number of process factors which impacted on their delivery, including:

- lack of nursing time to deliver projects;
- difficulties in production of publicity materials and lack of early publicity for the projects (due to financial management issues);
- chaotic nature of client group meaning considerable time needs investing in engaging them in projects;
- peer involvement being very positive in some cases, but needing time to nurture;
- issues with data collection, particularly how to measure soft/qualitative and economic outcomes and the potential need for guidance and support around the process of collecting evaluation data;
- need for project management training and input around project sustainability earlier in the projects and support around managing the financial aspects of projects.

What would more financial support achieve?
More financial support would provide a programme manager who would be responsible, for example, for networking with service leads and academic partners to ensure that the projects address priorities in improving the health of people experiencing homelessness; identification and implementation of shared data collection tools across the projects; collation of learning from the projects; dissemination of learning from the projects and development of implementation tools to support the implementation of project findings in other sites.

> ‘When you have an idea of how to improve services sometimes you can’t see how to achieve it. With the QNI support I was able to achieve so much in a short space of time.



Introduction

The QNI has funded nurse-led projects since 1990 aimed at improving services for people, families and communities, delivered by community nurses and supporting the development of those nurses delivering the projects.

Making use of this expertise in 2017, in partnership with the charity Oak Foundation, the QNI funded ten community nurse-led specialist innovation projects focused on the needs of people experiencing homelessness. This contributed to Oak Foundation's Housing and Homelessness Programme: 'ensuring individuals are not excluded from services' (http://www.oakfnd.org/housing-and-homelessness.html).

Programme Objectives

In the grant funding application to support these projects, the following objectives and outcomes were identified: 'To enable specialist community nurses to deliver a specialist programme of support for people experiencing homelessness, contributing to improved health outcomes.' (QNI, 2015: 7.1.a). The expected outcomes identified in the grant application (QNI, 2015: 7.1.c) were:

- The specialist innovation projects run by community nurses achieve their intended outcomes to improve care for people who are homeless
- Access to healthcare for people who are homeless improves in areas where the specialist innovation project takes place
- Patients feel their concerns are listened to and they have a leading role in their care in areas where the specialist innovation project takes place
- Patients report better ratings of quality of life and wellbeing in areas where the specialist innovation project takes place.

The activities specified to achieve these outcomes were:

- Develop and promote a nurse-led programme to improve care and support for people experiencing homelessness
- Select the best 10 applications from nurses to be awarded funds of £5000 to lead projects to improve care for people who are homeless in their areas
- Nurses to deliver these specialist innovation projects
- Deliver three 2-day workshops for nurses delivering specialist innovation projects. Topics include goal setting, flexible thinking, communications, business planning and help these projects become sustainable in the longer term
- Evaluate the 10 specialist innovation projects that are improving outcomes for people who are homeless.

Recruitment of the community nurses to lead the projects took place in 2017 and the projects ran from January – December 2018. The nurses were supported by the Homeless Health Programme Manager, the Homeless Health Programme Administrator, the Director of Programmes (to early 2018) and the Director of Nursing Programmes (from April 2018) and by a programme of workshops which addressed topics including planning, communicating, networking, creative thinking and sustainability of the projects.

Background Literature and Context

Definition of People Experiencing Homelessness

Defining the groups of people experiencing homelessness is not straightforward, as is illustrated in a Government Statistical Service (GSS) report which explores the possibility of harmonising definitions for statistical purposes across the four UK countries (GSS, 2019). This report describes the people experiencing homelessness as follows: 'Homelessness affects a wide range of people, covering not just people sleeping rough, but also those in temporary accommodation, sleeping temporarily at friends' houses, living in unfit dwellings and those threatened with homelessness' (p.4).

Dorney-Smith et al. (2018) identify many groups of people who are experiencing homelessness including those who may not be counted in government statistics, including:

- People sleeping rough;
- Single people who are homeless living in hostels, shelters and temporary supported accommodation;
- Statutorily household / families who are homeless – households who have had housing assistance from a local authority due to having no accommodation. These families will be living in some form of temporary accommodation;

- 'Hidden homeless' individuals and households – a wide variety of people who do not get counted in government statistics. This includes people living in severely overcrowded conditions, squatters, people 'sofa-surfing' with friends, family or acquaintances, boat dwellers without permanent moorings, people who sleep on buses, or spend their nights in 24-hour fast food restaurants, Gypsies and Travellers who are not on designated sites, and people living in non-residential buildings like sheds, and factories.

The 'All Our Health' resource on homelessness provides information on the needs of people who are homeless, resources, policy and interventions by commissioners and practitioners that may be helpful in addressing these needs (Public Health England, 2018). In addition, it provides a link to the e-learning resource which aims to increase knowledge amongst those working in health care about the needs of people experiencing homelessness.

Health Needs of People Experiencing Homelessness
Poor health is both a contributing factor to people becoming homeless and a result of being homeless. As the population of people who are homeless includes families with children, young people, middle aged people and people over 65, their health needs cover all conditions and areas of prevention common to any member of the population including, for example, prevention of infectious diseases through immunisation, pregnancy, prevention of obesity, diabetes and other long term conditions, treatment for asthma and other respiratory problems, accident prevention and treatment, alcohol and drug misuse management, mental health assessment and treatment, etc. (Local Government Association 2017).

Their experience of these conditions and poor access to health care is responsible for the high mortality at an early age amongst people who are homeless. In addition, many groups of people who are homeless have experienced trauma, for example, as refugees or those in childhood who have suffered adverse childhood experiences (ACEs). That many people who become homeless have a history of ACEs indicates the forward planning that is needed to reduce homelessness in future generations, through early identification of children at risk by health visitors (https://ihv.org.uk/) and application of science by everyone working in the area of early childhood development (https://developingchild.harvard.edu/).

> 'That many people who become homeless have a history of Adverse Childhood Experiences (ACEs) indicates the forward planning that is needed to reduce homelessness in future generations.

A quarter of a million households in the UK comprising approximately 400,000 people are estimated to be homeless or at risk of homelessness (Aldridge, 2019). Given the health risks, morbidity and early mortality associated with homelessness, Aldridge describes homelessness as a public health emergency commenting: 'Their health needs represent a system failure to intervene early and prevent serious harms'.

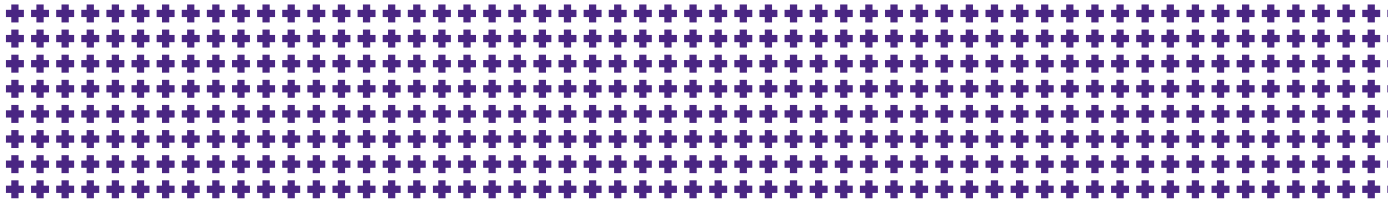
The 10 projects funded by the QNI/Oak Foundation tested interventions to help address and reduce the health problems suffered by people experiencing homelessness.

Evaluation Methods

The Health Foundation (2015, p.25) suggests that the evaluation of health interventions is concerned with: '... practical assessment of the implementation and impact of an intervention. It is conducted in a spirit of discovery rather than management or monitoring. It is concerned with developing understanding and supporting more strategic judgement and decision making, such as whether and how an intervention should continue, and continue to be funded'.
To support discovery concerning the implementation and impact of the projects, the collection of evaluation data concerning each of the innovation projects was informed by a realist evaluation approach (Pawson and Tilley, 1997). This approach considers contexts, mechanisms and outcomes to answer the question: 'What works, for whom, in what circumstances, how and why?' (Wong et al., 2017: xvii).

Realist evaluation is particularly useful in understanding innovations in complex social situations such as those found in community and primary care settings. Collection of data concerning the context in which an innovation is operating helps to identify why this innovation is effective, or not, in this particular place: 'Contexts do not refer to people, places, time or institutions per se, but to the social relationships, rules, norms and expectations that constitute them, as well as the resources available (or not).' (The RAMESES II Project, 2017: 3). Collection of this type of data helps to explain why an innovation may work in one place but not in another. A mechanism is summarised as: '… a theory of what causes changes in individual behaviour'. (Shaw et al., 2018: 3).

The outcomes of a programme of work or innovation are dependent on the interaction between the elements



within the context and mechanisms and are represented as: Context + Mechanism = Outcomes. Aspects of the context and the mechanisms can be supportive or restraining, providing facilitation or barriers to the implementation of an innovation (Herens et al., 2016).

The evaluation process for this report was undertaken between August 2019 and February 2020. To inform this evaluation, data were collected using different methods:

- Meeting with the interim QNI Homeless Health Programme Manager and the QNI Director of Nursing Programmes;
- A brief review of literature concerning homelessness and homeless health care
- Interviews with the former QNI Director of Programmes (by telephone), the former QNI Homeless Health Project Manager and one of the founders of the QNI Homeless Health Network (by Skype);
- Review of the project Reports written by the Project Leads;
- Visits to the 10 Innovation Projects;
- Interviews with the Project Leads, project clients, other staff available on the day of the visit to the project;
- Collection of any resources and evidence on the visits;
- Internet searches for evidence of dissemination of the findings from the Innovation Projects.

Interview schedules were developed (see Appendix 1), drawing on the meeting with the interim QNI Homeless Health Programme Manager and the QNI Director of Nursing Programmes; the report of the innovation projects (The QNI, 2019); questions regarding each project supplied by the interim QNI Homeless Health Programme Manager, and informed by the previous evaluation of QNI funded projects (Bryar, 2015). Visits to the project were arranged (see Appendix 2) and then undertaken over a period of four weeks (see Appendix 3).

As an evaluation, formal ethics approval was not required, but throughout the work has been undertaken with reference to research ethics standards for example, concerning confidentiality, information to the participants regarding time commitment and use of data.

Findings

The following tables summarise some of the key characteristics of the 10 projects. Table 1 shows the location and client group addressed as well as providing information about the nurse project leads.

Table 1: Key Characteristics of the Projects

No.	Project	Location	Nurse HH* Yrs	Nurse FT/PT**	HH Service	Clients
1	Drop-in and NHS Health Check	Birkenhead, The Wirral	28 years	PT	Yes	Hostel residents and non- residents who are homeless
2	Five Ways to Wellbeing	Bristol, South West	13 years	2 days	Yes	Hostel residents and non- residents who are homeless
3	GRT and Health Outreach Pro-ject***	East Surrey	5 years	FT	Yes	Gypsies, Romanies and Travellers in East Surrey
4	Health Cham-pions for the Homeless	Newham, London	2+ years	FT	Yes	People experiencing homelessness in the borough
5	Health Inclusion Team Plus	Southwark, London	11 years	FT	Yes	People sleeping rough
6	Latent TB Screening and Awareness	Birmingham, West Midlands	13 years	FT	No	Male prisoners
7	Leap Ahead	Darwen, Lancashire	None	FT	No	Residents in one local hostel
8	New Clothing for Rough Sleepers	Croydon, London	11+ years	FT	Yes	People sleeping rough, asylum seekers, hostel residents and non-residents who are homeless
9	Self-Harm	Weston-su-per-Mare, North Somerset	4+ years 4+ years	3 days/week FT	Yes	Hostel residents and non- residents who are homeless
10	Touch Base	Brighton, East Sussex	14 years	FT	No	Hostel residents and non-residents

*Homeless Health
**Full Time/Part Time
***GRT Health Outreach Project: formerly known as The Health Bus: Gypsy/Romany/Traveller Health Outreach Project

Table 2 shows whether the project leads are members of the QNI Homeless Health Network or are Queen's Nurses.

Table 2: Project Leads Membership of Homeless Health Network and Award of QN Title

No	Project	Location	HH Network Member	Queen's Nurse
1	Drop-in and NHS Health Check	Birkenhead, The Wirral	Yes - joined during project year	No
2	Five Ways to Wellbeing	Bristol, South West	Yes	No
3	GRT Health Outreach Project	East Surrey	Yes	No
4	Health Champions for the Homeless	Newham, London	Yes	No
5	Health Inclusion Team Plus	Southwark, London	Yes Yes	One is a QN
6	Latent TB Screening and Awareness	Birmingham, West MIdlands	Yes	No
7	Leap Ahead	Darwen, Lancashire	No	No
8	New Clothing for Rough Sleepers	Croydon, London	Yes	No
9	Self-Harm	Weston-super-Mare, North Somerset	Yes Yes	Yes, both for 3 years prior to project
10	Touch Base	Brighton, East Sussex	No	No

The projects were located in different parts of the country and Table 3 provides information about the extent of homelessness in the 10 different areas drawn from the Shelter Report (2019).

Table 3: Estimated Number of People Homeless on one Night in the Project Locations

National rank	Local Authority	Region	No. Rough Sleeping 2018	Estimated number of people who are homeless	Rate of people who are homeless (1 in x people)
1	Newham	London	79	14,535	24
14	Southwark	London	47	6886	46
23	Brighton and Hove	South East	64	3876	75
21	Birmingham	West Midlands	91	17,258	66
26	Croydon	London	15	4357	88
62	Bristol	South West	82	1609	288
68	Reigate and Banstead (part of East Surrey)	South East	2	426	347
179	North Somerset	South West	11	152	1411
195	Wirral	North West	16	201	1605
283	Blackburn with Darwen	North West	15	25	5958

Figures from: Shelter, 2019 Tables 6 and 8. Changes to the project plans made during the project duration are shown in Table 4. Some of these resulted from the project leads learning from each other or from responses from clients to the original project plan.

Table 4: Changes Made to the Project Plan

No.	Project	Location	Changes to plan
1	Drop-in and NHS Health Check	Birkenhead, The Wirral	Addition of learning from two other Homeless Health Projects
2	Five Ways to Wellbeing	Bristol, South West	Drop-in approach rather than attendance at a series of sessions; co-applicant acted as backfill due to difficulty recruiting sessional staff; senior health link worker acted as co-facilitator for sessions
3	GRT Health Outreach Project	East Surrey	Added child dental health; removed mental health as a focus; stopped using the health bus
4	Health Champions for the Homeless	Newham, London	Big Health Day included in project
5	Health Inclusion Team Plus	Southwark, London	Shifts moved to afternoon/evening
6	Latent TB Screening and Awareness	Birmingham, West Midlands	Nurse-led treatment clinics not held due to need for medical referral due to complex drug interactions with other drugs
7	Leap Ahead	Darwen, Lancashire	Clinics delivered by Practice Nurse not HCA; clinics moved from morning to afternoon
8	New Clothing for Rough Sleepers	Croydon, London	Service manager became the project lead in place of two staff members
9	Self-Harm	Weston-super-Mare, North Somerset	Groups discontinued; one-to-one approach introduced
10	Touch Base	Brighton, East Sussex	Extension of project to additional hostels. Establishment of Community Network meetings held each quarter

As discussed overleaf, the projects were all required to address a local need.

Table 5 shows whether the projects had this local impact, whether they had wider impact and whether continuing or not.

Table 5: Impact of Projects: Locally, more Widely and Continuation

No.	Project	Location	Local	National	Ongoing
1	Drop-in and NHS Health Check	Birkenhead, The Wirral	Yes	No	Yes
2	Five Ways to Wellbeing	Bristol, South West	Yes	No	No. Local interest in others running groups.
3	GRT and Health Outreach Project***	East Surrey	Yes	Yes	Yes. Extended to the whole of Surrey
4	Health Champions for the Homeless	Newham, London	Yes	Link on ELFT website to QNI film of project	No. Suspended due to lack of nursing staff
5	Health Inclusion Team Plus	Southwark, London	Yes	Yes	Yes
6	Latent TB Screening and Awareness	Birmingham, West Midlands	Yes	Yes through TB networks	Yes
7	Leap Ahead	Darwen, Lancashire	Yes	No	No. Annual flu clinic at hostel
8	New Clothing for Rough Sleepers	Croydon, London	Yes	No	Yes
9	Self-Harm	Weston-super-Mare, North Somerset	Yes	No but used in at least one other of the projects	Yes 1:1
10	Touch Base	Brighton, East Sussex	Yes	Yes, through Liver Networks	Yes. Replication in East Sussex; extended across the whole country

Summary of Project Findings

1
None of the **projects** except one would have taken place without QNI/ Oak Funding.

2
All the projects were concerned with **innovations** aimed at enhancing the health of people with complex health and social care needs.

3
All the projects have been **successful** in achieving outcomes for people experiencing homelessness, and a number have been outstandingly successful.

4
All the projects can be considered as **pilot projects** that tested different ways of delivering healthcare to people experiencing homelessness.

5
Learning from the projects relates to the process of developing and implementing the projects as well as the outcomes **achieved**.

6
The majority of the project leads had **extensive** prior experience in working in homeless health services or in other services working with people with complex health/social needs.

7
The majority of the projects were **embedded** in wider networks of homeless health or specialist health services.

8
Many of the project leads faced **challenges** in working with NHS Finance departments to set up budget lines for the QNI funding.

9
The **financial** issues resulted in a lack of early publicity for the projects and delays in production of appropriate marketing materials.

10
Many of the projects faced **difficulties** recruiting nurses to provide cover for the project leads.

11
The projects took up much more of the project leads **time** than was expected.

12
Pressures of their usual work meant that in some cases there was a lack of nursing time to deliver the projects.

13
All the projects found **engagement** of clients took a great deal of time and relationship building although at least three projects were successful in engaging clients as project champions.*

14
The **chaotic** nature of the lives of the client group means that the project leads had to invest a considerable amount of time in encouraging their participation.

15
Peer involvement was very positive in several of the projects and is something to promote but recruitment and ongoing support for **peer** involvement requires allocated time in projects.

16
All the project leads **developed** or made use of pre-existing tools to record project outcomes.

17
Data collection presented a number of challenges and additional support and guidance around this could be **beneficial**.

18
The majority of project leads found the **economic** evaluation of their projects challenging.

19
Information from all the projects has been **disseminated** locally, some regionally and a limited number have achieved national dissemination.

20
The project leads took on the projects in **addition** to their normal work and once the project ended the majority did not have any free or allocated time to undertake further development of the findings.

21
Learning from the projects largely stays with the project leads and colleagues around the project lead.

22
All the project leads valued the **support** they had received from the QNI and the flexibility regarding utilisation of the project funding.

23
All the project leads **valued** the workshops, the networking with the other project leads and learning from the other projects.

24
All the project leads were **supported** by QNI to produce a poster summarising their project. Several of the project leads have presented these posters at local and national events (see Appendix 4).

25
The workshop programme could have included project **management** training and input around project sustainability earlier.

* 1. 5 Ways of Wellbeing, Bristol; 2. Homeless Health Champions, Newham and 3. Latent TB Screening, Birmingham

26
Many project leads would have liked a **follow up** meeting after the end of the projects to learn from each other about maintaining the projects, what worked, how people obtained future funding, etc.

27
Three were already QNs but few of the others had applied to be QNs at the end of their projects partly due to the timing of the application process, which coincided with submission of their final reports.**

** However, more than one of the project leads applications were reportedly hampered by what might be categorised as 'tall poppy syndrome'.

The Projects

Drop-in and NHS Health Check, The Ark, Birkenhead, The Wirral

Context

Wirral Church's Ark Project provides a range of accommodation and other services for people experiencing homelessness in Birkenhead and The Wirral and is: '... a homelessness prevention, support and accommodation service' which aims '… to help homeless men and women on an individual level, working together to identify the support they need for their particular journey to recovery'. (https://wirralark.org.uk/our-projects/mary-cole-house/).

Wirral Ark started as a winter night shelter in the 1990s and Mary Cole House, where the nursing service is based, was opened in 2001. Mary Cole House has 27 rooms and was further extended in 2017 with the provision of a new nurses' room and two palliative care rooms, which were included following experiences with a resident who needed palliative care.

Patsy Dodd, the project lead and lead for the nursing team has been involved at Wirral Ark for 28 years, since 1991. Initially she undertook voluntary street outreach when she was working as an advanced nurse practitioner in a GP practice and later she developed the nursing service following the death of a person in a different night shelter. She has been a non-executive director on the local health authority and also leads voluntary work in The Gambia.

The nursing team includes a district nurse, a practice nurse and a refugee worker who is a health visitor. The CCG pays for some of this time and the shortfall in funding is made up by the Wirral Ark charity. With the project lead, they provide healthcare services for the residents of the hostel on four weekdays and weekends. The project lead and CEO described the health care work from the beginning in 1991 to the start of the QNI project as reactive. The QNI project enabled them to pilot a proactive service.

Project
As discussed above, people experiencing homelessness are at higher risk of a range of health conditions, are less likely to be registered or attend a GP surgery and have increased morbidity and mortality at a younger age than the general population. To address these issues the project aimed to test the provision of a Drop-in and preventive health service.

What the Project Funding was used for
The funding paid for an additional nurse session a week.

Aims of the Project
The aim was to improve the health and wellbeing of people experiencing homelessness through delivering a nurse-led clinic for Wirral Ark residents and non-residents in the area. The project objectives were to: Reduce attendance at A&E, walk-in-centres and GP practices and to reduce inequality of access to health care for people experiencing homelessness. These objectives were to be achieved through provision of NHS Health Checks to Wirral Ark residents aged 40-75, and a drop-in service for minor injuries and ailments for residents and non-residents.

Delivery of the Project
The launch of the project coincided with the renovation of the hostel, resulting in some delays but this allowed the project lead to disseminate information about the project within Wirral Ark and to other services in the area. A poster advertising the new services was designed by the project leads and residents.

The Drop-in clinic was open to residents and non-residents and was well attended by both groups. The CEO commented that nurses are very approachable which helped people to be able to access the clinics. In addition, the nurse lead comments in her report on the project: 'My existing relationship with the hostel residents meant that I was able to hit the ground running. The decision to deliver the NHS Health Checks on site meant that residents were familiar with their surroundings and it removed barriers'.

The NHS Health Check, which is offered to everyone aged 40-74 registered with a GP, aims to help prevent: '… heart disease, stroke, diabetes, kidney disease, and dementia' (Public Health England, 2013; https://www.nhs.uk/conditions/nhs-health-check/). Appointments for the NHS Health Check were offered during one nurse session a week, carried out by the nurse project lead.
The nurses are provided with a list of new residents each day and all are told on admission that they must have a health assessment. Those within the target age group are offered an NHS Health Check. The health check included cholesterol screening using a machine loaned by the local public health department for the year of the project.

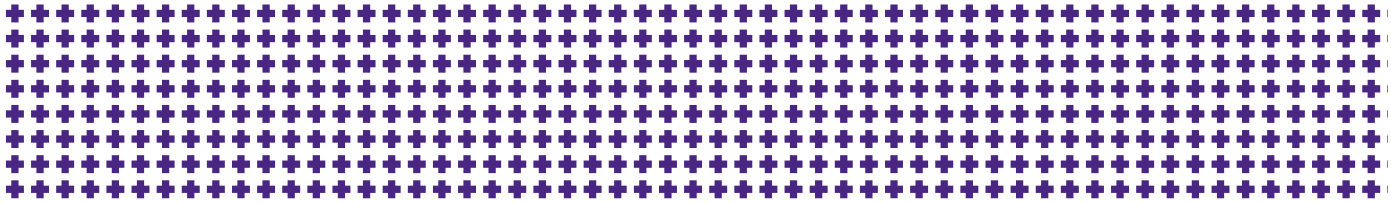
When the nurse lead attended the QNI workshops, she became aware of the work of other projects and decided to extend the scope of the Wirral Ark project by offering screening for Hepatitis C and giving out self-harm kits (see Appendix 5). The nurse project lead worked with the local substance misuse team and the community harm reduction nurse to develop a Hepatitis C screening and treatment programme. She then organised a session with residents to put together the self-harm kits; this generated a great deal of discussion among them about self-harm. They put together 200 kits, some of which she has taken to a women's refuge. A resident designed the artwork for the leaflet to go with the kits (see Appendix 5).

Computer records are kept of all residents seen, treatments and investigations. The nurse project lead collates these figures on a weekly basis and forwards the information to the administrative team in Wirral Ark. She undertakes monthly audits including NHS Health Checks undertaken, the number of flu vaccinations given, and these are sent to Wirral CCG. As Wirral Ark is a charity outside the NHS, these records are not linked to the residents' GP records. Similarly, when blood tests are needed, residents must go to their general practice.

'The aim was to improve the health and wellbeing of people experiencing homelessness through delivering a nurse-led clinic for Wirral Ark residents and non-residents in the area.

Measurement
Computer records were used to collate the number of people seen during the project and the interventions undertaken. In addition, the nurse project lead designed a patient satisfaction form and obtained verbal feedback from residents about the new services.

Outcomes
The drop-in clinics were very effective during the project year. Thirty-nine sessions were held and 117 residents and 62 non-residents were seen. Of these 40% said they would have attended A&E if the drop-in sessions were not available and 30% said they would have called an ambulance. The nurse project lead also commented that the self-harm kits had made a very significant difference to the number of infected wounds they had seen.



Similarly, the NHS Health Checks provided a new service and identified unmet need. None of the hostel residents had previously attended an NHS Health Check. Forty eight sessions were held and 96% (60) residents completed a full NHS Health Check. Of these two were helped to access practice nurses to support then with their diabetes and 11 who had a raised QRISK3 (cardiac risk) score were referred to their GP. Seven of these people were started on a statin, two are being monitored and two more have left the hostel.

The project achieved its aim of reducing inequalities in access to healthcare; its aim of providing early identification of chronic disease and the aim of empowering residents concerning their own health. This last aim was achieved through the ease of access provided by the nursing service and the length of appointments, which allowed better relationships to be built and gave time for residents to learn more about their health conditions. The nurse project lead comments in her report: 'This additional time in consultations allowed us to build better relationships and to gain an in-depth knowledge of the patient's conditions and to empower people to understand the importance of taking responsibility for their future health care. This aspect was extremely important as when residents left the hostel they needed to take full responsibility for their health care'.

Residents I met commented on the ease of access to the nurses and that they can see when the nurses are in, due to the design of the hostel which has glass walls around a garden in front of the nurses' room. The hostel manager also commented on the value of knowing when the nurses were available and the consistency provided by the team which has been the same for the past 12 years.

Reduction in A&E and walk-in-centre attendance, as well as information on GP follow-up, is difficult for the service to obtain as it is outside the NHS computer system.

Dissemination
Information about the project has been widely disseminated in the local area, for example, to the local NHS hospital trust, to the CCG, the Night Shelter, GP practices, Wirral Ways to Recovery and a Rotary District Conference in Liverpool.

Continuation
The continuation of the project was funded by the Wirral Ark Board of Trustees for an additional six months following the end of the QNI funding and the sessions have continued beyond this time funded by grants. In addition, very successful nurse drop-in sessions have been offered over the winter at emergency accommodation in church halls and other places.

Facilitators
- Long standing nursing service led by the nurse project lead based in the hostel;
- Support from organisation to pilot a preventive nurse service;
- Motivated hostel staff to encourage residents to attend for NHS Health Checks;
- Residents positive experience of nursing service;
- Residents engaged in supporting the project and additional elements of the project;
- Support from the Board of Trustees of the organisation.

Barriers
- Lack of access to NHS computer record systems;
- Cost of Cardiochek test strips not sustainable beyond the project;
- Initial low uptake of Drop-in clinic due to lack of local publicity.

The QNI
Through attending the workshops, the nurse project lead gained new knowledge, increased her leadership skills, presentation skills, and greater awareness regarding listening and empowering people. She learnt from the other project

leads about innovations which she then incorporated into the nursing service at Wirral Ark. She has formed strong relationships with other project leads who keep in contact via a WhatsApp group and commented that she hoped to visit some of them to learn more about their work. She made the comment that the QNI funding gave her permission to go to the QNI study days but that this was more difficult now the project had ended. She commented that it would be good to meet up with the other project leads about a year after the end of the projects to see how they had progressed, how they got additional funding and what outcomes they had achieved.

Key Messages: from the Project

- The NHS Health Check can be delivered to people who are experiencing homelessness;
- Offering the NHS Health Check in an environment familiar to people who are homeless may encourage take up;
- Project delivered by an experienced advanced nurse practitioner;
- Project supported by the organisation and its senior manager;
- Involvement of residents in different aspects of the project may have increased their engagement;
- Soft outcomes such as development of confidence, increase in self-esteem are difficult to measure.

Key Messages: from the Evaluation

- Lack of awareness of the value of dissemination of the project beyond the local area.

Recommendation

Exploration of computer linkages between hostels and NHS services to share health information; Development of ways to measure soft, qualitative outcomes.

Reference

- Public Health England (2013) Free NHS Health Check. Leaflet. PHE, London

> ‘The project achieved its aim of reducing inequalities in access to healthcare; providing early identification of chronic disease and empowering residents concerning their own health.

Five Ways to Wellbeing, Homeless Health Service, Bristol

Context
This project was initiated by a member of the Homeless Health Team, a team of eight nurses (including a nurse manager), doctors, link workers and others. They deliver primary health care services at The Compass Centre, where services for homeless people are provided in Bristol. They also deliver outreach health clinics in hostels for homeless people in other parts of the city. The team have been employed by BrisDoc Healthcare Services since 2016 and provide the following health services:

- General health advice and treatment;
- Support and advice for mental health issues;
- Sexual health and contraception advice; Safe injecting advice;
- Drugs/alcohol support and referral to other specialist services;
- Minor injury care;
- Wound care, dressings and Doppler scans;
- Testing and counselling for bloodborne viruses such as HIV/hepatitis B & C;
- Podiatry clinic;
- Referrals and liaison with other health and homeless services;
- Free flu and hep B vaccination
- (http://homelesshealthservice.co.uk/)

Clinics are held at The Compass Centre by the nurses every morning and afternoon Monday to Friday.

The project lead, Claire O'Connell, is a dual qualified registered nurse and registered mental health nurse. She has worked in the Bristol Homeless Health Team for 13 years, since 2006. She works two days per week and her manager, Sheila Shatford, who was a co-applicant on the project, works four days a week. Most of the other nurses in the team are also part-time.

The nurses were formerly known as Primary Care Nurses, but the project lead commented that her manager had asked for the nurses to be titled Specialist Homeless Nurses, to indicate the breadth and significance of their role. The project lead is a member of the QNI Homeless Health Network and has attended study days run by the Network in London and Bristol.

Project

Given her mental health background and experience working with people who were experiencing homelessness she was interested in doing a project concerned with mental health. She referred to the impact of adverse childhood experiences (ACEs) on many people experiencing homelessness and the consequences of these for their mental wellbeing throughout their lives. She read about the Five Ways to Wellbeing and found that no one had used this with people who are experiencing homelessness.

The project lead proposed that she would run a series of sessions on the Five Ways to Wellbeing for people who are homeless at The Compass Centre. In 2008 the Foresight Mental Capital and Wellbeing Project identified the Five Ways to Wellbeing as a means to support mental wellbeing from childhood through to old age, in families and in workplaces. More information about the approach is available on the NHS website: https://www.nhs.uk/conditions/stress-anxiety-depression/improve-mental-wellbeing/.

What the Project Funding was used for

The QNI funding paid for the nurse time to prepare for, run and write up the sessions and for healthy snacks for the sessions.

> 'Mental health is often not seen as a priority and there is a lack of mental health service provision for the homeless client group.

Aim of the Project

The project aim was to improve the emotional wellbeing of people experiencing homelessness in Bristol, using the 'Five Ways to Wellbeing' approach. The Five Ways are listed on the project resource as: Connect, Be Active, Keep Learning, Take Notice and Give to others (as shown on the poster, Appendix 4).

The project lead commented that mental health is often not seen as a priority and there is a lack of mental health service provision for the homeless client group. In addition, the soft outcomes from mental health work are hard to measure. For example, if the objective measure of success of an intervention is reduction of attendances at A&E then it is difficult to link this back to a mental health intervention. To measure outcomes of the project she searched on the Internet for a measurement tool and found the Warwick-Edinburgh Mental Wellbeing Scales (https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/). This scale has 14 items with five possible responses for each item. The responses are added to provide a single score. Before and after measurement shows if an intervention has had an impact on mental wellbeing.

Delivery of the Project

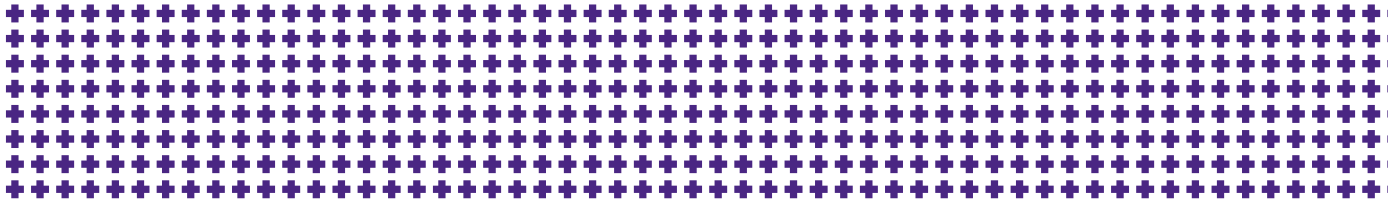
A focus group was set up which included two people who were experiencing homelessness, one of whom contributed to the project throughout. Posters were made and displayed inviting people to attend the groups. However, both the project lead and the senior health link worker who co-facilitated the sessions said that they felt it was important to have the right people in the groups. The two people in the focus group joined the first group and other people who joined the first groups were known to the project lead and co-facilitator.

The project lead said that she had been worried about the management of the groups and that people might become angry. Therefore for the first two groups, she held a 1:1 interview with anyone interested in attending to allow them to ask her any questions and to agree a contract with them about behaviour, for example, they were not to be intoxicated. In the event the two groups were successful and the attendees were very supportive, offering advice to each other from their own experiences.

In preparation for the groups the project lead had prepared detailed lesson plans but in the event the co-facilitator commented: 'You had to throw the lesson plans away'. A more informal approach was needed.

After the first two groups the room that had been booked for the groups was withdrawn and they were given another room which also had a television in it, which led to difficulties when other people wanted to come in and watch it. It also became difficult to recruit people to attend and only one person attended the third group along with the two facilitators.

Having received encouragement from QNI to continue, changes were made to the project and the next sessions were held in a different hostel. These were open sessions



and people could come to one or more of the sessions. The initial interview was discontinued, as was the Warwick-Edinburgh Scale. As people dropped into sessions it was not possible to use a before and after measure, so emoji cards were used instead to measure satisfaction.

Recruiting people continued to be a problem. When hostel workers who knew the residents were involved, this worked better. However, even when people had said they would attend, very often they did not.

The final group was held in a Salvation Army Hostel at which a staff member helped to recruit people to attend. This hostel also had a system of stamps that people could gain by attending groups and then exchange for food. The final session of this group on mindfulness involved a minibus trip to go for a woodland walk and this ended the project 'on a high point'.

Measurement
For the first two groups, the 14 item Warwick-Edinburgh Scale was used. This was completed at the initial interview and at the end of the five sessions. The co-facilitator commented that some people needed help to complete this due to some of the words used on the Scale and literacy issues, which are common amongst people who are experiencing homelessness. To measure outcomes more easily, they developed an emoji card which people completed at the end of each session indicating how helpful they had found the session and also giving them the opportunity to add comments. The project lead also conducted a number of evaluation interviews with clients and obtained some feedback from support workers.

Outcomes
During the project, five courses of five sessions were held and 22 clients attended the sessions. Improvement in wellbeing was shown for eight clients who attended a full course and completed the Warwick-Edinburgh Scale. Detailed findings concerning the changes in the scores for these people are provided in the project leads' report. Emoji cards were completed by 56 clients who scored the sessions as helpful or better and by 33 clients who scored the sessions as extremely helpful.

In interviews with a number of clients they were able to identify how the sessions had helped them. For example, one had found they could listen better to other people and also said that, 'People were listening to me'. Evidence was collected which showed that the project had achieved its aims: clients' anxiety was reduced and their willingness to attend groups had increased; clients' overall mental and emotional wellbeing had improved, and clients reported that they were more willing to prioritise their own healthcare.

In addition, there were a number of unexpected outcomes some which related to client achievements from attending the groups and some to the ways that the groups were run. Clients formed friendships in the groups, they learnt from each other in the group, they recommended the group sessions to others and had a feeling of achievement when they gained their certificate of attendance. Involving hostel staff in co-facilitating the groups enabled the staff to gain a better understanding of some of their clients. Changing to open sessions meant clients could come to a session to test it out, rather than having to commit to attend five sessions. Holding sessions in different hostels led to closer working with these places.

Dissemination
The project has been disseminated to some hostels in Bristol for people who are homeless. It has been discussed with service managers, the medical director in BrisDoc and a member of the CCG.

Continuation
It is hoped that the project will be taken forward in partnership with some of the hostels and other services.

Facilitators
- As the project lead only worked two days per week her manager gave her administration time to work at home to prepare for the sessions;
- Knowing the people who might potentially attend the groups so that the right mix of people could be selected for

each group;
- Support from hostel staff to recruit people to come to the sessions;
- Timing is important - people need to be ready to benefit from the group;
- Taking an informal approach in the sessions rather than sticking to prepared lesson plans;
- Holding sessions in different hostels;
- Asking people attending what snacks and drinks they wanted for the next session;
- Giving a certificate to everyone who attended.
- Barriers
- Lack of nurses to cover the usual clinics run by the project lead. This meant that her manager had to cover the clinics rather than acting as a co-facilitator for the groups.
- Lack of nurses in the area with the necessary skills to work with this client group and who are available for a four hour session rather than a 12 hour hospital shift;
- Lack of a regular room to hold the group sessions;
- Workers who did not know residents trying to recruit them to attend sessions;
- Chaotic lives of the residents preventing them from attending.

The QNI
The project lead commented that the QNI staff team were extremely supportive, for example when she wanted to give up the project due to the lack of people coming to the sessions and concern about not being able to cover her usual clinics. In addition, she would have liked to have had some feedback on her evaluation report and her case study which she felt would have helped her personal development.

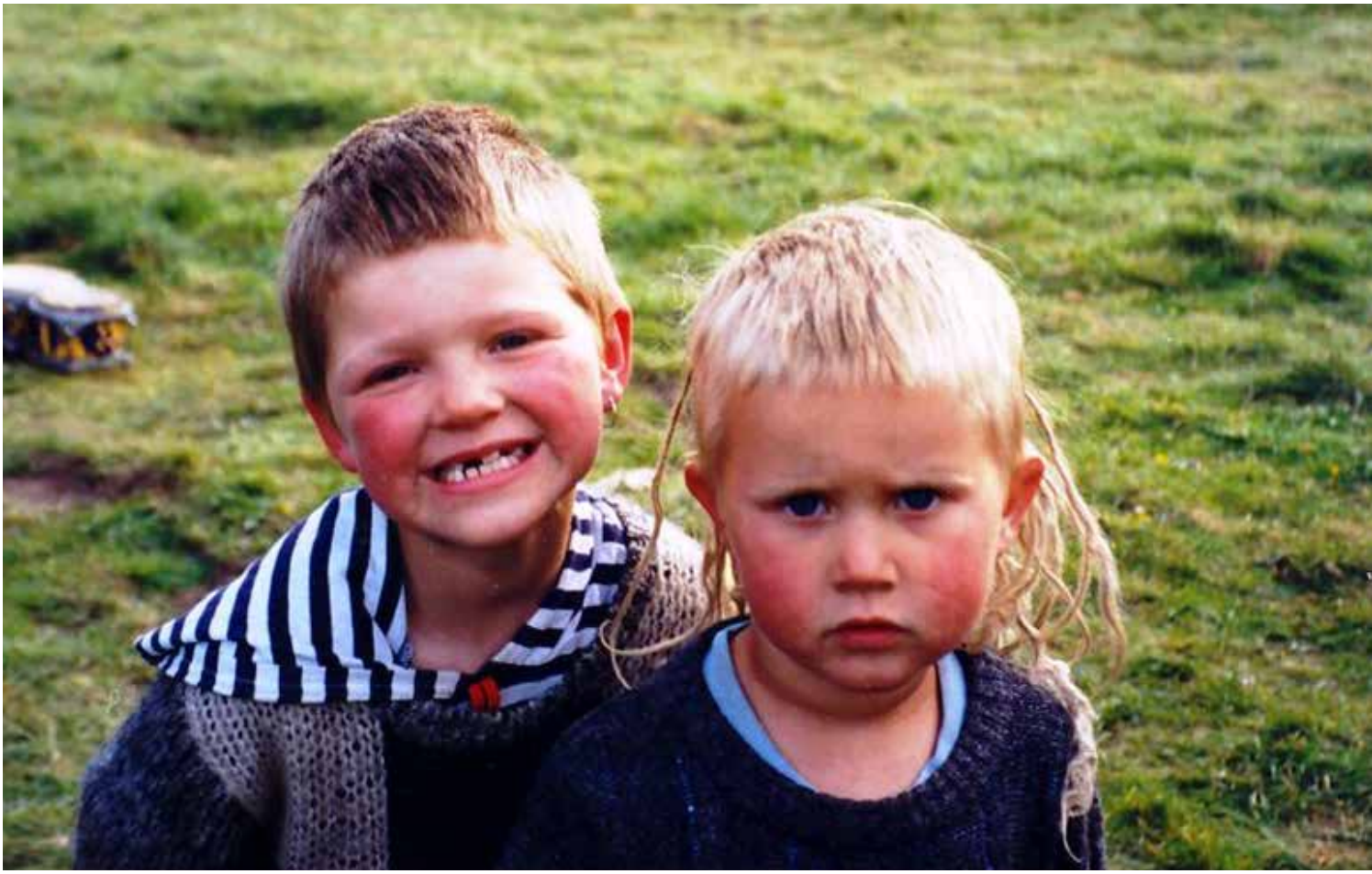
Key Messages: from the Project
- Identification of tools, such as the Warwick-Edinburgh Mental Wellbeing Scales, to measure outcomes could be made by a Programme Manager and used across projects so that it would be possible to make comparisons across the projects;
- Nurse cover for time the project lead is working on the project;
- Flexibility needed about use of the project funding if it is not possible to use it for the original reason specified in the bid.

Key Messages: from the Evaluation
The nature of work with people experiencing homelessness is all consuming, physically and emotionally leaving little space for project leads to think about dissemination and further development of their project after the project year.

Recommendation
- Project leads who are part-time may need additional support.

> ‘Clients formed friendships in the groups, they learnt from each other in the group, they recommended the group sessions to others and had a feeling of achievement when they gained their certificate of attendance.

Gypsy/Romany/Traveller Health Outreach, East Surrey



Context
The largest community of Gypsy/Romany/Travellers (GRT) is found in the South East of England (Cromarty, 2019). Surrey has the fourth largest community of all counties in England and they form the largest ethnic minority community in the county. It is conservatively estimated that there are 10-12,000 members of the GRT community in the county (First Community Health and Care, 2019). Members of this community experience severe inequalities in health. The Homeless Health Team in the east of the county, at the time of submitting the application for funding, were working informally with members of this community but were aware that there was a need for greater involvement to identify and address health needs.

Lisa Gavin, the nurse project lead attended a QNI Homeless Health conference and having joined the Homeless Health Network received information about the funding available. The bid was submitted against a background of reorganisation and tendering of children's community health services in the county, which led to the dissolution of the Homeless Health Team. The nurse project lead, remained in employment with First Community Health and Care but her role was designated as Homeless Lead, in the re-structuring of 0-19 services in a Surrey-wide umbrella body called Children and Family Health Surrey. Lisa Gavin has a background in health visiting and has worked in public health nursing for almost 20 years and in homeless health care for the past 5 years.

Project
The project was informed by the work of the Homeless Team community staff nurse who had begun to visit the GRT sites and requests from the GRT communities for direct engagement with trusted health professionals. The project is

described by the nurse lead in her report as '… a program of targeted, assertive outreach, to seek health needs and facilitate engagement with universal health services'. She also stated, 'The project was nurse-led but very much a partnership between the health and non-health worker (co-partner, Mark Haythorne).' Mark, the joint project lead, was the project officer in Surrey County Council for the Council's Brighter Futures for GRT children at the time of the bid but when his post was decommissioned in 2018 he continued with the project in a voluntary capacity until summer 2018.

What the Project Funding was used for

The QNI funding supported the project by paying for administrative support, for visual aids and for a conference held to launch the expansion of the project.

Aim of the Project

The project aimed to improve the health of people living in the GRT communities in East Surrey.

Delivery of the Project

The project was initially titled: The Health Bus: GRT Health Outreach Project East Surrey and the plan was for the project to make use of an Early Years Play Bus, which already visited GRT sites, to provide a venue for the nurse to meet members of the community and provide health care. The project initially aimed to focus on screening for diabetes, stroke, heart disease and mental health as well as improving the uptake of immunisations. A second objective was to develop visual materials to support public health message delivery, taking account of the low levels of literacy within GRT communities which makes leaflets and other conventional materials inappropriate.

Early on in the project it was identified that many of the children in the communities had poor dental health and work was started with a very supportive Consultant Paediatric Dentist in the local hospital, which resulted in the production of a Vulnerable Children's Dental Pathway. The focus on fast-track dental health care for children replaced the focus on mental health in the original plan.
Visits were made to the GRT sites by the community staff nurse and the Surrey Council project lead who was familiar with many of the communities and facilitated access. Problems were experienced in using the Play Bus, including the inflexibility of the timetable and difficulties of accessing smaller sites. It was also found that clients preferred to see the nurses in their own homes rather than on the bus. Joint visits were held by the community staff nurse and the Council worker which enabled both health and non-health related issues to be addressed at the one visit. In addition, the project was supported by an advocate and outreach worker employed by Friends, Families and Travellers who also facilitated access and supported people who were sign posted to other services.

During the project the reorganisation of services resulted in redeployment of the community staff nurse to another service meaning that there was potentially no nurse to deliver the project. Following negotiation, the nurse project lead was able to secure one day of her time from her new post almost to the end of the project. The community staff nurse resigned before the end of the project due to her unhappiness with the new post to which she had been redeployed.

Measurement

Data was collected manually during visits to the sites and recorded anonymously on an Excel spread sheet in the office. This recording template is one of the tools that has been taken forward into the expanded project and it has been further developed to give more detail about interventions and outcomes.

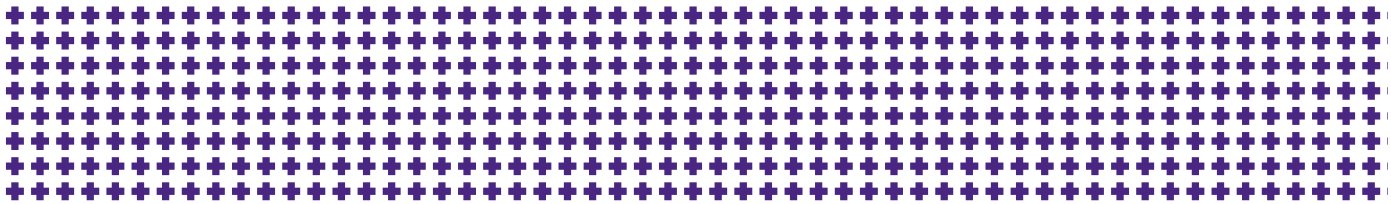
The same system was used to record children referred for dental treatment but in addition referrals and follow up were made using EMIS, with the parents' consent, allowing electronic tracking of these children and their dental care. Childhood immunisations were given on-site in collaboration with the local Immunisation Team as well as those that had been missed.

Outcomes

During the project 54 adults were offered screening and 22 accepted: 22 were weighed, eight had a blood pressure measurement and two had their BMI calculated. Two people were screened for diabetes and offered referrals and advocacy to access treatment. Other outcomes included discussion of health and non-health issues and resulted in 16 referrals, 44 signposting and 40 direct advocacy.

The development of the Vulnerable Children's Dental Pathway during the project led to 26 children being referred for treatment, including extractions and health education. 42 health promotion discussions were held concerning childhood immunisations and three immunisations were

> 'Wider discussion within the community was also initiated and the opportunity to challenge myths and beliefs about immunisations has a value and impact that is difficult to measure but valuable nonetheless.



given by a nurse from the 0-19 immunisation service. These discussions enabled the project team members to develop a greater understanding of the cultural factors which affect immunisation uptake in the community and this information was shared with the local immunisation team. The discussions also contributed to the building of relationships and trust between the nurses and the community concerning this aspect of health care.

The nurse project lead comments in her report: 'Although many health promotion contacts did not result in immediate uptake of immunisations, this may be reflected in future contacts. Wider discussion within the community was also initiated and the opportunity to challenge myths and beliefs about immunisations has a value and impact that is difficult to measure but valuable nonetheless'. The qualitative research by Jackson et al. (2017) demonstrates the value of in depth discussions about immunisation, helping to identify barriers to uptake in similarly marginalised communities.

The major outcome of this project was to identify the range of health needs experienced by these communities which formed the basis for a bid to develop assertive health outreach across the whole of Surrey, with a designated GRT Health Improvement Project.

Dissemination
The project has been widely disseminated locally to partner agencies and services, to staff in First Community Health and Care, through the Surrey County Council Brighter Futures interagency meetings, to students and to other partners. The project was also presented at a conference held to launch the two year Surrey wide GRT Health Project in 2019. The nurse lead has delivered cultural awareness training in both community and hospital settings, following the completion of the QNI project. In collaboration with the Surrey Community Gypsy Forum, a Cultural awareness training package has been negotiated with the Surrey Safeguarding Partnership Board (SSPB) and is now being offered to all agencies through the SSPB.

The nurse lead has also discussed the project with Public Health England. She has visited and discussed the project with other nurse-led services for the GRT community, for example, in Yorkshire and a special interest group for nurses working with GRT communities has been suggested. She has also been approached by Best Beginnings (https://www.bestbeginnings.org.uk/) to provide input into the Baby Buddy app that would be culturally relevant to GRT communities. She has also been asked to write a monthly column in a community nursing journal on work with the GRT community, but at the time of the evaluation visit had not made a decision about this. A television company is also interested in making a film about unauthorised encampments and the team will assist the film-maker in identifying suitable clients.

Continuation
Following the success of the initial project, a bid to Surrey Heartlands (SH) (https://www.surreyheartlands.uk/) was prepared for a new, county-wide GRT Health Outreach Project and SH awarded £250,000 in April 2019.

An additional £250,000 was awarded to develop a similar Outreach Health Project for homeless families across Surrey (called the Inclusion Health Project), a two year project led by Lisa Gavin. The plan is to eventually combine the two projects into a 0-19 Surrey-wide Inclusion Health Team, subject to funding. A local commissioner commented that the total £500,000 additional funding would not have been secured without the initial funding of £5,000 from the QNI. She commented that the £5,000 has actually made more impact after the project and the money was still working now.

Facilitators
- Two project leads brought expertise from different areas: health and knowledge of GRT communities;
- Getting different people with different skills on board;
- GRT staff nurse enthusiasm and interest;
- Building trust with the communities;
- Meeting the members of the community where they were rather than following the health professionals' agenda;
- Support from Consultant Paediatric Dentist.

Barriers

- Local NHS and Council reorganisations during the project leading to staff reductions;
- Withdrawal of the Traveller outreach worker due to health issues;
- Lack of organisational support during the project;
- Practicalities around using the Play Bus;
- Challenges of running the project while delivering the wider homelessness work;
- Travelling by the families especially during the summer months.

The QNI

The project lead valued the workshop days but felt that some of the input could have come earlier in the year. For example, she would have benefitted from the session on business models/cost benefit having been held earlier, as well as the input on the mapping tool for contacts. She also felt she needed more project management support and more frequent contact with the QNI project team support her, in view of her isolated position. Having hard copies of The QNI report on the homeless health projects she felt would be useful to help disseminate knowledge about the projects.

Key Messages: from the Project

- That time is needed to build trust with GRT communities, and it is important to meet them where they are;
- Systematic collection of data on health need is essential to obtaining additional funding.

Key Messages: from the Evaluation

- That project plans need to be flexible to allow the project lead to take advantage of unexpected resources, in this case the Consultant Paediatric Dentist;
- Project leads need a high level of resilience.

Recommendation

- That the content and order of the workshop programme be reviewed.

References

- Cromarty H (2019) Gypsies and Travellers. House of Commons Library Briefing Paper Number 08083. House of Commons, London. Available at: CBP-8083%20(1).pdf. (accessed 1.1.20).

- First Community Health and Care (2019), First Community, as part of Children and Family Health Surrey, launches Surrey-wide Gypsy, Roma and Traveller health outreach programme. Available at: https://www.firstcommunityhealthcare.co.uk/news/2019/first-community-as-part-of-children-and-family-health-surrey-launches-surrey-wide-gypsy-roma-and-traveller-health-outreach-programme (accessed 1.1.20).

- Jackson C, Bedford H, Cheater FM, et al. Needles, Jabs and Jags: a qualitative exploration of barriers and facilitators to child and adult immunisation uptake among Gypsies, Travellers and Roma. BMC Public Health. 2017;17(1):254. Published 2017 Mar 14. doi:10.1186/s12889-017-4178-y

> The largest community of Gypsy/Romany/Travellers (GRT) is found in the South East of England. Surrey has the fourth largest community of all counties in England and they form the largest ethnic minority community in the county.

Health Champions for the Homeless, Newham, London

Context

This project was based in the Newham Transitional Practice, a primary care practice based on two sites in Newham, provided by East London NHS Foundation Trust (ELFT), a mental health and community trust. The practice provides primary health care services for people who do not have a permanent GP and who have experienced difficulties in registering locally with a GP. It includes a 'New Entrants Screening Service' for new arrivals to the UK and a Homeless Service for people without a permanent residence. (https://www.elft.nhs.uk/Services/Adult-Community-Health/Newham-Community-Services--MHCOP/Community-Care--Nursing-Adult/Newham-Transitional-Practice---Main-Site).

Nurse-led outreach clinics are held in hostels, day centres and other settings. The practice is staffed by GPs, a nurse practitioner, a practice nurse, a health care assistant, a psychologist, a nurse for people who are homeless, a nurse for new entrants and an administrator. The practice is located in a large multi-disciplinary health centre. Since 2016, Shelter has produced a report on homelessness in England and in London Newham has consistently headed the list of London boroughs with the highest rates of homelessness. In London 1 in 52 people were estimated to be homeless or in temporary accommodation in 2019, while in Newham the figure was 1 in 24. 79 people were estimated to sleep rough in the borough which is the third highest in London (Shelter, 2019a, b; see Table 3).

The project was led by three people: Sihle Malapela, Nurse Practitioner in the Transitional Team, Sultan Ahmed, Administrator in the Transitional Team and Abdul Rawkib, Commissioning Manager in the CCG. The nurse lead has been in her current post since 2016; at the time of application to the QNI project she had been in post for nine months.

Project
The QNI project was suggested to the nurse lead by a CCG Commissioning Manager who suggested setting up a patient participation group for people who are experiencing homelessness.

What the Project Funding was used for
The QNI funding supported the funding for a band 5 nurse and administrators' time, and venue hire, catering and marketing materials for the Big Health Day.

Aim of the Project
The aim of the project was to improve the general health of people experiencing homelessness in Newham through establishment of a peer support group (health champions) for people who were homeless; to identify undiagnosed conditions with a focus on diabetes, mental health and respiratory conditions, and to start people identified with these conditions on a treatment plan.

Delivery of the Project
The project leads worked with the Trust lead for patient participation who provided advice and tools including a job description for the health champions. To recruit the health champions, leaflets were developed and distributed through the two practice sites and at locations attended by people experiencing homelessness and through other service providers. The nurse lead commented that the administrator working on the project had been critical to recruitment of the health champions; he encouraged people to become health champions and was 'very persuasive'. Seven health champions were recruited and five of these completed the training programme focused on diabetes, mental health, respiratory conditions and ways of accessing various services including pharmacies in different areas, dental health and primary care, enabling them to pass on this information to other people experiencing homelessness and to signpost them to relevant services. The health champions were provided with incentives in the form of Oyster cards and lunches.
In addition to passing on information to other people, the health champions worked with the project leads to design and deliver a health day for people experiencing homelessness. The 'Big Health Day' included a range of talks on topics including mental health, talking therapies, podiatry and respiratory conditions. During the day people were able to have health interventions including podiatry, foot management for people with diabetes, health checks. Interaction of service providers with people experiencing homelessness during the Big Health Day, as shown in one of the videos, also provided education for providers and, as the project lead comments in the video, the perspective of these service providers towards people experiencing homelessness: '…totally changed today'.

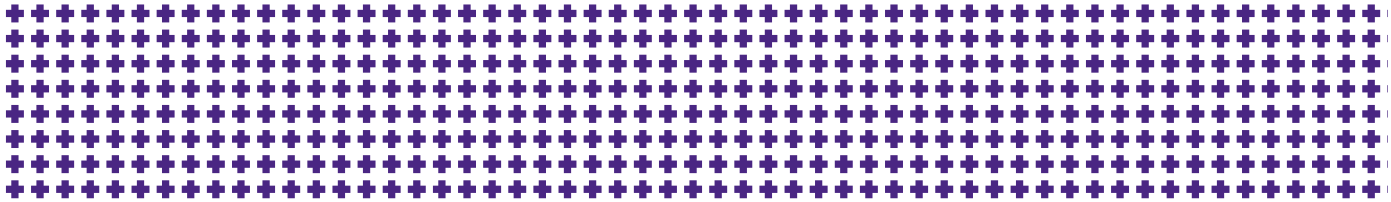
Throughout the project, the number of nursing staff in the team was depleted by sickness which meant that the nurse project lead had less time for the project. In addition, the project lead comments in her report that, although the project funds were transferred by the QNI to the Trust at the start of the project, there was then a lengthy process of accessing the project funds from the Trust, which delayed the start of the project.

Measurement
Measurement of this project can be made in terms of the number of health champions who were recruited and the number of people to whom they gave health advice. The commitment of the health champions was dependent on their personal circumstances and often chaotic lifestyles. Each was given a diary in which to record contacts, health and referral information that they had passed on to other people, but they found these difficult to complete or misplaced the books, so gave verbal feedback at the training sessions on the numbers of people they had spoken with. All the health champions were men, which meant that there may have been less engagement with women.

Outcomes
Seven health champions were recruited during the project and all gained greater knowledge of health conditions and different services and how to help people to access services. The project leads reported that over the project the health champions gained in confidence. People experiencing homelessness were given information by the health champions but evidence of this was largely provided verbally to the project leads.

In a film made about the project, the health champions comment on their enjoyment of the programme and what they learnt (https://www.qni.org.uk/explore-qni/nurse-led-projects/homeless-health/). The nurse project lead said that the health champions believed that before the project no-one ever listened to them, but that being a health champion gave them a sense of being accepted as a person and a sense of purpose which was very satisfying.

> 'The aim was to improve the general health of people experiencing homelessness through establishment of a peer support group (health champions) for people who were homeless.



The nurse project lead commented that an important outcome for herself and the Transitional Practice had been the number of contacts and networking with other services that had been formed as a result of the project. For example, she had had to research access to dentistry, forming a link with the mobile dental service for people experiencing homelessness (https://www.newhamrecorder.co.uk/news/health/mobile-dental-service-for-the-homeless-1-6201752). In addition, involvement of a wide range of health care providers in the Big Health Day provided them with contact with people experiencing homelessness and impacted positively on their views about this group of people.

Dissemination

The project has been widely disseminated locally through the activities to engage people experiencing homelessness as health champions and through the Big Health Day. Information about the project is on the ELFT web site and has been fed into the ELFT work on Patient Participation Groups. It has been reported to Newham CCG via the project lead who is a member of the CCG, to the local Homelessness Forum and Newham Homelessness Action Group. More widely, the project has been disseminated through two videos, one describing the project and one discussing evaluation, which were made during the project and are on the QNI website.

Continuation

The project was not operating at the time of the evaluation visit, due to the lack of nursing staff in the team. However, the project lead was hoping to recruit new nursing staff and continue the programme. In the evaluation video and in the evaluation meeting with the nurse project lead, different ways in which the health champions could work with the Transitional Team were discussed, for example going to soup clinics and night shelters with a team member. It is hoped that the health champions will form a patient participation group for the Transitional Practice; the GP lead for the practice comments in one of the films that the health champions are part of the Transitional Practice team taking health messages out to people. The nurse project lead commented that the health champions often ask her when the project is going to start again, demonstrating their interest and engagement in the aims of the project.

Facilitators

- Support from the Transitional Practice team;
- Commitment of the health champions who were recruited;
- Support from the local CCG;
- Support from ELFT which has a well-developed approach to involving service users in service delivery and in research in the Trust;
- Support from services for the Big Health Day;
- Three person project team bringing different expertise to the project.

Barriers

- Difficulties organising access to the project funds from the NHS Trust;
- Delays in printing marketing materials which delayed the recruitment of health champions;
- Low staffing numbers and difficulty recruiting new nurse team members;
- Nurse lead lacked time to provide as much support to the health champions as was needed;
- Limited recording of contacts by the health champions;
- Health champions continuing to deal with their own chaotic lifestyles.

The QNI

The nurse project lead found the input on the QNI study days and from the other project leads very useful in helping to reflect on how things could be done differently in the project.

Key Messages: from the Project

- People experiencing homelessness do want to become health champions and provide health information to other people in the community;
- Health champions need support to develop confidence in delivering health messages
- Lack of staff had a negative impact on the project and its continuation;
- Having someone on the project team with project management experience was very beneficial to the project.

Key Messages: from the Evaluation

- A method of managing project finances needs to be established to prevent issues around finance delaying the start of projects;
- The setting up of a project takes a considerable amount of time and could be allowed for by having a preparation period before the project is launched or extending the projects to, for example, 18 months;
- Development of a greater pool of nurses with expertise in homeless healthcare might prevent difficulties around recruitment.

Recommendation

- Extend the length of projects to take into account the project set up tasks.

References

- Shelter (2019a) 280,000 people in England are homeless, with thousands more at risk. Press release. Shelter, London. Available at:
- https://england.shelter.org.uk/media/press_releases/articles/280,000_people_in_england_are_homeless,_with_thousands_more_at_risk (accessed 28.12.19).
- Shelter (2019b) This is England: A picture of homelessness in 2019. The numbers behind the story. Shelter, London. Available at:
- https://england.shelter.org.uk/__data/assets/pdf_file/0009/1883817/This_is_England_A_picture_of_homelessness_in_2019.pdf (accessed: 28.12.19).
- Videos:
- https://www.qni.org.uk/explore-qni/nurse-led-projects/homeless-health/
- https://www.qni.org.uk/explore-qni/nurse-led-projects/homeless-health/

> The nurse project lead commented that an important outcome for herself and the Transitional Practice had been the number of contacts and networking with other services that had been formed as a result of the project.

Health Inclusion Team Plus (HITPlus), Southwark, London

Context

The Health Inclusion Team (HIT), Guys and St Thomas' NHS Foundation Trust is a long established nurse-led team providing a wide range of services for people experiencing homelessness in the three London boroughs of Southwark, Lewisham and Lambeth shown in Box 1 below. The team comprises approximately 35 people including nurses with different clinical backgrounds, GPs, caseworkers, administrators, occupational therapist, technician and others.

Box 1: The Health Inclusion Team

The Health Inclusion is a nurse-led specialist community team which provides primary health care level services for vulnerable groups (people who are homeless, refugees, asylum seekers and drug and alcohol users). The homeless service is across Lambeth, Southwark and Lewisham. The refugee, asylum and drug and alcohol services are across Southwark and Lambeth. Our clinics are run at day centres, drug and alcohol services or hostels based across Lambeth, Southwark and Lewisham. They are all drop-in services, so you do not need an appointment.

Our service

Our team provides a range of free and confidential services, including: *a full health assessment*; screening for blood borne viruses; *sexual health screening*; contraception advice; *routine blood tests;* treatment for minor illnesses, wounds or injuries; *advice on how to manage long-term diseases*; advice and intervention for people who suffer from long-term pain related to traumatic experiences; *health promotion for young people in homeless hostels*; referrals to other services where necessary; *care workers support for refugees and asylum seekers*; primary care GP service for destitute failed asylum seekers; *street outreach (Southwark) health service in collaboration with the street outreach team for rough sleepers*.

https://www.guysandstthomas.nhs.uk/our-services/community-health-inclusion-team/overview.aspx
The HITPlus project was led by two nurses: Kendra Schneller and Serina Aboim. They are both nurse practitioners. Kendra has worked in different services for people experiencing homelessness for more than 11 years and Serina for 7 years. Their manager, a non-nurse, has a background of 20 years in services aimed at marginalised communities. The two project leads are members of the Homeless Health Network and of the London Network of Nurses and Midwives of which Kendra is Vice Chair (http://homelesshealthnetwork.net/lnnm-team/). Kendra is also a Queen's Nurse (see Table 2) and in 2019 she was a Windrush Scholar.

Project
The team were aware that there was a group of rough sleepers who did not access health care or drop-in centres, in some cases due to restrictions in place in centres on substance/alcohol use. These clients, as the project leads comment '…are not seeking advice regarding their health. This will have an impact on hospital services as the clients are more likely to present at A&E in a state of crisis.' (QNI, 2019) To address this need they started a pilot project in Southwark called HITPlus (Southwark). This pilot work formed the basis for the application for QNI/Oak Foundation funding.

What the Project Funding was used for
The QNI funding paid for bank nurses to cover some of the regular clinics run by the project leads and to buy toiletry bags to be given to people sleeping rough as well as for a portable spirometer.

Aim of the Project
The HIT Plus project aimed to ensure that people who are sleeping rough have the same access to health care services as the population in general. The key outcomes that HITPlus was aimed at achieving were:

- Increased uptake of pneumonia, influenza and Hepatitis A and B vaccinations;
- Identification and starting on treatment plans for clients with blood borne viruses, human papillomavirus, diabetes, sexually transmitted diseases;
- Connecting clients to primary health care, housing and homelessness support services;
- Clients engaging in ongoing treatment.

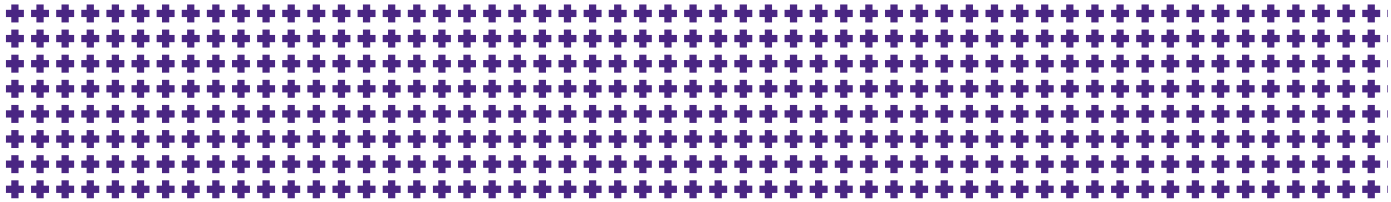
> During the year the team saw 109 people on the streets, 77 same day health checks and 69 health interventions were carried out.

Delivery of the Project
Guidelines were developed by the project leads concerning the operation of HITPlus. A nurse from HIT joined the Street Population and Outreach Team (SPOT) in Southwark for one shift a month. Of the people seen by the SPOT team, approximately 50% have no recourse to public funds and therefore have little or no means of support. Several days before the shift the nurse met with the SPOT team to identify clients that they would try to meet with on the shift (Bingham-Smith and Skinner, 2018). In addition to working with the SPOT team a General Practice offered appointments for people identified by the HIT Plus nurse. In the event the location of the GP practice meant that these appointments could not be utilised due to distance. Initially the nurse went out on a morning shift with the SPOT team but at this time of day it was found that it was difficult to engage with clients. Later in the project, the shift was changed to start in the afternoon finishing in the evening when it was found to be easier to engage with clients. Reduction in the numbers of nurses in the HIT from four to three during the project also impacted on the availability of nurses to undertake the shift as well as deliver their usual clinics.

During the shifts across the project year HITPlus saw 109 clients on the streets. In the third quarter report for the project 2018/19 the project leads provide some case studies. Box 2 illustrates the complexity of the needs and interventions for one client who engaged with the project.

Box 2: Needs and interventions for one client of HITPlus
Referred into addictions service • *Had full health assessment including screening for blood borne viruses, liver, kidney, cholesterol, HbA1C, thyroid function, infection markers.* • Sexual health screening - Chlamydia, Gonorrhoea and Trichomonas vaginalis. • *Specialist blood test requested for Hepatitis C management* • Sexual health assessment and health education • *Health education given cervical cytology* • Health education given long acting reversal contraception • *She was registered with a local GP which facilitated her getting prescribed with methadone as this is a mandatory need for the local addiction service.* • Once blood results available she consented to share information and these where sent to the addiction service. • *She was given both the seasonal influenza and the pneumococcal vaccinations.* • She was started on a Hepatitis B vaccine course • *Case managed and accompanied to appointments – GP for back pain* • Supported with letter to assist with housing application to facilitate accommodation • *Diagnosed with multiple infections and prescribed antibiotics (Aboim S, Schneller K and Jolly F (2019:8)).*

Measurement
Information about clients' health needs, interventions and outcomes was kept on EMIS records, nursing records and GP shared care records. The project leads found extracting



this data to include in the project report quite cumbersome and, building on learning from the QNI project, a data analyst has been employed to manage the data in the expanded HITPlus service.

Outcomes
In the evaluation report commissioned by the project leads as part of the QNI project, the SPOT team express their enthusiasm for the nursing input and the focus on health, which they comment has helped them to engage with people who are often hard to engage: 'SPOT commented that people respond well to nurses, the approach is friendly, kind and understanding, yet firm, factual and directive. The service offers very practical assistance, such as calling a GP or dressing a wound'. One comment was that: 'There is no philosophical debate whether someone needs health care; it is clear what is required and what the treatment should be. The focus on health, with clear guidance of what needs to be done to treat a problematic health condition has worked well with clients who had proven difficult to engage by SPOT alone. The focus on physical health has been successful with people who have otherwise kept the outreach team at arm's length, yet they have responded to the primary need of health. This has then allowed the outreach team to approach the client with housing or other options'. (Bingham-Smith and Skinner, 2018:8).

During the year the team saw 109 people on the streets, 77 same day health checks and 69 health interventions were carried out. Bingham-Smith and Skinner (2018) comment on the amount of time needed, in addition to the face-to-face time on the streets, to provide referrals and other support for these clients estimating that an average of six hours was needed to provide follow-up administration after a shift where a nurse had met clients with the SPOT team.

Dissemination
The outcomes of the project have been widely disseminated locally and across London. Presentations have been made to service commissioners in Lambeth and Lewisham and at a workshop held as part of the Mayor of London's strategy to tackle homelessness (https://www.london.gov.uk/what-we-do/housing-and-land/homelessness). They have had contact with other boroughs in London including Islington, Haringey and Enfield which are all interested in learning more about the approach to use in their own areas. The project leads have been approached to write a series of articles for a practice nurse journal on working with people who are homeless.

The project has also had wide publicity in the press and through TV and radio. For example, in a local Southwark paper (https://www.southwarknews.co.uk/news/southwark-rough-sleepers-health-st-mungos/) and the project was highlighted nationally in The Times Christmas appeal 2018 (https://www.thetimes.co.uk/article/dawn-patrols-tackle-sickness-on-streets-with-instant-checks-bcgmlfq5d#).

Continuation
The project has received ongoing funding from the Ministry of Housing, Communities and Local Government (MHCLG) Rough Sleepers Initiative in Southwark. As mentioned above, the lessons from the project are informing development of services in other London boroughs, including Lambeth and Lewisham.

Facilitators
- Experienced team of nurses;
- Strong organisational support from their manager and the Trust Director of Nursing for innovations in practice;
- Long standing networks in the local area with other services involved with people sleeping rough;
- Support from GP practice.

Barriers
- Reduction in nursing team numbers during the project;
- Access to people sleeping rough at times when they were available;
- Collection of data for evaluation purposes was laborious.

The QNI
The support from the QNI enabled the project leaders to develop their project management and leadership skills as well as giving them the opportunity to present their project at homeless health network events thus contributing to

dissemination of the project. They were very appreciative of the communications input with the design of their leaflets. During the project they would have appreciated more clarity around the level of support available from QNI, but they are grateful for the ongoing support of QNI staff. While they had complete support from their own organisations in relation to their project, they suggested that the QNI could make contact with Trust Directors or other leads to ensure that a project was being given full support.

Key Messages: from the Project

- That nurses working with outreach teams can enable people who are rough sleeping and have not engaged with health or other services to become engaged;
- That the health and social condition of people who are rough sleeping can be improved by street outreach by nurses;
- That addressing the multiple health needs of people who have not previously accessed care takes a considerable amount of time.

Key Messages: from the Evaluation

- Project leads need to be clear about what is required of them and the support available during delivery of the projects;
- That publicising and presenting a project raises the profile of the project and its achievements.

Recommendation

- That support for projects by senior staff is given more consideration in QNI reference materials.

References

- Aboim S, Schneller K and Jolly F (2019) HIT Plus Quarterly Report Q3 2018/2019. Guy's and St Thomas' NHS Foundation Trust, King's Health Partners, London
- Bingham-Smith A and Skinner A (2018) Evaluation of the HITPlus Service. January – March 2018. Guy's and St Thomas' NHS Foundation Trust, London
- Dorney-Smith, S, Schneller, K, Aboim, S, Radcliffe, M, Tanner, N, Ungpakorn, R, O'Brien, R & Hall, A (2019). Meeting the healthcare needs of people experiencing homelessness. Nursing Standard. 34 (1): 27-34. doi10.7748/ns.2018.e11155 (accessed 27.12.19)

> Presentations have been made to service commissioners in Lambeth and Lewisham and at a workshop held as part of the Mayor of London's strategy to tackle homelessness. The project has also had wide publicity in the press and through TV and radio.

Latent TB Screening and Awareness, HMP Birmingham, West Midlands

Context

The Birmingham Chest Clinic is located in the centre of Birmingham. It was built by the City Council in 1933 and in 2013 the clinic held an open day to celebrate 80 years of treating people (BBC News, 2013). In 2012 the Birmingham and Solihull services were combined, and the Birmingham and Solihull TB Service is now the largest such service in Europe. The nursing service comprises nurses and support workers who each have a caseload providing care for all age groups. It is a community based service with 80% of their work being carried out in people's homes. A proportion of the client group are living in hostels for people experiencing homelessness, people who are street homeless, people in other types of temporary accommodation and in prison. The nursing team is widely networked with TB services, research teams and professional organisations. For example, Hanna Kaur, TB Lead Nurse and joint project lead for this project, is a member of the RCN Public Health Steering Committee and contributed to RCN guidance on the management of people with tuberculosis (RCN, 2019).

The project was jointly led by Julie McLoughlin, TB Clinical Nurse Specialist, Hanna Kaur TB Lead Nurse and Kim Bruton, TB Support Worker. Julie has been a member of the TB staff for 13 years and has a background in paediatrics and health visiting. For the past 10 years she has been responsible for nursing care of people with TB at HMP Birmingham.

Project

HMP Birmingham is a prison for men, with a capacity of over 1000. Prisoners are screened on admission to the prison for active TB by the prison nurses using an assessment tool but there was no service to screen prisoners for latent TB. People with latent TB have been infected at some time in their lives with TB but do not have active TB. Of people

with latent TB, 10% will however go on to develop the active form of the disease. The initial idea for the project was to screen new entrants to the UK for latent TB who had come into the prison, but the project leads found that over 80% of the prisoners were UK-born (NHS England, 2015). The aim of the project then broadened out to the detection of latent TB in at-risk groups of prisoners in HMP Birmingham.

What the Project Funding was used for
QuantiFERON Igra blood tests for latent TB were paid for by the QNI funding; the local NHS Trust, which undertook the tests, charged a reduced rate for each test completed.

Aim of the Project
The aim of the project was to pilot the screening and treatment of latent TB in a nurse-led clinic at the prison to a designated cohort of prisoners at HMP Birmingham under the age of 65 years (NICE, 2017). In addition, the project aimed to raise awareness of TB amongst prisoners, healthcare and prison staff, so that they would be able to recognise symptoms and access treatment. The project aimed to improve the health outcomes of a vulnerable population who often have a history of homelessness, drug or alcohol misuse and are a high risk group for developing TB disease following exposure, and often present late to services.

Delivery of the Project
To undertake the project, the project leads' caseload was reduced so that she and the support worker could go into the prison regularly to undertake screening and education sessions. A Latent TB Screening Pathway was developed as well as a TB Screening Tool, which were introduced into the prison along with a referral form to make referrals to the TB service.

Seven TB awareness sessions were held which were attended by 35 prison staff and ad hoc conversations were held with staff and prisoners over the course of the project concerning TB and latent TB. A number of these sessions were held in the first month of the project to increase awareness amongst staff before the screening sessions began. Nine staff were also screened as a result of learning more about TB (these tests were not paid for by the QNI).

> ‘ Ten prisoners were identified as having latent TB. Of these, eight prisoners agreed to have treatment and were either being followed up at the prison, at another prison or in the community.

Over the course of nine months, 20 screening sessions were held. 100 prisoners in three sections of the prison were screened for latent TB using the TB Screening Tool and an interferon-gamma release assay blood test (QuantiFERON Igra). The support worker was highly skilled in taking blood from people who often had compromised veins. Prisoners are informed of the outcome of the test by a letter delivered to their cell.

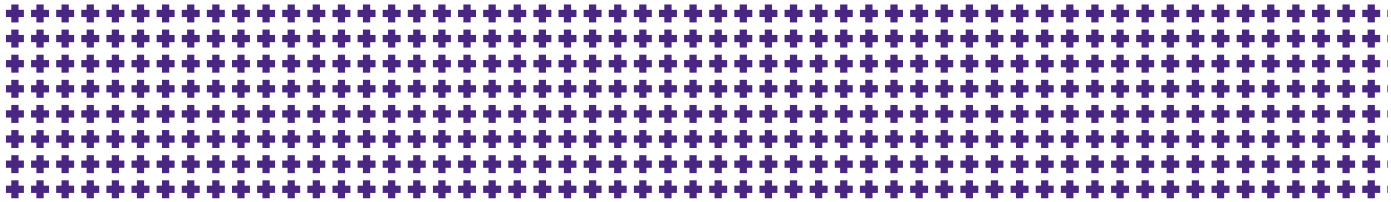
Screening was targeted on areas of the prison housing the most at risk groups including the detoxification wing, the healthcare inpatient ward and the older/vulnerable prisoner wing. Of the 10 people who had a positive test result, 80% were drug users, 100% smoked tobacco and cannabis and 100% had a history of homelessness. On average these 10 people had served nine prison sentences each.

During the project 120 people refused the blood test but were given information about TB. Prisoner health advocates also promoted the testing to prisoners. One prisoner who initially refused the test later had it and became a fervent advocate for the test and in directing the nurses to people who wanted to have the test.

Over the course of the project, staff at the prison become more familiar with the project lead. Although she had been going into the prison for many years some staff were not familiar with the role of the TB nurse. Prior to the project, each time the project lead had gone to the prison she had had to phone up to arrange to visit, had to wait for often up to an hour before she was collected at the prison gate and then had to be accompanied on her visit by a prison officer. As a result of the project she was put forwarded by the healthcare manager in the prison to become a key holder at the prison.

To become a keyholder she had to undertake two periods of training, first with the private company G4S and later with the Ministry of Justice, which took direct control of the prison during the project. She is now able to go to the prison as soon as she receives referrals or to undertake screening sessions and, having informed the prison officers who she is going to see, she can make her own way around the prison. One issue throughout the project was that having been given this access, she had to be extremely careful about the security of testing equipment taken into the prison.

Measurement
A database was set up to record the interventions in each screening session and included recording of: numbers of blood tests; numbers who refused a blood test; numbers who received TB awareness information; results of tests; social risk factors; how many were offered TB treatment; how many completed treatment. A record was also made in the prisoners' medical records of tests and results.



A before and after knowledge test was used in the TB awareness raising sessions with staff.

Outcomes
Knowledge about TB was increased within the prison and the prison nursing staff gained in confidence in assessment and referral to the TB service. There was an increase of 52% of referrals of TB symptomatic patients during the project year.

Ten prisoners were identified as having latent TB. Of these, eight prisoners agreed to have treatment and were either being followed up at the prison, at another prison or in the community. One prisoner who was admitted to hospital following an accident after discharge from prison informed hospital staff of his positive test. He was isolated and was found to have active pulmonary TB which, without the QNI project test result, would have put a large number of patients and staff at risk.

The project lead was made a keyholder at the prison giving her very much easier access to respond quickly to referrals from prison staff and to undertake screening sessions.

The project lead has also developed a greater knowledge of the wide range of illegal substances used by prisoners and the potential impact of these on TB medication.

Dissemination
Information about the project has been disseminated to different service areas within the prison. Locally consultant staff with the TB service know about and are supportive of the project. Information has been disseminated to local hostels and other services for people experiencing homelessness. A presentation to the local TB Board was also planned but had been delayed due to the appointment of a new director of public health.

The project has also been disseminated through TB networks including a TB Summit Workshop for TB and Infection Control Prison Link Nurses organised by NHS England and PHE and the 2019 Qiagen TB conference. At the Qiagen conference the project lead presented the QNI poster, which was given an award. The project lead hopes to use the money from this award to fund healthy snacks that can be distributed during the screening sessions in the prison.

Continuation
The project is continuing with approximately five prisoners being screened each fortnight. The cost of this screening has been absorbed by the Trust, but discussions have not yet taken place with the CCG regarding ongoing testing. In November 2019 a health day was held at the prison where screening was offered, and every March on World TB Day screening will be offered in the prison.

Nationally, the TB leads in NHS England and PHE are aware of the project and it is anticipated that dissemination of the learning from the project will be taken forward by these bodies.

Facilitators
- Support from TB nursing team;
- Support from prison staff;
- Long standing prior relationship with the prison;
- Increased access to the prison;
- Phlebotomy skills of the support worker project lead;
- Reduced cost of the test provided by the Trust.

Barriers
- Rapid turnover in the prison population presenting follow up difficulties;
- The prison was in a 'state of crisis' during the project year (2018) resulting in a change of managing organisation;
- Refusal of the blood test by prisoners for a range of reasons including previous damage and scarring of blood vessels.

The QNI
The project leads gained a great deal from the workshop days which helped them feel they were not on their own and gave them information, for example on how to talk with service commissioners. In their report the leads comment that, 'The regular emails from QNI helped to keep the project on track'. They suggested that support from a mentor might be helpful as well as a template for an article as they have not been able to write up the project for publication. In their report they also make the observation: 'I believe a lot of nurses are not aware of the fantastic work that QNI are involved in'.

Key Messages: from the Project
- QNI project enabled the project lead to become a keyholder in the prison which has transformed her access and her work in the prison;
- Latent TB screening can be offered to at risk groups in prisons;
- Latent TB screening in prisons does identify people who have latent TB who then can be offered treatment, to prevent progression to active disease and thus prevent transmission to others.

Key Messages: from the Evaluation
- Having a stable project leadership team helped delivery of the project;
- Having a pre-existing relationship with the prison over may years facilitated delivery of the project;
- National links in specialist services facilitate dissemination of findings.

Recommendation
- This project shows that services which are not focused solely on the needs of people who are experiencing homelessness can have a significant impact on particular aspects of the health of this group.

References

- BBC News (2013) Birmingham Chest Clinic marks its 80th year. Available at: https://www.bbc.co.uk/news/uk-england-birmingham-21618365 (accessed 31.12.19).
- HM Chief Inspector of Prisons (2018) Report of an unannounced inspection HMP Birmingham. Available at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/12/HMP-Birmingham-Web-2018.pdf (accessed 18.2.20).
- NHS England (2015) Tuberculosis strategy for England 2015-2020. NHS England. Available at: https://www.england.nhs.uk/tuberculosis-strategy-for-england-2015-2020/. (accessed 31.12.19).
- Royal College of Nursing (2019) A Case Management Tool for TB Prevention, Care and Control in the UK. RCN, London. Available at: https://www.rcn.org.uk/professional-development/publications/pub-006194 (accessed 31.12.19).

> 'The project aimed to improve the health outcomes of a vulnerable population who often have a history of homelessness, drug or alcohol misuse and are a high risk group for developing TB disease following exposure, and often present late to services.

Leap Ahead, Nurse Led Drop-In, Darwen, Lancashire

Context
The Leap Ahead Project was delivered by nurses and a health care assistant who are part of Darwen Healthcare, a large primary care organisation in Darwen, Lancashire. Darwen Healthcare is a proactive training practice located in a modern health centre building. In 2019 the whole Darwen Healthcare Practice Team was awarded the GP Practice Team of the Year Award and the Nursing Team was awarded Practice Nursing Team of the Year Award in the General Practice Awards (https://darwenhealthcare.co.uk/). The Nursing Team won the award in recognition for '…their innovative and quality work, especially involving those patients with Frailty, Dementia, pre-diabetic, Stroke/TIA, Cervical, Bowel and Breast Screening and COPD'.

This project is the second of three QNI project awards that have been held by nurses in the Darwen Healthcare Team. The project was jointly led by Julia Mullaney, Advanced Nurse Practitioner and Ann Neville, Practice Business Manager. Julia has been qualified as an Advanced Nurse Practitioner for four years and prior to this worked in the community as a community matron and district nurse. She commented that she had no background in working with people experiencing homelessness. Ann Neville provided the budget management for the project.

Another member of the nursing team is a Queen's Nurse and she advised the team of the funding opportunity. At the same time Blackburn with Darwen Healthwatch had published a report in 2017 showing that many people in the area experiencing homelessness were having difficulties registering with GP practices. The report recommended

that practices adopt a standard process for registration and that they provide outreach to places frequented by people experiencing homelessness. (A further report was produced in 2019 revisiting the original recommendations: Healthwatch Blackburn with Darwen, 2019).

Project
Close to the health centre there is a 35 bed hostel which used to have an NHS health outreach team providing care in the hostel, but this had been discontinued. The project was therefore designed to deliver nurse-led care to residents in the local hostel.

What the Project Funding was used for
The funding was used for promotional materials, for locum cover for the project leads' time and for staff time to deliver and support sessions.

Aims of the Project
The project aimed to reduce inequalities and improve access to general practice for individuals at a local hostel and secondly 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.

Delivery of the Project
Within the hostel there is a clinical room and also a separate counselling room, providing suitable space for the project. The start of the project was delayed due to work needed to gain support from the practice for the sessions and difficulties releasing a staff member to deliver the sessions, due to staff sickness and other pressures. The nurse project lead commented that an advanced nurse practitioner was not needed to deliver the health sessions, so a health care assistant was allocated to deliver the sessions and posters were designed and put up in the hostel and in the health centre.
Initially, sessions were offered fortnightly on alternate Tuesday mornings at the hostel. However, uptake was very low, and it was decided, after the clinic had been running for a couple of months, in summer 2018 that it would be held in the afternoon instead. It was also decided that one of the Practice Nurses should run the sessions, taking a more proactive approach to engaging with the hostel residents. Following these changes, the attendance at the now nurse-led sessions improved. Uptake of the service was also affected by the very hot summer weather, which meant that residents were often out when the health sessions were held.

The Practice Nurse did not have any background in homeless health care, but she had previously worked as a prison nurse. She made the service more visible and went around the hostel knocking on doors to meet the residents and gave out leaflets with her picture on so that people would get to know her. The hostel staff also promoted the service to residents and information including emails, posters and business cards were sent to other service providers in the area so that they could inform people experiencing homelessness of the clinics. Members of the practice patient participation group were also involved in promoting the service.

The Practice Nurse commented that it was difficult to build up rapport and trust with the residents but that she did achieve success in this respect. She gave immunisations, undertook NHS Health Checks and signposted people to other services, as well as encouraging them to register with the practice or to register as a temporary patient if they were registered elsewhere.

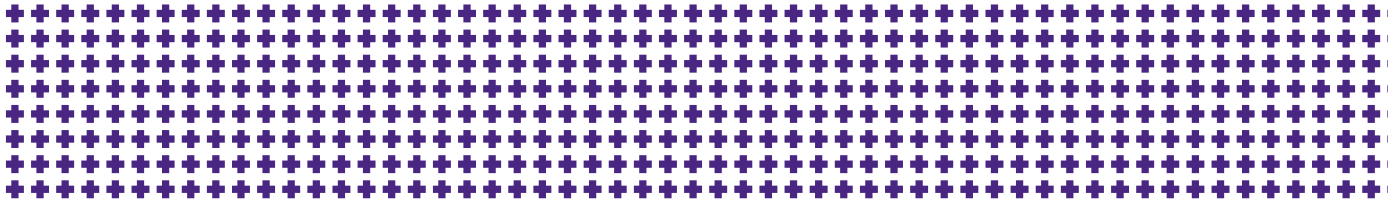
> ‘The project lead commented that the wider impact of the project had made a huge difference that continues beyond the end of the project. All staff in the practice are now more aware of what is on offer for people who are experiencing homelessness and are able to advise appropriately.

Measurement
A record of the numbers of people seen, and actions taken was kept in a paper log and also recorded on the patients' EMIS record. Patient satisfaction questionnaires were used as another means of measurement and were distributed but none were returned. During the summer months very often, no one attended the clinic.

Outcomes
The project was successful in delivering 11 NHS Health Checks, 31 flu vaccinations and a number of other vaccinations as well as preventing a fatality through the identification of a resident who was in renal failure. Staff at the hostel now encourage residents to register with the practice and in November 2019, 15 (almost 50%) of the hostel residents were registered with the practice. A flu vaccination clinic was also planned to be held at the hostel for winter 2019.

Dissemination
The project has been discussed with the local CCG and the local authority public health department.

Continuation
Although the Leap Ahead Project has not continued in its entirety, as a fortnightly session in the hostel, the project



lead commented that the wider impact of the project had made a huge difference that continues beyond the end of the project. All staff in the practice are now more aware of what is on offer for people who are experiencing homelessness and are able to advise appropriately.

The QNI Leap Ahead Project posters remain up in the health centre (see Appendix 5) and generate a lot of enquiries so that staff members are able to signpost/see patients and assess them following these enquiries. In addition, staff are doing a lot of work with the Department for Work and Pensions in the practice and this has resulted in numerous successful outcomes such as helping people back to work through something as simple as getting some funding for a pair of shoes, to helping patients get the benefits they are entitled to. Staff in the local hostel now encourage new residents to register with the practice so that they can be offered a full health check followed by any necessary treatment and referrals. An annual flu vaccination clinic to be held in the hostel is planned.

Some funding has been made available by the CCG to provide health screening, NHS Health Checks and other health interventions at a number of other centres in the district for people who are homeless.

Facilitators
- Support from the hostel staff for the project
- Suitable facilities in the hostel in which to hold clinics
- Skills of Practice Nurse in establishing trust of hostel residents.

Barriers
- Lack of preparation of the practice prior to commencement of the project
- Staff member who initially ran the clinics lacking skills in engaging residents
- Initially running clinics in the morning when residents were not ready to access them
- Running clinics on alternate weeks
- Lack of appreciation of the complexity of the lives and health needs of people who are homeless or resident in hostels.

The QNI
The nurse project lead and later the Practice Nurse attended the workshop days and gained a great deal of additional information and ideas from the days and networking with the other project leads.

Key Messages: from the Project
- Hostel residents will access preventive health services offered on hostel premises;
- Hostel residents will register with a local GP practice.

Key Messages: from the Evaluation
A period of preparation, for example, three months before the launch of the project might have helped this project to achieve more.

Recommendation

- Project leads should ideally have prior experience with the client group who are the focus of the project, or be part of a service with relevant knowledge and expertise.

Reference

- Healthwatch Blackburn with Darwen (2019) Revisit of the Homelessness & Vulnerable Reports Project 2018/19.

Available at:
http://www.healthwatchblackburnwithdarwen.co.uk/sites/default/files/uploads/revisit_of_homelessness_vulnerable_report_-_final.pdf (accessed 30.12.19).

> The project was successful in delivering 11 NHS Health Checks, 31 flu vaccinations and a number of other vaccinations as well as preventing a fatality through the identification of a resident who was in renal failure.

New Clothing for Rough Sleepers and Asylum Seekers, Homeless and Refugee Health Services, Croydon, London

Context
This project is delivered by members of the nurse-led Homeless Health Team who are employed by Croydon Health Services NHS Trust. The team is based at the Rainbow Health Centre providing primary care services for people experiencing homelessness and asylum seekers including those who are '…sleeping rough, accommodated in hostels, bed and breakfast accommodation, sofa surfers and asylum seekers in Initial Accommodation'. (https://www.croydonhealthservices.nhs.uk/search/service/homeless-health-196).

The Homeless Health Team includes a specialist health visitor, a specialist midwife, four nurses, an employed GP and administrator and they provide the following services:

- Diagnosis and treatment of Long Term Conditions including Asthma, COPD and Diabetes
- Childhood immunizations
- Men's Health Screening
- Women's Health Screening
- Minor illness treatment and management
- Minor injury treatment and management
- Wound Care/ Management

- Foot Care
- Smoking Cessation
- Referral into Alcohol and Substance misuse Support and Treatment Services.

The team is led by Paul Coleman, Consultant Nurse, who has an MSc in Advanced Practice and has been operational lead of the team since 2008 when local health services for people experiencing homelessness and asylum seekers were combined. He was appointed as a Consultant Nurse in Homeless and Refugee Health Services two years ago. He commented that they provide trauma-informed care as about 90% of the clients who access the service have experienced trauma in their lives, for example in childhood or as refugees, and that time is therefore needed to identify and then help the person with their wide range of needs.

The Homeless Health Team is a well-recognised team, for example, they won the Nursing Times Student Nurse Placement of the Year Award in 2015 as noted by Healthwatch Croydon: 'Healthwatch Croydon, through its engagement, has also recorded praise for this team, who continue to provide an essential frontline service, to a high standard.' (Healthwatch Croydon, 2016: 21).

The project lead was contacted by the Trust's Director of Nursing when the project funding was announced and initially it was planned that the specialist health visitor and midwife would lead the project. However, both went on maternity leave at the same time and Paul wrote the bid and became the project lead in addition to his other roles, which include teaching on advanced practice courses.

Project
Many people experiencing homelessness or asylum seekers have very few clothes and may only have the clothes that they are wearing. They may also have limited access to washing facilities to wash their clothes. The project bid was informed by experiences that the service had had that a number of clients had been seen suffering from scabies and other skin infestations. To help manage these conditions it was proposed that clients would be given new clothes as part of the health intervention to treat these conditions. People experiencing homelessness very often have access to second-hand clothing that has been donated by members of the public but, the project lead commented, this is often the wrong size, for example too large for clients who are often thin or underweight, or more suitable for older people than the average population experiencing homelessness. The provision of new clothes means that clients could have clothes that were the right size and contemporary as well as being clean.

'Many people experiencing homelessness or asylum seekers have very few clothes and may only have the clothes that they are wearing.

What the Project Funding was used for
The funding from the QNI paid for new clothes.

Aim of the Project
To ensure the timely treatment of scabies and infestations by improving access to new clothing provision and seamless transition for dermatological support for the complete treatment cycle.

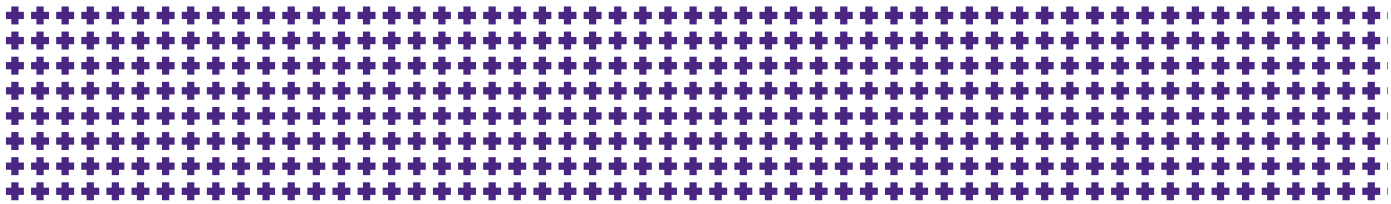
To treat people who are sleeping rough with skin or respiratory conditions (rashes and infections) by providing new underwear, socks and shoes, and other clothing, as part of the treatment, with the aim to measure and improve conditions more effectively than usual care.

Delivery of the Project
The project was based in the Crisis Centre which is in the centre of Croydon and therefore easy for people experiencing homelessness to access. At the Crisis Centre a wide range of support services, training and advice are provided in addition to health clinics run by members of the Homeless Health Team. The new clothing was stored in a cupboard in the Crisis Centre and distributed by the nurses seeing clients.

The delivery of the project faced a number of challenges including staff being off sick and the team diminished in numbers; challenges with transfer of funds from the QNI to the NHS Trust due to fraud legislation, and challenges around obtaining the new clothing from Marks & Spencer. With support from QNI, issues around transfer of funds to the NHS Trust were eventually resolved. It was initially hoped to set up an account between the Trust and Marks & Spencer but due to the small amount of money involved and NHS rules about new suppliers a voucher scheme was eventually put in place. Marks & Spencer issue vouchers which staff from the Homeless Health Team take to the local store and exchange for clothes as the stocks need replenishing.

The project was delayed in starting due to these difficulties and during the year of the project only a small number of clients were seen who fitted the criteria for new clothes and none with scabies. The reduction of the number of clients with scabies and other skin infections, which had been 20-30 per year prior to the project, is thought to be due to closure of the Calais Jungle refugee and migrant encampment in late 2016, as many of the people seen with scabies had come from this camp.

In addition to the expected physical health benefits of having new clothing, for example for a woman with a urinary tract infection or for people with inadequate



shoes, a key benefit of the clothes was on the psychosocial wellbeing of clients. Staff at Crisis commented about the positive impact of the clothes on the self-esteem and general wellbeing of clients. The project lead referred to Maslow's Hierarchy of Needs, commenting that clothing was an essential requirement such as food, to meet physiological needs, provide safety (protection and treatment of illness) and feelings of self-esteem. The provision of new clothing also acted as a pull factor bringing people who had not engaged before to see the Homeless Health Team, as they had heard about the new clothes.

Measurement
When the nurse provides someone with new clothes this is recoded manually on a record sheet. The date, client identification code, the health need for which the clothes are being provided and the clothes that have been given are recorded. These sheets provide the opportunity to audit the numbers of people, types of need, types of clothing etc. that the project has met. Cross reference to the clients' nursing records could also show if the clothing was effective in managing or preventing recurrence of the health condition.

Outcomes
The project report (2018) states that 10 clients had been given new clothes by the Homeless Health Team. The project has continued, and additional clients have benefitted. Unfortunately, due to staffing issues, the project lead has not been able to undertake an audit of the numbers of clients who have benefitted nor undertaken the proposed survey of the clients concerning preferred clothing.

Dissemination
Locally the project lead has promoted the project via Croydon Health Services NHS Trust weekly forum and through the wide range of stakeholders with whom they work, including Crisis, The Salvation Army, Evolve Housing, Croydon Reach, Migrant Helpline, the Junior Doctors Forum and others. The project lead has presented the QNI poster of the project at Kingston University where it generated a great deal of interest.

Nationally, the project lead presented the work at a QNI Homeless Health Network day in Newcastle. He has written a blog entitled Working with the Most Vulnerable in Croydon for the QNI website which provides information about the work of the Homeless Health Team and has a link to the web page giving details of the new clothing innovation project (https://www.qni.org.uk/2019/08/09/working-with-the-most-vulnerable-in-croydon/).

The project lead commented on the lack of time to undertake writing for publication and also the need for NHS Trust approval for publications by employees.

Continuation
The project has continued and has received additional funding of £5000 from NHS England. The project lead is committed to applying for additional funding as and when the clothing runs out.

Facilitators
- Skin infections, scabies and respiratory problems are identifiable needs;
- Provision of clothing for these needs (and not others) can be clearly conveyed to clients;
- Team administrator to undertake financial negotiations;
- Team support and enthusiasm e.g. when going to buy the clothes;
- Location of the service in Crisis provided a lockable cupboard and enabled referral of clients to the service;
- New clothing helped to pull clients into healthcare services.

Barriers
- Reduction in staff numbers and difficulty of recruiting new staff with the necessary; skills in working with people experiencing homelessness;
- More time and work required to deliver the project than anticipated;
- Financial systems in the NHS and in the clothing supplier;
- Additional work generated for finance and other departments in NHS Trust which needs to be recognised;
- Need for adequate storage.

The QNI

The project lead commented that the QNI provided, 'amazing support and training. In particular, some of the outside trainers offered new and inspirational ways of looking at or thinking differently about challenges.' (Project Report, 2018).

Key Messages: From the Project

- Unexpected benefit of the clothing on the mental health of clients. This suggests that new clothing could be considered as a health intervention for people who are homeless and have other health conditions.

Key Messages: From the Evaluation

- Need for consideration of how project money is managed between the QNI and NHS Trusts;
- Single project leads face greater challenges in managing time and other priorities
- Audit of outcome data could be undertaken by an external agent;
- Provision of new clothing is a potentially scalable intervention which may have as great an impact on mental health and wellbeing as on specific physical conditions.

Recommendation

- The project lead managed the project singly (due to the changes in the project leadership discussed above). He commented in the project report, 'The main challenge is how to deliver the project with constant competing demands and a huge workload. I would therefore advise identifying local support at the beginning of the project.'

- Identification of support/mentoring should be part of the application process and the role of this person clearly described by the QNI, for example, based on the mentoring model in the leadership development programmes.

Reference

- Healthwatch Croydon, (2016) Refugees and Asylum Seekers: A report by Healthwatch Croydon. Available at: https://www.healthwatchcroydon.co.uk/wp-content/uploads/2018/06/refugees_and_asylum_seekers_a_report_by_healthwatch_croydon-final.pdf) (accessed 26.12.19).

> 'A key benefit of the clothes was on the psychosocial wellbeing of clients. Staff at Crisis commented about the positive impact of the clothes on the self-esteem and general wellbeing of clients.

Self-Harm, Community Outreach Team, Weston-super-Mare, North Somerset

Context

This project is based in North Somerset Community Partnership, a social enterprise providing community services in North Somerset. The Community Outreach service provides: 'Support for homeless patients with a background of substance and/or alcohol misuse.' This nursing team provides the following services: General health advice; Dietary advice; Minor injury care; Advice on safer sex/drug use; Drugs/alcohol advice; Help registering with a GP and other health services in North Somerset. (https://www.nscphealth.co.uk/services/community-outreach).

The Community Outreach service was put in place following the closure of the local GP practice for people experiencing homelessness. The Community Outreach service is provided by two nurses in Weston-super-Mare: Kelly Smith and Rebekah Jeavons, both Community Matrons. Both have a wide range of nursing experience in hospital and community and both have been in the role for 4-5 years. The nurses have a base in the local council offices but spend each day running drop-in clinics in hostels, soup kitchens and other service centres in the town, where they see up to 30 people each day. They attend a weekly meeting with social workers, other services and street wardens to review people at high risk. They have little or no contact with any other nurses in the social enterprise but are part of a wider team of people working with people who are homeless including staff in social services, Addaction, street wardens, police and volunteers at the different centres, many of whom are their previous clients.

The community services were put out to tender in 2019 and the contract has been awarded to another provider who is taking over in April 2020. Similarly, a key service that the project leads worked with was out to tender at the time of the evaluation visit suggesting the turbulence surrounding the provision of health and social care services for staff and for people in marginal communities.

Project
Both the nurses are Queen's Nurses and they heard about the funding through the QNI emails they receive. They initially thought about doing a project concerning access to contraception but while they were thinking about the project a man experiencing homelessness came to see them with a self-inflicted wound covered with toilet paper. They advised him to go to hospital to have the wound cared for, but he came back to them on the following three days to have the wound dressed. Each time the wound was covered with toilet paper. On the third day they finally realised that he had nothing else to put on the wound. This led them to develop the bid to undertake the self-harm project.

In preparing the bid they were not able to locate any literature on self-harm in the population of people who are homeless in England. A study in Ireland found that people who were homeless were 30 times more likely to attend Emergency Departments having self-harmed compared to people with a fixed residence (Barrett et al., 2017). This study includes all forms of self-harm but also found that the odds of repetition of self-cutting were higher in people who were homeless. These findings suggest that the present project, which defined self-harm as cutting and burning that produced a wound, may be very important in testing out a means of supporting people at risk of this form of harm.

What the Project Funding was used for
The QNI funding paid for self-harm first aid kits and for marketing materials.

Aim of the Project
The project aimed to provide a regular self-harm support group, providing health education on reduction in self-harm and for first aid kits.

Delivery of the Project
The start of the project was affected by delays in the printing of posters and other materials, so initial publicity had to be done by word of mouth to service providers and people who were homeless. The project was also held up by delays in receiving the materials needed for the self-harm kits. Once these arrived, the project leads made up enough kits to start the project and then made up more later (see Appendix 5).

A simple room was provided for the group meetings in the premises of one of the local services where the nurses held a clinic. The project leads had gathered information from other sources including a charity that provided people with diaries and distraction tools such as loon bands. They obtained some of these resources to use in the group sessions.

In the event there was no take up of the group sessions, which was disappointing for the project leads, but the project continued providing one-to-one input for people identified as being at risk of self-harm, giving them the space to talk about self-harming and to be introduced to the self-harm first aid kit. The project leads comment in their report: 'We were able to look on our nursing records to see if any existing or new patients had any history of self-harm, either current or in the past. If it was appropriate we were able to talk to them on a one to one basis.' They also developed a referral form to be used by other services if they identified someone at risk of self-harm. Referrals were obtained from other services, but most provided verbal referral rather than using the form.

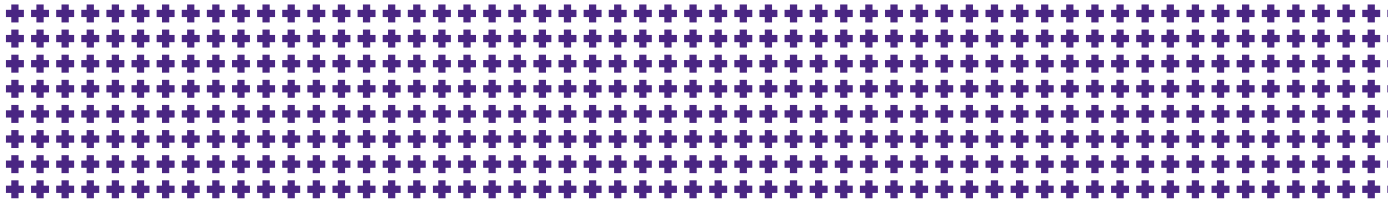
During the project, the project leads were approached by the Salvation Army hostel staff who requested training in use of the self-harm kits. The project leads were not able to provide this at the time, but they consider training for other services is something that could be explored.

Measurement
The number of people seen with whom self-harm was discussed and who were given a kit was recorded, with no patient identifiable information. This information was also recorded on their EMIS record. Approximately five people a month were recorded as having been given self-harm kits. Over nine months, this equates to approximately 45 people. They were also able to collect information on infections to wounds caused by self-harm and prescribing of antibiotics.

> 'Self-harm was discussed with people at risk of self-harm and kits were distributed on a one-to-one basis to approximately 45 people over the course of the project.

The project leads attended a monthly meeting at the local hospital at which high frequency attendees at the Emergency Department were discussed. These meetings showed that there had been a reduction in the number of people experiencing homelessness attending the Emergency Department. They comment in their report: 'Locally, we have reduced the number of visits to the emergency department that some patients would have made, either because they looked after their wounds themselves and then seen us, or because they reduced the amount of times they self-harmed.'

The project leads designed a patient feedback form, but most people did not want to complete it but rather gave verbal feedback. The project leads commented in their report: 'Many patients have felt better just by being able to talk about their self-harm and have benefitted from someone taking the time to listen. Many of these [people]



would only seek help in more severe situations for example, infection, and now they can see us before that stage. They are aware of the service we provide and they have the first aid kits that can be replenished.' A man I was introduced to during the evaluation visit said that he had been given a self-harm pack when he 'was in a bad place'. Now he was doing much better but 'it was good to have someone to talk to who listened and cared'.

Outcomes
Self-harm was discussed with people at risk of self-harm and kits were distributed on a one-to-one basis to approximately 45 people over the course of the project. The number of people attending the Emergency Department following self-harm was reduced, though precise figures are not available.

Verbal feedback from people given the packs showed that they valued having the chance to talk about their self-harm behaviour, in addition to being provided with the first aid kits. Service providers in the area were aware of the self-help kits and referred people to the project leads for this intervention.

Dissemination
The project has been widely disseminated locally at GP surgeries, in service centres used by people who are homeless, in the local hospital and the social enterprise. They also presented to Public Health about the project when there was an invasive streptococcal outbreak in the area.

Continuation
The project has been absorbed into the day-to-day work of the nurses. They have a stock of the packs with the other equipment that they use and supply to people experiencing homelessness at the different locations where they work. They expect to be able to order clinical materials for the packs in the same way they order other materials they need; if they need any additional materials they would seek funding from local charities or companies.

Facilitators
- Two project leads with expertise in working with people experiencing homelessness;
- Strong network between the project leads, other services and volunteers in the area;
- Established drop-in clinics.

Barriers
- Delay in starting the project due to delays in printing;
- Lack of uptake of the group sessions by people who are homeless.

The QNI
The project leads were very appreciative of the project team at QNI. They found the day that the project manager visited very helpful as he gave them different ideas and motivation to carry on with the project. They also appreciated the help given to them with the design of the posters, leaflets, etc.

Initially they were not clear that their travel and accommodation expenses for QNI workshops were paid for separately to the £5,000 award. This led them for example, to get the 5am National Express bus to London for the first workshop. They suggested that project leads could be provided with a list of accommodation in London. They also commented in their report that the application form looks very daunting.

The last workshop day was on writing the evaluation report and they commented that it was a relief to get this done. They would like another day on writing for publication.

The two project leads very often do not see each other for weeks due to their work in different places. They commented during the evaluation visit that an added benefit of the QNI award was that they got to see each other and work on the project together.

Key Messages: from the Project

- The delivery of the self-harm kits incorporates two activities: listening and talking to the person at risk of self-harm and explaining about the use of the first aid kit.

Key Messages: from the Evaluation

- Interviews with people who have participated in a session about self-harm and received or used the kits would provide their perspective on the value of this intervention;
- The QNI Workshop Days enable sharing of learning from the projects amongst the project leads and, in the case of this project, implementation of the self-harm kits in at least one of the other projects.

Recommendation

- To support wider dissemination of the process and findings of the projects, the evaluation report could be replaced with a paper for publication.

Reference

- Barrett, P., Griffin, E., Corcoran, P., O'Mahony, M. T. and Arensman, E. (2017) Self-harm among the homeless population in Ireland: a national registry-based study of incidence and associated factors, Journal of Affective Disorders, 229, pp. 523-531. doi: 10.1016/j.jad.2017.12.040 https://cora.ucc.ie/handle/10468/5234 (accessed 31.12.19)

> 'A man I was introduced to during the evaluation visit said that he had been given a self-harm pack when he 'was in a bad place'. Now he was doing much better but 'it was good to have someone to talk to who listened and cared'.

Touch Base, Community Viral Hepatitis Service, Brighton, East Sussex

Context

The Touch Base Project is similar to the Latent TB Screening and Awareness Project in that it was delivered as part of a specialist health service rather than as part of the work of a homeless health or primary care team. Hepatitis C (HCV) is a blood borne virus which causes few if any immediate symptoms, but which over 20 – 30 years or more causes cirrhosis of the liver in one in three people infected, some of whom will go on to develop liver failure or cancer of the liver (https://www.nhs.uk/conditions/hepatitis-c/).

Public Health England has a target to eliminate HCV as a major public health threat by 2030 in line with the WHO strategy (Public Health England, 2019). In England, this report estimates that '… around 113,000 people are chronically infected with hepatitis C (HCV), most of whom in the present day are drawn from marginalised and underserved groups in society' (PHE, 2019: 3). The level of HCV is four times higher in the population of people who are homeless compared to the rest of the population. HCV is treatable and curable over three months with oral drug treatment.

The project lead, Margaret O'Sullivan, is the Community Viral Hepatitis Nurse Specialist for the local hepatology service (https://www.bsuh.nhs.uk/services/hepatology/). She has worked in Brighton for the past six years and prior to this worked in community based hepatitis, substance misuse and addiction services and in research. She is co-author on a number of research publications (see for example Hashim, et al., 2018) and one of eight HCV Action Ambassadors across England (http://www.hcvaction.org.uk/hcv-action-ambassador-network).

Project
The project lead was told about the project funding by a colleague who is a district nurse and a Queen's Nurse. Prior to undertaking the project, the project lead was working with the substance misuse service but was therefore only reaching people who used that service to offer them testing for HCV. This meant that a large part of the vulnerable homeless population did not have access to screening. To extend screening to a wider population, discussions were held with the manager of a drop-in day centre in the town who was supportive of screening for HCV being introduced into the centre.

What the Project Funding was used for
The funding paid for the 300 screening kits used in the project.

Aim of the Project
The aim of the project was to increase testing, diagnosis and treatment of Hepatitis C in the vulnerable homeless population.

Delivery of the Project
Initial screening for HCV is undertaken by a saliva swab, which detects HCV antibodies indicating exposure to the virus, with the result available within 30 minutes. The project started by training staff in the day centre about HCV, how to raise awareness with clients, how it is tested, the disease progression, treatment and health benefits of treatment. Day centre staff started undertaking swabbing in April 2018 following the training period. When someone with a positive test is identified, staff made use of the referral pathway developed as part of the project. A person with a positive result is referred to the project lead and attends a clinic in the day centre where they have further blood tests and liver fibroscan. Initially staff were concerned about doing the test and having to give the result to the person tested, who might be distressed by the result. They were reassured that a positive result does not mean that the person is infected, but only that they have been exposed to the virus. The staff are able to give this information to people who agree to be tested.

> Around 113,000 people are chronically infected with hepatitis C (HCV), most of whom in the present day are drawn from marginalised and underserved groups in society.

At the day centre, most of the testing was undertaken by one staff member who left the centre later in the year while the project was ongoing. At the same time reorganisation was taking place in the day centre which was required to extend their services to provide a night shelter. These issues led to disruption of testing at this site.

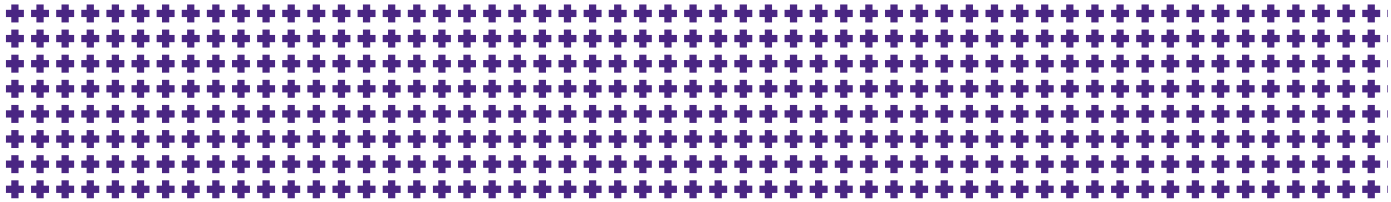
However, other services and hostels for people experiencing homelessness had expressed interest in the project by this time and the project lead decided to hold a community network meeting to which these people were invited. Each of the homeless services was asked to nominate a named member of staff to attend the meeting who would also bring with them a peer, who had ideally experienced HCV treatment and was willing to share their experiences. The meeting was attended by people from homeless hostels, street outreach teams, detoxification and rehabilitation units and the health promotion department. One outcome of the meeting was recruitment of an additional hostel and a detoxification/ rehabilitation unit who were keen to offer testing. Staff in these centres were trained and started screening towards the end of the project year (see Appendix 5).

In the hostel, one of the staff members had experienced HCV treatment some years previously and has been a very strong advocate for screening in the hostel particularly in light of the changes in the treatment regime, which mean that it has changed from an invasive infusion based treatment to a tablet based treatment involving taking one tablet a day. This change in treatment means that people are more willing to be screened. Hostel staff members work together to undertake screening, giving the results to residents and administering treatment. Hostel residents, one who had completed treatment and one currently on treatment, described the impact of the treatment on their feelings of wellness, an increase in their energy levels and that the abdominal pain they had been experiencing had disappeared.

Measurement
Hostel staff keep a record of residents, who has been tested, who has been referred to the project lead for further investigation and who is currently receiving treatment. The project lead kept records of all the people referred to her with a positive test and the outcomes of further screening.

Outcomes
Non-nursing/healthcare staff in the day centre and other settings were trained to carry out saliva swabs and to give the result of the swabs to people experiencing homelessness, demonstrating that frontline non-health staff were able and willing to undertake this testing. Through their involvement they also held many discussions with people who were homeless about HCV prevention, testing and treatment, increasing the knowledge in the community about this infection.

Seventy-six tests were carried out during the project year and 28 people were referred to the project lead. Of these, six people who were new cases of HCV were identified and they were followed up by specialist services, further



investigations and treatment. In addition, one person was found to be co-infected with hepatitis B and another to have HIV. In addition to the identification of new clients the project also resulted in people dropping in to see the project lead to discuss other health concerns and she was then able to refer them on to appropriate services.

The community network was established towards the end of the project year bringing together a wide range of services and people who have experienced HCV treatment and who are enthusiastic about supporting the identification and treatment of people with HCV. The network meets once a quarter.

The project lead sums up the achievements of the project in her report: 'In one year we now have a network of workers and peers which we didn't have last year. We have also been able to prove testing can be done by non-nurses and that you can and should treat people with HCV who are homeless. This is a great sense of professional achievement, as I truly believe that healthcare needs to be where the patient is. Personally, I begin this year [2019] with great hope and a sense of renewed energy knowing that I am not alone in pushing this agenda forward. I now have a community beside me.' During the evaluation visit the project lead stressed the importance of this community, 'her team', which she had developed during the project year.

Dissemination

The project has been widely disseminated locally and this has led to the setting up of the community network. Meetings have been held with local commissioners, HIV services, GPs, the homeless healthcare team and others. In a peer review of the overall hepatic service in Sussex the community work was highly commended.

More widely the project has been discussed with Public Health England and NHS England. The project lead has presented the project at a meeting of the Operational Delivery Networks for Hepatitis C Care for England. This project is seen as a prototype providing information on how staff in other Networks could engage more effectively with people experiencing homelessness. The project lead commented that the project has put Brighton 'ahead of the game' in terms of accessing 'the most marginalised and underserved' people (PHE, 2019). The project lead also presented the project at the 2019 National Liver Nurses Day at the British Association for the Study of the Liver (BASL) meeting (https://www.basl.org.uk/).

Continuation

The project has continued with the support of the wide community team that was established during the project. The aim is to achieve micro-elimination in each hostel, i.e. that HCV will be eliminated from each of the hostels through keeping records of each resident who has been screened, offered treatment and cleared of the virus. New residents will be screened at the time they move into the hostel to maintain the micro-elimination in that hostel. The continued use of this process, which was tested in the QNI Touch Base project, is illustrated in the description by the project lead in Box 3. Ongoing funding for the screening test kits has been agreed by the management of the local hospital.

Box 3: Applying learning from the QNI Touch Base Project in a Hostel

A micro-elimination strategy has been introduced in a large high support hostel for single people who are homeless in Brighton with multiple complex needs. HCV micro-elimination in this hostel was identified as a need, due to a re-infection with HCV by a client who was living there for over five years. It was decided that everyone's Blood Bourne Virus (BBV) screen needed to be checked to ensure it was up to date and to treat at once all those with HCV.

This was done by checking recent blood tests at the hospital and Substance Misuse Services (SMS) followed by the offer of tests using the oral swabs for those where there was lack of information. Since training the staff at the hostel to use oral swabs to test for HCV they have tested 16 people with the oral swab; three refused; four had had recent blood tests in hospital; 12 had Dried Blood spot testing done by the project lead or their SMS worker. This screening identified eight clients who had already been treated and nine clients who needed treatment for HCV.

A specific staff member took on the lead role as BBV champion and link person. This ensures that there is an identified person to speak with for staff and clients. This BBV champion lead will also ensure that the work is carried forward. All new clients booked into the hostel are offered an HCV oral test so that any new clients with HCV can be identified quickly.

A novel idea of secure medicine boxes came from the first site used in the QNI Project. Lockers were used at the

homeless day centre to store client's medication. In the present hostel, secure digital locked storage boxes have been sourced for the HCV medication. They are secured in the medical room and the pharmacist delivers the client's monthly supply. The clients are able to access their individual medicine box with a private secure code supporting ease of access to their medication. This reduces issues with home delivery and the need for clients to be in when medicine is delivered.
Clients in the hostel voiced how they felt the project, with services based in the hostel, was a great idea and supported the project for micro-elimination to reduce future risk.

Elsewhere in East Sussex, a colleague in another homeless service has started a pilot project based on this work. The project lead has also helped to introduce some of the methods used in this project across the whole county.

Facilitators
- Project leads' expertise in working with marginalised groups;
- Support of workers in local services;
- Funding from QNI for the test kits.

Barriers
- Disruption of testing due to reorganisation in the first site.

The QNI
The project provided the evidence to take to local commissioners and the project lead and others are now using this evidence to build expansion and dissemination of the methods used in the project. This project and the evidence it produced would not have happened without the QNI funding.

The project lead valued the workshop days which allowed her to talk about the project and '… not feel you are alone or that you are failing.' She commented in her report: 'Working on the project was/is difficult but it also gives me great happiness and the opportunity to work creatively and innovatively. The support was immense, thank you.'

> 'Working on the project was difficult but it also gave me great happiness and the opportunity to work creatively and innovatively. The support was immense, thank you.

And: 'Coming together with the other project candidates also inspired me and I always came away with renewed energy and focus.'

Key Messages: from the Project
- That non-nurse, front line staff in services for people experiencing homelessness can be trained to deliver HCV screening;
- That such screening does identify people with HCV who have not been identified before;
- That a wide range of services are keen to support the identification of people in this population with HCV.

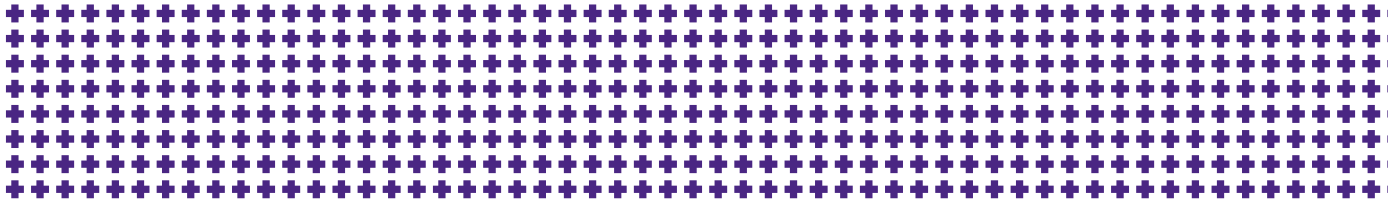
Key Messages: from the Evaluation
- Feedback from clients who have experienced treatment provides powerful testimony of the value of this case finding and treatment.

Recommendation
The project lead comments in her report on the value of having two people lead the project: 'I would strongly advise to have two people doing the project. That is one thing I am sorry I didn't do and in hindsight would definitely insist a colleague to be joint partners in the organisation and delivery.' She also suggested an additional workshop on writing the project report and, in particular, the sections on outcome indicators, would be helpful.

References

- Hashim, A., O'Sullivan, M., Williams, H., & Verma, S. (2018). Developing a community HCV service: Project ITTREAT (integrated community-based test – stage – TREAT) service for people who inject drugs. Primary Health Care Research & Development, 19(2), 110-120. doi:10.1017/S1463423617000731

- Public Health England (2019) Hepatitis C in England 2019. Working to eliminate hepatitis C as a major public health threat. PHE, London. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_da/ta/file/855064/HCV_in_England_2019.pdf (accessed 1.1.20).



Programme Recommendations

Reclassification of the projects as 'pilot projects': the projects tested out new or different ways of delivering health care to people experiencing homelessness. Refocusing the projects in this way would then lead to the collection of process/ implementation data on those factors which supported or inhibited the implementation of the projects, in addition to outcomes data. Learning regarding the process of implementation would be as valuable as outcome data in relation to scaling up the projects.

Project management: project applicants to be realistic about the amount of time involved in undertaking a particular project and to be supported with more project management training. Involving peer clients in project design is a challenge and project leads need support involving them in the project process and in measuring the process and outcome impact of projects on peers. Support from a mentor for each project lead would enable discussion of these types of issues and support around finding realistic solutions.

Scaling up the projects: a number of the projects have developed their own momentum and have been scaled up in their local area, for example, the HITPlus Project, Southwark and the Gypsy/Romany/Traveller Health Outreach Project, Surrey. However, these and other projects have the potential for scaling up at a regional or national level. For example, the Self-Harm Project, Weston-super-Mare, has tested the value of providing people at risk of self-harming with a basic kit to prevent infection and thus reduce distress to the individual and costs to NHS services. To achieve scaling up of the projects additional project management and financial resources would be needed.

Use of standardised data collection tools: the project leads developed different ways to record contacts and activities with clients, they searched for tools, for example, to measure wellbeing and found the collection and presentation of economic data very challenging. Support with data collection, service and economic evaluation methods would be of benefit to project leads. Provision of a pack of data collection tools and resources would enable sharing of data across the projects as well as reducing pressure on the project leads.

Inclusion of external evaluation into the projects from the start: as part of the projects, project leads were required to collect evidence of the impact of their projects and in their final reports to provide information on process factors which helped or impacted on their projects. Building in external evaluation from the start of the projects would help to identify the individual and shared learning regarding structure, process and outcome factors (see for example, The Health Foundation, 2015; NHS Improvement (no date)).

Dissemination of findings: the majority of the project leads have been involved in disseminating their projects in their local area, to commissioners, to other NHS and homeless services and to potential funders. However, few have undertaken any national dissemination. Additional support from a Programme Manager, a follow up workshop with guidance on a framework for writing, mentoring, for example from QNI Fellows (building on the mentoring programme for the leadership programmes) could help to support future dissemination. In addition, for future projects rather than having to produce an evaluation report the final report from the projects could be in the form of a paper for publication. Project Manager: appointment of a project manager who is dedicated to supporting the pilot projects, scaling up of projects and undertaking activities including, for example, identification with other stakeholders of homeless health priority areas; project planning support; provision of standardised data collection tools; networking of project leads with other organisations; location of additional funding for dissemination of resources developed in the pilots, etc.

References

- Aldridge, R (2019) Comment: Homelessness: a barometer of social justice. The Lancet Public Health. https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(19)30240-3.pdf (accessed 27.12.19)

- Bryar, R (2015) Rising Stars. Evaluation Report of The Queen's Nursing Institute's Fund for innovation and Leadership. Queen's Nursing Institute, London. https://www.qni.org.uk/resources/rising-stars-evaluation/ (accessed 26.12.19)

- Dorney-Smith, S, Schneller, K, Aboim, S, Radcliffe, M, Tanner, N, Ungpakorn, R, O'Brien, R & Hall, A (2019). Meeting the healthcare needs of people experiencing homelessness. Nursing Standard. 34 91): 27-34. doi10.7748/ns.2018.e11155 (accessed 27.12.19)

- Foresight Mental Capital and Wellbeing Project (2008) Final Project Report – Executive Summary. The Government Office for Science, London. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/292453/mental-capital-wellbeing-summary.pdf (accessed 27.12.19)

- Government Statistical Service (2018) Harmonisation of Definitions of Homelessness for UK Official Statistics: A Feasibility Report. Government Statistical Service. https://gss.civilservice.gov.uk/wp-content/uploads/2019/02/GSS-homelessness-report-1.pdf (accessed 27.12.19)

- Herens, M, Wagemakers, A, Vaandrager, L, van Ophem, J and Koelen, M (2016) Contexts, Mechanisms and Outcomes That Matter in Dutch Community-Based Physical Activity Programs Targeting Socially Vulnerable Groups. Evaluation and the Health Professions 40(3): 294-331 doi.org/10.1177/0163278716652940. (accessed 26.12.19)

- Local Government Association (2017) The Impact of Homelessness on Health. A Guide for Local Authorities. Local Government Association, London. https://www.local.gov.uk/impact-health-homelessness-guide-local-authorities. (accessed 1.1.20)

- NHS Improvement (no date) A model for measuring quality care. Online library of Quality, Service Improvement and Redesign Tools. ACT Academy. https://improvement.nhs.uk/documents/2135/measuring-quality-care-model.pdf (accessed 31.12.19)

- Pawson R, Tilley N (1997) Realistic Evaluation. London: Sage Publishing

- Public Health England (2018) Homelessness: applying All Our Health. https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health (accessed 1.1.20)

- Shaw, J., Gray, C.S., Baker, G.R. et al. (2018) Mechanisms, contexts and points of contention: operationalizing realist-informed research for complex health interventions. BMC Medical Research Methodology 18, article number: 178 https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/s12874-018-0641-4 (accessed 26.12.19)

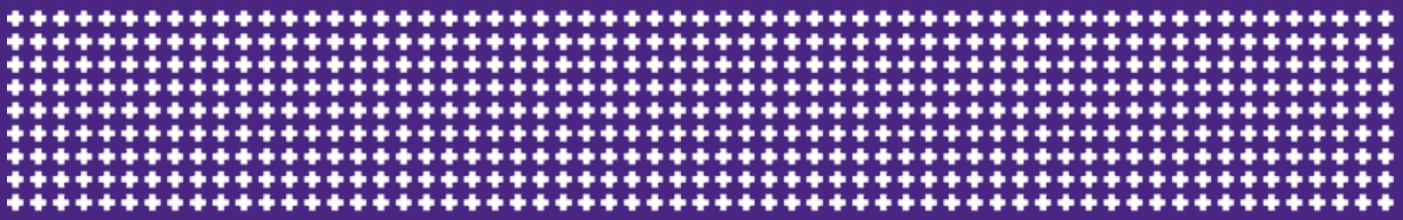
- The Health Foundation (2015) Evaluation: what to consider. The Health Foundation, London. https://www.health.org.uk/publications/evaluation-what-to-consider (accessed 19.1.20)

- The Queen's Nursing Institute (2018) Nurse-led Projects in the Community: For people experiencing homelessness. QNI, London. https://www.qni.org.uk/wp-content/uploads/2019/07/Homeless-Health-Innovation-Projects-2018.pdf (accessed 27.12.19)

- The RAMESES II Project (2017) What realists mean by context; or, Why nothing works everywhere or for everyone. https://www.ramesesproject.org/media/RAMESES_II_Context.pdf (accessed 26.12.19)

- Wong G, Westhorp G, Greenhalgh J, Manzano A, Jagosh J, Greenhalgh T. (2017) Quality and reporting standards, resources, training materials and information for realist evaluation: the RAMESES II project. National Institute for Health Research. Health Service Delivery Research 5(28). https://www.ncbi.nlm.nih.gov/books/NBK459059/ (accessed 26.12.19)

> Scaling up the projects: a number of the projects have developed their own momentum and have been scaled up in their local area.



The Queen's Nursing Institute
www.qni.org.uk
Charity number: 213128
Founded 1887
Patron, HM The Queen