Burdett Trust for Nursing

The Queen's Nursing Institute

The QNI and the Burdett Trust for Nursing:

20 years of improving patient care: 2002 - 2022

The Queen's Nursing Institute is a registered charity dedicated to improving nursing care for people in the home and community.

We promote excellent nursing care for everyone, where and when they need it, provided by nurses and their teams with specific skills and knowledge.

How do we do it?

- Through our national network of Queen's Nurses, who are committed to the highest standards of care and who lead and inspire others
- By funding nurses' own ideas to improve patient care,
- By publishing research into nursing practice, workforce and education, improving knowledge and standards
- By influencing government and policy makers, and campaigning for investment in high quality community nursing services
- By offering educational grants to enhance nurses' clinical knowledge
- By helping working and retired community nurses in times of financial need or life crisis
- By linking up working and retired nurses for regular telephone contact, with our Keep in Touch project
- By offering a free listening service for all nurses working in the community and social care.

Foreword from the Chief Executive

The Queen's Nursing Institute (QNI) is a national charity that supports nurses to deliver best nursing care to individuals, carers, families, and communities.

Nurse-led projects are one of the most direct ways in which the QNI helps nurses improve patient care. Since 1990 the QNI has supported over 300 innovative nurse-led projects across the whole range of community nursing specialties.

These projects have helped many thousands of patients and also assisted hundreds of nurses to realise their potential to implement innovation in practice. The projects improve care for individuals, families and carers directly and through sharing the learning, the nurses have advanced practice locally and regionally.

Sharing the results of these projects helps us to drive improvements in knowledge and practice. Often, these proof of concept projects become part of mainstream services, benefiting thousand more people in the community.

This year we are delighted to be celebrating 20 years of partnership with the Burdett Trust for Nursing, which has generously funded so many of the QNI's innovation projects.

On the following pages you can read summaries of ten projects that highlight the innovative care that community nurses have been able to implement thanks to this vital support.

Dr Crystal Oldman CBE, QNI Chief Executive

'These projects have helped many thousands of patients and also assisted hundreds of nurses to realise their potential to implement innovation in practice. The projects improve care for individuals, families and carers directly and through sharing the learning, the nurses have advanced practice locally and regionally.'
Dr Crystal Oldman CBE, QNI Chief Executive

Project title: Play Safe, Stay Safe

Project team: Samantha McNeely, Practice Nurse Manager, Nicola Inglesfield, Kate Wadsworth, Laura Poston-Lord, Practice Nurses and Diane Scholefield, Senior Healthcare Assistant, The University Health Centre, Huddersfield

Summary of project: Sexually transmitted infections in Huddersfield were found to be increasing, with reinfection rates for males at 10% (the national is 9.1%). The University Health Centre carried out an audit that revealed that males attending the in-house sexual health clinic were nearly two thirds lower than that of females. 'Play Safe, Stay Safe' was created to help try and improve the uptake of men accessing sexual health screening by providing a self-screening STI pack which was available to pick up from boxes in the student union of the university and the University Health Centre. The boxes were emptied each day and processed by the clinical staff at the health centre and sent to the local microbiology lab. Upon receipt of the individual's results they were either texted with a negative result message or invited into the clinic to be seen for follow up care and, where needed, treatment of any diagnosed infection.

Project aims:

- Bespoke sexual health service targeting the male population (registered and non registered students)
- To increase the number of male patients accessing screening
- To offer evidence based health promotion and advice

Outcomes:

- In 2016 only 255 male patients were screened for STIs within the Health Centre. Since the introduction of the packs, 668 male patients were screened
- 967 kits were completed and returned 578 female and 389 male) with 149 of these patients being unregistered with the health centre.
- 109 cases of chlamydia and 4 cases of gonorrhoea were diagnosed
- The University Health Centre worked collaboratively with the university to promote and support the project.
- STI screening was normalised and made accessible for all students.
- Increased uptake from students who were not registered with the Health Centre and those who were previous deemed 'unreachable'
- The project team was nominated and consequently won an award for the Sexual Health Team of the year for the GP awards 2017
- Samantha McNeely, the project lead won the Practice Nurse Innovator of the Year 2018.
- STI screening kits were created, one blue for men, one pink for women (these were pre-approved by the university's transgender population). Each kit contained: information sheet for patients details; instruction leaflet on how to do the test information about STIs; sign posting leaflet; 'Cover your Lover' token for a condom; pen and urine bottle/ swabs.
- Pick up and drop off points (post boxes for the completed kits) were posted in male and female toilets, around the student union and in the University Health Centre foyer.
- Posters were created and placed in appropriate locations.

Case study:

'James* was a 19 year old young male who was brought up in a very rural part of South Wales and had a very strict upbringing. He arrived at university and soon found himself out partying on most nights and had numerous one-night stands. He had been told about the drop-in sexual health clinic but didn't intend to attend as he was having a great time and could not possibly catch a sexually transmitted infection (STI) as he and his friends were invincible!

As part of a competition, he sent in an STI kit as the team that submitted the most kits, would win a prize. He submitted his pack and the next day his team received the prize. James' friends received texts saying their results were negative but instead, he received a phone call telling him he had tested positive for Chlamydia. James was very shocked by this. He was provided with treatment but could not remember the names of all sexual contacts that he had had to inform them so they could be treated, as there had been so many. James was embarrassed about this and was cross with himself. The nurse discussed the importance of safe sex and also discussed safe alcohol limits. He was advised to re-screen in 3 months to ensure he had a negative result. He would also have a follow up telephone call in two weeks to ensure his treatment went to plan.

Above: project poster

James decided he needed to act more responsibly when out with his friends and not have as many encounters whilst under the influence of alcohol. He had taken some condoms from the nurse and whilst he did not intend to stop having a good time, he had decided to be more responsible for his actions.'

> 'James was having a great time and believed he could not possibly catch a sexually transmitted infection as he and his friends were invincible!
>
> Project lead

Project title: Best Foot Forward

Project team: Claire Coleman, Nurse Practitioner, Bath

Summary of project: Poor foot care and subsequent health-related problems are particularly problematic for homeless people who are often leading chaotic lives. Neglect can cause sore and painful ulcers which can sometimes lead to foot loss. Service users can find maintaining appointments a challenge and often impossible due to their personal circumstances. The problems that homeless people present with can go beyond the knowledge and ability to treat of a GP practice but service users would not be eligible to use local NHS podiatry services. Service users lack access to facilities to carry out basic self-care such as soaking and washing their feet and changing their socks regularly.

Project aims:

- To provide high-quality foot care and improve the health of homeless men.
- To establish a one-to-one podiatry clinic once a month on a drop-in basis.
- To enable the purchase of socks and equipment such as nail clippers, foot products and files to promote
- self-management of foot care.

Outcomes:

- 32 homeless men were engaged and came to the sessions but also took care of their own foot health.
- Some of the most marginalised members of the population attended on a regular basis.
- The foot care of all who attended was improved and one client's foot possibly saved.
- While service users were having their feet attended to, they would often open up about other health issues.
- 2 years after the project began, the project lead extended it to women experiencing homelessness too

Case study:

John* was a 42 year old man who had lived a transient lifestyle for most of his adult life having spent all his childhood in foster care where he had experienced frequent abuse. He alternated between rough sleeping and prison after leaving the care system.

John was unable to care for himself properly because of physical disabilities due to excessive alcohol use but also frequent falls and physical assaults, which resulted in head injuries. When I first met him he was struggling to hold objects and was using an old bicycle as a frame to walk with. He was unkempt and often urinated in his clothes as he was unable to open his trousers in time. He had developed leg ulcers and had frequent bouts of trench foot. His feet were in an extremely poor condition.

It took a lot of persuasion to get John to come to the foot clinic. He was very embarrassed not only about his feet but about his appearance and his inability to care for himself. We took the opportunity to change his clothes and spruce him up which increased his confidence. John was often very low at the start of a session but usually left laughing and joking. He used to say that he couldn't believe we would want to help someone like him, especially considering the state of his feet. Throughout the duration of the project, John was a sporadic attender, however his leg ulcers cleared up and his feet improved. He recommended the clinic to other service users frequently.

Above: project poster

Sadly John passed away a few days before his 43rd birthday. John did not have a particularly happy childhood or adult life. He had had few positive experiences of dealing with healthcare professionals. However during the last few months of his life we were able to demonstrate to him that he was cared for and valued.'

> ' John did not have a particularly happy childhood or adult life. However during the last few months of his life, we were able to demonstrate to him that he was cared for and valued.
>
> Project lead

Project title: Water for Wellbeing - Improving Hydration in Older People

Project lead: Carolyn Lindsay, Specialist Health Visitor Injury Prevention, Solihull Borough

Location: Solihull, England

Summary of project:

Guidance recommends that adults aged 51+ drink at least 1.5 to 2.5 litres (2.5 - 4 pints) a day including at least 4 glasses of water. It is estimated that many older people do not drink anywhere near this amount. Adverse effects of dehydration include: dizziness, headaches, constipation, confusion, increased risk of urinary tract infections, poor skin tissue viability and healing, low blood pressure or Postural Hypotension which may lead to falls.

Project aims:

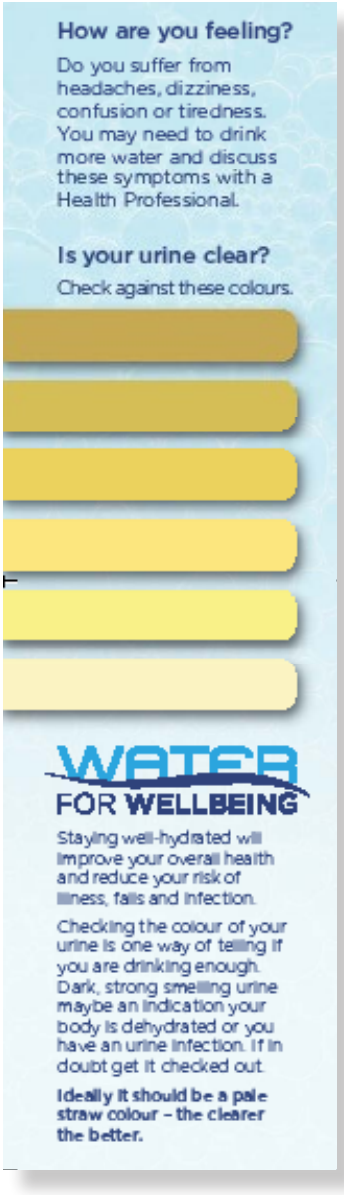
- to support and encourage older people to increase their fluid intake. Improving hydration in older people would improve their general health and reduce the risk of falls.
- to raise awareness of the health benefits of drinking more fluids especially water.
- to work with Age UK Solihull to raise awareness and assess the benefits of improved hydration.

Outcomes:

- All targeted groups reported an increase in the amount of water they drank and a reduction in caffeinated drinks.
- One group reported an increase in the amount of water they drank: 67% had reduced the amount of caffeinated drinks consumed.
- In another group 69% were drinking more water: 45% had increased by two glasses of water a day and 22% had increased by up to four glasses a day.
- Other groups reported other health benefits e.g. sleeping better, better appetite, less constipated and smoother, clearer skin, 'clearer head', more energy and feeling less tired.

Resources

- 'Water for wellbeing' information booklet
- Water bottle
- Bookmark containing different yellow colour bands tool to check urine concentration as an indicator of hydration status



Above: client group; right: project resources

> ‘I didn’t know tea and coffee contained caffeine or how it affects the body; I didn’t realise how important water and fluids are for good health. I will tell my friends and family what I have learnt and spread the word.
>
> Client feedback

Project title: Managing an Unsafe Swallow

Project lead: Gerard Wainwright, Registered Manager, West Yorkshire

Summary of project:

The project is designed for people who have an unsafe swallow or staff who support people with an unsafe swallow and as a result are at risk of developing aspiration pneumonia. The focus is on clearly communicating how best to reduce the risks and what action to take if the risks occur.

Project aims:

- To have a dedicated campaign aimed at clients and frontline staff in St Anne's Community Services
- To increase the understanding of what an unsafe swallow is and how it can increase the risk of developing aspiration pneumonia
- To improve the knowledge of staff supporting people who have a Learning Disability and an unsafe swallow and provide accessible resources to enable them to reduce risks which could lead to developing aspiration pneumonia.
- To recognise the signs and symptoms of aspiration pneumonia and take prompt action if they occur
- To include people with a Learning Disability in the planning, delivery and review of the project.

Outcomes:

- Since the project began, following a delay due to the onset of the covid pandemic and the subsequent impact on all our working and personal lives, there were undoubtedly positive benefits to adopting remote ways of working. This has provided an opportunity to reach a wider number of people, which can be demonstrated in the views to date of the introductory video to the unsafe swallow project https://youtu.be/q_efMcAdRLY
- In 2021 this stands at 971 views, in addition it has been shown to webinar and Zoom groups of 25 people on occasion so the number of people who have seen the video, completed the training, and are subsequently aware of the project, is significantly in excess of this number and gives an indication of its reach.
- Six videos were created (developed from the webinars):
  - Video 1 - Health Inequalities https://youtu.be/2DC7JC6WZd4
  - Video 2 – What is an Unsafe Swallow https://youtu.be/AN5MQmR8PvE
  - Video 3 – Signs to Look Out For https://youtu.be/iYJFNyVC2tQ
  - Video 4 – How to Manage an Unsafe Swallow https://youtu.be/PLGUu5OkHH4
  - Video 5 – Modified Diets https://youtu.be/ShIP3NsIqWU
  - Video 6 – Aspiration risks when PEG fed https://youtu.be/VV7F-nUAwTY

Above: Gerard Wainwright with a patient

‘ On a personal note, the project has been an incredible development opportunity. It’s provided a focus during the more challenging times of the pandemic, given me hope and optimism and something to strive towards. It’s made me realise that health promotion is the aspect of my work I feel most enthused about, and after twenty eight years of working for the same organisation I was successful in gaining a post with the NHS as an Advanced Nurse Practitioner for People with Learning Disabilities – the first of its kind in the region.
Project lead

Project title: AHEAD Project

Project lead: Debbie Yates, Advanced Nurse Practitioner, Darwen

Summary of project: Darwen Healthcare is located in the town of Darwen in East Lancashire and holds a current practice list size of 12,479 of which 6216 are male. Darwen is a fairly deprived area with a high level of patients who have multiple long term conditions. An audit completed in 2016/2017 confirmed that there was a higher uptake of female patients attending NHS Health Checks (52%) when invited, than male patients (37%). The Ahead project aimed to improve the uptake of men attending NHS Health Checks, respiratory, cardiovascular, and diabetes chronic disease reviews in General Practice.

Project aims:

- To increase uptake of NHS health checks in 40-65 year olds
- To improve screenings of suspected COPD
- To actively screen patients for Pre-diabetes and improve diabetic control

Outcomes:

- 60.9% attendance for NHS Health Checks
- 407 male patients attended their NHS health check (compared to 158 the year before)
- Pre-diabetic register has increased from initial 85 patients three years ago to 631 patients
- 118 males were screened for COPD (compared to 60 the year before)
- 10 patients confirmed with new diagnosis of COPD
- Project selected as finalist in the Burdett Nursing Awards 2018 - Men's Health (and won £2500 for the project as a result).

Case study:

Hamid* was a 64 year old man who was diagnosed with asthma in his teenage years. As his asthma didn't trouble him he had not attended his annual reviews for the last three years. Due to his age he was also invited for an NHS Health check and came up on our AHEAD project audit as a man who had not attended previous invitations. He believed he was healthy and fit as he attended the gym three times a week and had never smoked and had no family history of heart disease therefore felt he didn't need a health check.

At his asthma review he mentioned to the practice nurse that he was feeling his age as he couldn't do what he used to in the gym. The practice nurse wondered if his asthma medication needed reviewing so referred him to the advanced nurse practitioner. On listening to his description of how his blue inhaler didn't help his chest discomfort, I felt that his symptoms were more suggestive of a cardiac cause, even though he had never smoked and didn't have any family history of cardiac disease. I referred him to the rapid access chest pain clinic. He was very shocked at this presumption of a cardiac cause.

He returned to see our Healthcare Assistant (HCA) the following week and stated that he had been listed for an urgent triple heart bypass. He spoke with the HCA about his shock and misunderstanding of his symptoms and how he just thought his asthma was 'playing up' and he was getting old. He said that had he not attended for his review then it was highly likely that he would have had a heart attack at any time or even died. He asked the HCA to let me know that the AHEAD project had saved his life and he was so grateful for the review

Above: Project team with Anne Pearson, former Director of Nursing Programmes

> 'Mike had just thought his asthma was 'playing up' and he was getting old. He actually required a triple bypass. He said that if he had not attended his review then it was highly likely that he would have had a heart attack at any time or even died. He asked the HCA to let me know that I had saved his life and he was so grateful for the review.
>
> Project lead

Project title: From Enteral to Oral

Project lead: Sara Logan, Shropshire

Summary of project: Enteral feeding or tube feeding is often necessary to ensure adequate nutrition in sick infants and children. Weaning a child off enteral feeding can be difficult as many will have developed feeding problems. At the time in Shropshire no care pathway existed.

Project aims:

- to develop a care pathway to re-introduce oral feeding to enterally fed children.

Outcomes:

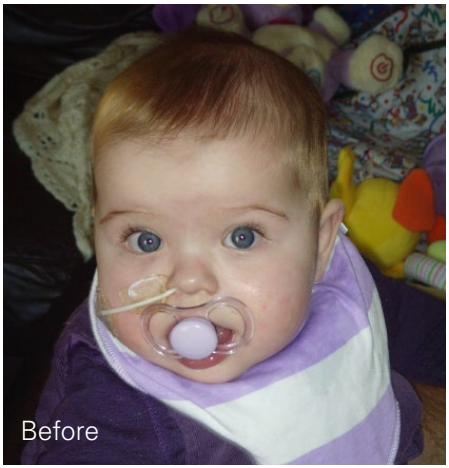
- Screening tool and care pathway developed.
- Four children have successfully returned to being completely orally fed and feeding devices have been permanently removed.
- Four remaining children have significantly reduced their need for enteral feeding.
- Feeding team now well established and is improving multi-disciplinary working.
- Families reported feeling better supported through the process of weaning.

Resources:

- Parental information literature
- Screening tool and pathway developed.

Case study: Lucy was 16 months old at the start of the programme and unable to take any food or drink orally. She was receiving five feeds per day given via a gastrostomy device. Her mother was trying to offer her juice but she was refusing to take anything orally. The first feed was reduced by half and replaced with the same volume of water. This was to ensure that she remained hydrated whilst allowing her to become hungrier for her tea time meal. Over the next few months Lucy's feeds were gradually reduced and her weight very carefully monitored. She started to take small amounts of food and found that she loved garden peas! After 6 months she was taking juice from a cup and was beginning to ask for food, something her parents hadn't dared hope she would ever do.

At the end of the project year, Lucy is eating well on most days. She loves to share a bit of pizza with her brother. She still needs two half feeds per day to keep her weight up but she has made amazing progress. For Lucy and her family, the biggest bonus has been to venture out as a family without the ties of a 4 hourly pump feeding schedule. Lucy's parents involvement in her weaning programme was vital. They reported how supported they felt during the programme and how the liaison with the feeding team helped them.



Above: patient

> ‘ The plan worked so well and fitted into family life. The team have been invaluable. My child no longer has a tube.
>
> Patient's parent

Project title: Tai Chi for Increased Wellbeing

Project lead: Naomi Purdie, Lead Nurse Practitioner, Older People's Team, Wiltshire

Summary of project: Poor mental health and falls are two of the major morbidities in frail elderly. This project was looking at improving the well-being of people living with frailty by attending weekly Tai Chi classes over 10 months. As part of this project, I was also looking to reduce falls and improve balance. We explained that people can participate either standing or seated, so as not to exclude anyone. The participants were assessed for falls risk and balance by having timed get up and go (TGUG), Timed unsupported stand (TUSS), and functional reach tests before starting the classes, at 5 months and again at 10 months. Their well-being was measured using the Warwick-Edinburgh Mental Wellbeing Scale. I chose 2 care homes for this project, group one had moderate or severe frailty due to physical limitations, and group 2 had moderate or severe frailty depending on their degree of dementia.

Project aims:

- Show increased 'functional reach' and reduced 'get up and go' time following a 3 month weekly hour long Tai Chi classes, and improved FEV1 for COPD and peak flow for Asthma patients.
- Demonstrate increased wellbeing through changed wellbeing scores after 3 months of weekly hour long Tai Chi classes.
- Participant satisfaction and enjoyment questionnaire OR demonstrate an actual falls reduction if recruitment and study group big enough.

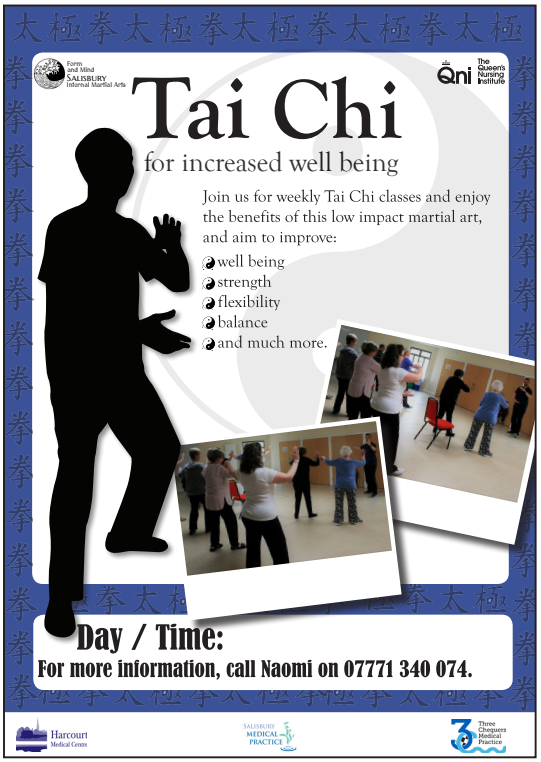
Outcomes:

- Primary outcome was to have an improvement in overall wellbeing and improved wellbeing scores at the end of the project, and for this I used the Warwick-Edinburgh Mental Wellbeing Scale.
- Secondary outcome was to improve balance and reduce falls risk.
- For dynamic balance, I measured the mean TGUG which measures how many seconds it takes for the participant to stand and walk 3 meters, turn and sit back down.
- For functional balance, I measured the mean TUSS, for this test the person stands unsupported for as long as they can for up to 60 seconds. The timing stops when they place their hand on the table or until they have stood steadily for 60 seconds.
- In addition, I used the functional reach test, which is a simple test of balance that can be used to identify people who may be at risk for falling while reaching.
- This experience was started with a bit of apprehension; however, I am so glad I pursued it, and I have enjoyed every minute of working with the QNI. It has not only changed the lives of my participants but has changed my whole outlook on how we manage frailty.

Case study

Ella is an 84-year-old lady who was feeling low about recently making the difficult decision to leave her own home and move into a residential care home. Ella had been diagnosed recently with early onset Alzheimer's, and wanted to be able to make the decisions regarding her health while she was still able. Currently, she was mildly to moderately frail. Ella was keen to take part in the Tai Chi classes as it was an activity that she had tried before and enjoyed. Unfortunately, before the project was underway Ella had a fall and fractured her hip. She was admitted to hospital for surgery and came back to the care home a different person. Her energy and spark had disappeared. She was physically frailer and was classified as severely frail as she needed more help. She had lost her confidence and did not want to participate in any activity.

We had lots of confidence building discussions and with the support of the activity coordinators Ella came along to the Tai Chi classes in her wheelchair. We explained that people can participate either standing or seated, so as not to exclude anyone. There were times that her mood dipped and she felt that she couldn't face the Tai Chi class. More often than not, with the encouragement from the activity coordinators and the welcome from the group, she would come down and join in, and enjoy it. Ella said that she was starting to feel part of a small community and began to look forward to the weekly classes.



Above: project poster

Ella has had no further falls throughout the year and has progressed from transferring only, to mobilizing with a Zimmer frame independently. One of the main aims of this project was to look at improving well-being and promote inclusion. On the final assessment her wellbeing score was 59 which on this scale is considered above average.

Ella said she enjoys being part of a group, and she has made friendships with people. Ella says she has a sense of worth and she has been made the lead voice for the group to help the Tai Chi classes continue after the funding has ended. Ella said that she feels like she has more energy, and that she is starting to feel like a person again. She was recently re assessed for her frailty and is now considered moderately frail instead of severely frail. The best part for me has been seeing her interacting and happier. On one conversation she said something to me that I did not understand, so I asked her what she had said. She laughed at me and said that she has spoken in Swahili and said, 'You won't understand this!!' Her sense of humour had certainly returned.

> ' Ella said she feels like she has more energy and that she is starting to feel like a person again.
>
> Project lead

Project title: Improved nutrition and hydration in a residential care home

Project lead: Julie Eldridge, Advanced Nurse Practitioner and Lola Soloye, Senior Specialist Nurse Practitioner/ Practice Educator, London.

Summary of project: Fewer people in Tower Hamlets consumed the recommended level of fruit and vegetables (12%) compared with the national average (30%). For the over 65s in Tower Hamlets it drops to 10% so there is a need in our borough to promote healthy eating. Malnutrition in the UK affects more than 3 million people per year. If care home residents become unwell they can become frailer. Frailty is not static. It can fluctuate like other long term conditions. Our project aims to prevent the progression of frailty by using proactive methods rather than reactive methods such as antibiotic prescribing.

Project aims:

- This project aimed to improve the health of residents in a care home. The residents have dementia and other long term conditions and are at risk of malnutrition. This increases their risk of falls, delirium and hospital admission.
- The aim was to reduce malnutrition by using social prescribing methods enabling the residents to enjoy a healthier, happier life. The project aimed to encourage a dementia friendly approach to food and hydration.

Outcomes:

The CQC recognised the project work in their report; seeing the residents become more active – gardening, playing the hydration game, clapping their hands when the drinks trolley arrives; no longer prescribing unnecessary nutritional supplements and making financial savings; the care home tweeted their new hydration station; the practice recognised the project achievements by rewarding the two project leads with employees of the month; there is an interest from the CCG to use the training package on nutrition and hydration for residential care homes in the borough.

Case study:

Daisy was a 93 year old lady who has lived in the residential care home for over 7 years. She would not leave her bedroom to socialise with others. She explained because she was deaf she could not hear others easily. She also mentioned that the light is very bright in the communal areas which hurts her eyes. She also had been prescribed multiple antibiotics for urinary tract symptoms. Her daughter visited on a weekly basis and was very active in her care.

We launched our project with a coffee morning. We invited all the residents and their families as well as the care workers. We had some fun activities including demonstration about how much water the residents were drinking and sampling of home-made shakes and ice creams. We also had leaflets to launch our project which explained that not drinking enough fluids could results in a deterioration of health. Daisy's daughter was very interested in this and enjoyed the coffee morning (although Daisy did not feel she wanted to attend as she would have to come out of her room).

By using our contacts with other health care professionals we asked our Occupational Therapist if she had any ideas to encourage Daisy out of her room. After an assessment she was provided with some dark glasses to help with the bright lights. Daisy slowly came down to the day room and has made friends with 2 other ladies and she now feels safe. Our extra drinks trolley round where a bell is rung alerts Daisy to the fact that a drink is on the way (as she cannot see) and she now drinks much more than she did.

The care workers reported that Daisy now sits in the common room with the rest of the residents. She is now drinking with the rest of the residents. She is easier to monitor in the communal areas. Daisy still goes back to her room in the afternoons if she wants too to watch TV etc. She has made friends with another resident and they always sit together. Daisy reported that it is difficult to join in with activities because she cannot see properly or hear but the bright lights are now much better with her new sunglasses.

Above: project poster, leaflet and nutrition buddy pin badge

> ‘Some staff were involved in a ‘nutrition buddies’ training programme, which helped to raise their understanding and awareness about the support people needed. We observed a number of positive interactions with people being supported and encouraged at mealtimes, and with other choices being offered if people said they were not hungry’.
>
> Project lead

Project title: The Lightbulb Course

Project team: Cassandra McLaughlin, Clinical Nurse Specialist - Military Mental Health, Joanna Wise, Counselling Psychologist, Leon Culloty, Assistant Psychologist, London

Summary of project: There are 2.5 million veterans in the UK and approximately 4% have Post Traumatic Stress Disorder (PTSD) (MHF, 2016) which suggests that 100,000 veterans in the UK may have some form of PTSD at any one time. It is well known that many men are resistant to seeking out, or engaging in, the standard evidence-based psychological treatments – or 'talking therapies' - recommended for mental health problems. Veterans in particular are likely to experience a variety of barriers preventing them from accessing mental health services. Coming from a 'macho' Armed Forces culture, many veterans with mental health problems often report feeling ashamed of their 'invisible injuries'. This project aims to encourage veterans to attend a first course of treatment and become known to services.

Project aims:

- To provide male veterans diagnosed with PTSD with a new format for psycho-education and skills training to help them to better understand and manage common symptoms of PTSD, encourage them to develop strategies to overcome the avoidance that typically maintains trauma symptoms through gradated exposure, alongside learning and practicing tools to regulate nervous system arousal.

Outcomes:

- 20 veterans in total have completed the course
- Four groups have been run in the past year with many more planned
- Feedback from veterans has been positive
- PTSD symptoms have decreased
- Scores on understanding of PTSD increased
- Scores on being able to cope with PTSD symptoms increased
- Two new facilitators have been trained in the delivery of the project
- Plans are now being made to run groups and train facilitators across South East England in Surrey, East Sussex, West Sussex and Kent
- Newly designed posters and business cards will also be distributed to a host of veterans' charities and mental health services in order to ensure an adequate degree of public awareness for the project among relevant services.

Case study:

Henry presented with a diagnosis of PTSD from the military due to traumatic experience in Iraq and Afghanistan. His primary symptoms included intrusive memories, flashbacks and hypervigilance; within the context of transitioning from the military to the civilian world since his recent medical discharge. Though Henry had undergone some traumatic therapy work during his time in the military, he found the experience of talking about his traumas very difficult and found it hard to fully engage and cope.

Session one involved Henry and the other clients introducing themselves to one another and anonymously sharing some of their symptoms on post-it notes. This simple task began the theme of normalisation that Henry and his fellow group members were all going through the same experiences rather than suffering alone. Throughout the course this would develop into a sense of camaraderie that allowed clients to open up about their struggles and how they try to cope. A topic Henry found of particular significance was the importance of sleep and what role this plays in helping us to clear our minds of the stresses of the previous day. Henry learned more about what factors help to maintain PTSD, namely thoughts and behaviours that attempt to avoid engaging with the initial trauma. Of all the modules within the light bulb course, Henry stated that this one had the biggest impact as it provided him with the motivation to really engage with how he thinks and to reassess his approach not just to the traumatic experience, but also to his life in general, thus giving him some psychological tools to deal not only with his PTSD but also his transition to civilian life.

After a review session that occurred two weeks after the end of session five, Henry completed the Light bulb course and provided feedback on how he felt it went and how it benefitted him. In particular he says that he wishes this level of intervention could've been given to him during his discharge proves from the military. He also said he wished the course was provided to him before his trauma therapy in the military as it has allowed him to understand the wider context of trauma and the role that therapy plays in helping to manage symptoms.

Henry went on the engage with a counselling psychologist within the TILS for one-to-one therapy to extend and consolidate what he had learned during the light bulb course. It is felt that now Henry has had an extended course of symptoms management and psycho-education; he shall be able to better engage and make full use of traumatic therapy this time around. Henry stated that these interventions have allowed him to 'feel steady and ready' to engage more fully in the future.

Above: project poster and business card

> 'Henry said that these interventions have allowed him to 'feel steady and ready' to engage more fully in the future.
> Project lead

Project title: Health Inclusion Team (HIT) Plus

Project team: Kendra Schneller, Serina Aboim, Nurse Practitioners, London

Summary of project: There is currently a cohort of clients experiencing homelessness who are unable to access day centre services due to the restrictions in place with regards to substance/alcohol use. Therefore these clients are not seeking advice regarding their health. This will have an impact on hospital services as the clients are more likely to present to A+E in a state of crisis. The project is also needed to help reduce the burden and costs to the NHS as a whole, by providing specific primary care advice and services, reducing A&E attendances. It also helps with GP identification and proof of address issues, targeting a cohort of rough sleepers who do not access day centres for individual reasons and to respond to issues related to public health concerns.

Project aims:

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

Outcomes:

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

Case study:

Max was a 39 year old Romanian who was sleeping rough. He had been in the UK for 10 months and had recently came to London from Leeds. He had a history of alcohol dependence, depression and anxiety and only used A+E/acute care services for health concerns. He was apprehensive to use primary care services as he was worried about potential charging for health care. He suffered from bouts of depression and anxiety - and would drink to relieve these symptoms - and 'forget' about physical health. English was not his first language. He was unsure what services he could access or whether he could register with a GP.

We gave him self/care management advice about personal hygiene and hand washing and referred him to GP services

- for continuation of medications. We referred him to day centre services - for continuation of nurse input regarding his blood pressure and vaccinations. A prescription was written for thiamine and provision of multivitamins via protocol. Health education was also given - diet, exercise, alcohol, drugs, sexual health and general lifestyle. A full health assessment was undertaken - BBV screen (blood samples including liver, kidney, lipid and glucose screen), TB screen (verbal questioning).

He successful registered with a GP, started taking his prescribed medications and was vaccinated against influenza. He was also entered into emergency cold weather accommodation.

Unfortunately Max was lost to follow up. He was accommodated in 'Routes Home' which is an organisation that helps to re-connect people. Despite this, this case study shows how important the HITPlus service is, through its targeted impact and even if the client does not go on to do any of the advice suggested, they are made aware of what services are available to them despite their circumstances. It shows how needed street outreach nursing is.

Above: Kendra and Serina

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

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