Working in partnership

Department of Health & Social Care

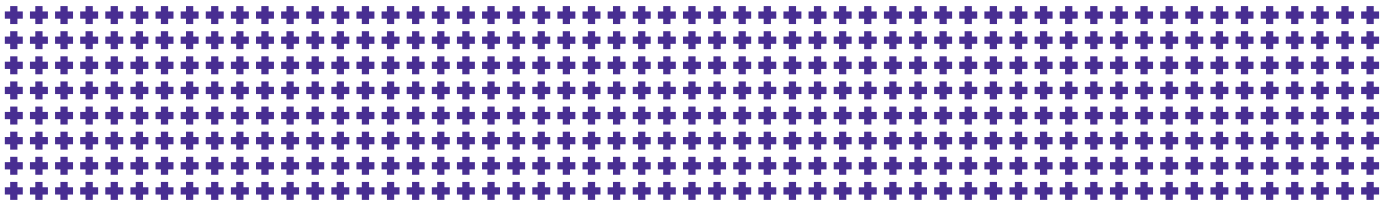
The Queen's Nursing Institute

Homeless and Inclusion Health Nursing

Case Studies

Raising awareness and understanding of Homeless and Inclusion Health Nursing and demonstrating the value of this specialist role.

Contents



Introduction

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

The QNI has supported a growing network of 1900 Homeless and Inclusion Health practitioners since 2007, providing resources and continuing professional development, advice and networking opportunities.

The QNI with the support of these practitioners has also contributed significantly to homeless and inclusion health policy development over many years as the only nursing organisation in the UK that supports a network of practitioners with this collective level of experience and expertise.

During the pandemic, the QNI has provided additional help and support for nurses and health visitors supporting individuals and families experiencing homelessness, creating three specific groups - health visitors working with families experiencing homelessness; nurses and health visitors supporting Gypsy, Roma, Traveller, Boater and Showman communities and more recently with nurses delivering Street Outreach services for individuals who are rough sleeping.

The QNI Homeless and Inclusion Health network is the only network supporting inclusion health practitioners and we have utilised this network to identify best practice responses to addressing vulnerabilities and Covid-19 in these specialist clinical areas, drawing out the public health nurse leadership and demonstrating impact.

Thanks to generous funding from the Office of Health Inequalities and Disparities (formerly Public Health England), we have been able to use the Homeless and Inclusion Health network to identify and produce the series of evidence-based case studies and practice examples that follow.

These robust case studies highlight the impact of nurse leadership in addressing health inequalities and demonstrate why early identification of individual and collective vulnerabilities is crucial as a public health intervention, particularly in response to the Covid-19 pandemic.

Case Study 1

Title Facing a new Community Health Challenge: Setting up a holistic health and support offer for mothers and their babies seeking asylum

By Lisa Gavin, Clinical Service Manager, Inclusion Health Team, Children and Family Health, Surrey.

Context

Increasing numbers of asylum seekers in London due to the pandemic meant that in April 2021, 45 mothers and babies were removed from the London hotels where they had been living and forming networks, and relocated at a few days' notice to a disused office block in Surrey.

Within weeks, there were 65 families in this building.

With no existing local services to meet their needs, a multiagency response was urgently required. All mothers had No Recourse to Public Funds (NRPF). This meant that all would require access to a range of support services, such as Food and Baby Banks and additional support, as well as specialist asylum support services that did not currently exist in Surrey (one charity Care4 Calais (C4C) was involved). The initial response was chaotic and inconsistent. As news of the arrival of these vulnerable mothers and babies spread locally, there was a well-intentioned but ineffective response from several food banks, churches and voluntary groups, as well as community and health services, including our own. Some families were inundated with food parcels, clothes and offers of help, while others were missed altogether. The range of complex needs and the distress of the clients, together with a general sense of chaos and difficulty triaging and meeting their needs, resulted in high levels of stress for both the clients and agencies involved.

Different approaches, from different agencies, further compounded the confusion, so, for example, a lack of boundaries

Photo courtesy of Alex Green from Pexels

> Weekly community health clinic for mothers and babies were set up and continue to manage emerging needs / reduce A&E attendances or inappropriate GP visits.

and support for some C4C workers meant that they were on call to these families 24/7. As a result, at least one worker became burnt out and left the charity, which affected remaining workers and the clients who, once again, felt abandoned.

This case study details this response and the successful development of a community health-led service for a cohort of vulnerable women and their babies, to provide appropriate support and care.

Solution

Access to health and support services needed to be facilitated and immediate needs scoped, to develop an appropriate response.

Recruitment of 3 additional staff.

Collaboration with all local services, including food banks, faith-based organisations and a range of voluntary and statutory services was required to target available resources effectively and identify service gaps.
Effective linking of all local health services including Community, Primary Care and Maternity was required to provide an effective and joined-up service to meet the complex needs of these families.

This will improve the situation by:

- Reducing confusion among residents and professionals about where/how families could access a range of health/ other services
- Providing more equitable distribution of goods and services, including health support
- Clarifying roles and responsibilities of all agencies to avoid duplicating/missing interventions
- Targeting available resources and providing evidence of gaps for commissioning purposes
- Establishing an effective network to improve communication and reduce the risk of unmet needs/inequitable access to support
- Providing a trauma-informed approach through consistency and co-ordination, which improves the patient experience and builds trust with agencies and services

Action

Scoping, collaborating, coordinating an effective response.

By meeting with the women, none of whom could speak English, and by using Language Line it was clear that they were distressed, worried about their babies, asking for help and describing their own anxiety, such as being unable to sleep, not knowing where they were and wanting to go back to their hotels in London, where they had started to develop friendships and access support. Many were angry, others were crying, as they described parts of their traumatic experiences. It was clear that a multiagency response was needed.

How will this be done?

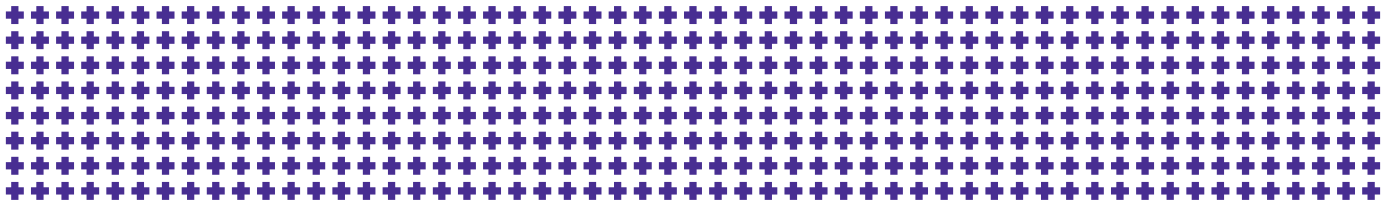
From the Inclusion Health Team perspective, the focus was to meet the health needs of this vulnerable cohort in the most effective way, by working collaboratively.

The scoping exercise involved contacting all involved agencies and arranging to meet weekly and share the needs we had identified and produce a coordinated response.

The first priority was to identify key contacts in each service and to define roles and responsibilities. This streamlined the numbers of professionals and voluntary partners leading the response, while enabling every service to manage their own staff and keep them informed and involved.

One Food bank was identified as the main provider and regular days were agreed for specific families to attend to make sure everyone got what they needed. All the other Food Banks stopped direct deliveries and agreed to support the main Food Bank by supplying them directly with the specific foods and items that were needed, each week.

We all agreed that communication was key.



Weekly, then monthly meetings of voluntary service agencies to coordinate and review the response were chaired by the Local Authority, which provided general oversight and effective leadership. Strong and productive relationships were quickly established and have continued, as the response evolved. These relationships have been beneficial, across the wider Integrated Care System (ICS).

Weekly strategic meetings with health commissioners and partners to review risks and resources and monitor progress were set up.

Collaboration with midwifery colleagues, with weekly on-site clinics. This encouraged and opened up feedback mechanisms and enhanced communication.

The Inclusion Health team (IHT) assessed every family, including a mental health assessment and developmental reviews (baseline) for all.

Weekly community health clinic for mothers and babies were set up and continue to manage emerging needs / reduce A&E attendances or inappropriate GP visits.

A business case was put to commissioners to provide additional resource by contracting a specialist asylum charity Happy Baby Community to support the women.

Importantly, psychological support was set up for the team.

There was a trauma informed focus on care. Harnessing voluntary offers of support from Muslim GPs was also very beneficial.

Outcome and Impact

Patient outcomes

In the first two months from May-July 2021 the Inclusion Health Team made:

- 201 contacts
- 114 referrals including 33 referrals to Children's Services for Safeguarding and/or Early Help Support
- 44 clients were signposted to local services
- 61 children were identified as having missed developmental reviews (which were then completed by the team)
- There are still 40 children under 4 years old being supported by the team (as of March 2022)

Additionally, close working with the Vaccine equity coordinator provided 1st, 2nd, 3rd doses of COVID vaccines From July 2021-February 2022, 57 clients had 985 interventions provided by Happy Baby Community (commissioned for the population).

After six months of support in place

- Vulnerable families access to healthcare improved maternal anxiety and mental health:
- Reduced face -to face contacts with IHT was requested by mothers July 2020 to March 2021

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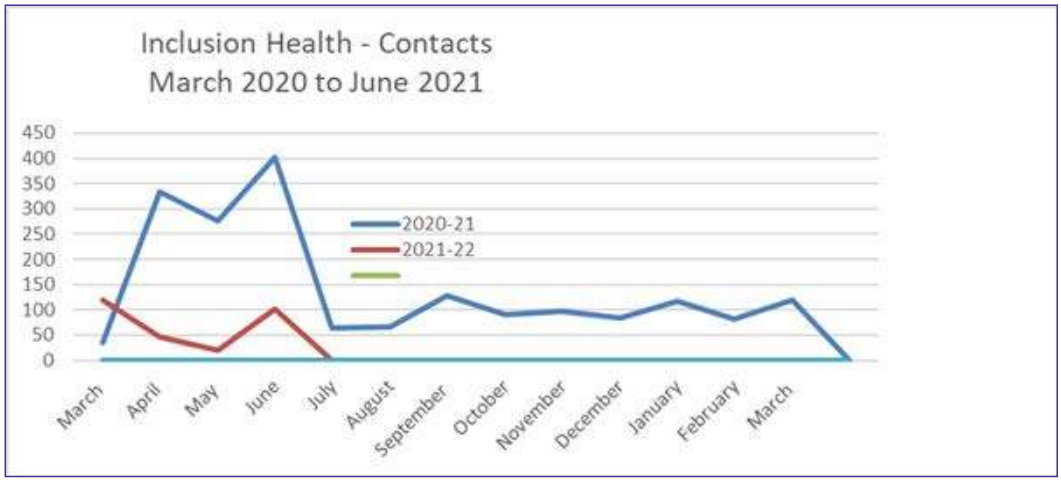

- Reduced late presentation for a range of health conditions (or assessed and treated faster) Maternal cancer diagnoses identified two mothers who had received diagnoses in London, so it was arranged for them to be relocated to continue to access established treatment after interruption by being moved
- Better oversight, with more involved. A recent disclosure of domestic abuse continuing control by Vietnamese traffickers for another mother, triggered Safeguarding processes (this was disclosed when a staff member walked a mother and child to the GP, as trust had been established)
- Reduced pressure on already overstretched local Health Visiting services, who have no capacity to provide enhanced service to this population
- More efficient use of all overstretched resources

Increased engagement, trust, and integration

- Regular attendances at Child Health Clinic
- Increased confidence and capacity to arrange own GP appointments etc
- Good engagement with provision offered, including Happy Baby Community, a World Café toddler group set up by a local church for the asylum seekers and ESOL lessons at the local Family Centre and a local college
- Emerging disclosures of past and current risks, as trust built

IHT outcomes

- Ability to support 0-19 health visiting colleagues who are unable to provide the additional resource required for these families and facilitate access to Universal services
- Ability to improve the links and build on developing maternity and health visiting pathways improving maternal and neonatal experience and outcomes
- Ability to improve the symbiosis between Family Nurse Partnership and Inclusion Health and support collaboration/ mutual referrals
- Capacity/expertise to lead on Public Health issues/culturally specific interventions
- Sustain and improve trusted relationships with refugee communities
- Improved vaccination uptake particularly during the recent COVID-19 pandemic
- Responsive Public health outreach work such as managing covid vaccinations (Number administered 85).

System outcomes

- Collaborative response & strategy in place. Clarity of roles to support families.
- Avoided duplication and increased efficiency
- Avoided ambulance calls/inappropriate use of A&E/more appropriate use of medical resources
- Improved trust between women and other services and NHS services

> ‘I am so happy to meet the peoples - so lovely and nice people. I had a very good time with them and I learn it from a computer class. I am very happy well done you are helping so much.

- Families inform and influence strategy, through effective consultation
- Reducing health inequalities.

Lessons Learned and Recommendations

What worked Well

The collaborative approach with multiagency working meant that there was:

- Reduction in associated costs of inappropriate A&E attendances by supporting with GP registration
- Reduction in associated costs of inappropriate ambulance callouts (as above, plus advice/support) (22 in 3 months reduced to 4, 3 of which were for child seizures)
- Reduction in costs associated with Safeguarding processes by offering early intervention and support provided by Inclusion Health Team, in collaboration with partner agencies avoiding escalation into Safeguarding by timely intervention
- Identification of vulnerable antenatal mothers, facilitating and supporting access to maternity care, to aim for safer, low risk births. Where maternity history is unknown or incomplete, births are designated high risk, which comes with additional costs and intervention, which in turn, reduces maternal choice and affects birth experience
- Supporting the use and access to the 0-19 Advice Line. The team acts as a conduit between vulnerable families (including homeless, asylum seeking/refugee and Gypsy, Roma,
- Traveller families) and Universal services and can provide the additional support with appropriate use of this resource so that the Advice Line is not overwhelmed by inappropriate calls
- Reducing late presentation for a range of health conditions to impact a calculable financial cost, as well as the incalculable cost of unnecessary pain and suffering, complications, and shortened lifespans.

How will this be sustained

This pathway of support has enabled the development of a successful business plan to continue to provide a planned response for future Overflow-Dispersed Accommodation. A Consultation is currently underway in another part of Surrey, proposing a unit for a further 340 vulnerable mothers and babies. The learning from this initiative will provide a blueprint and evidenced model for successful access to health and support services that is holistic, sustainable and utilises existing services, as well as identifying gaps in provision that require additional resource. It also enables a proactive, planned response, rather than an ineffective, reactive response. The Inclusion Health Team would also be able to support this response and lead on the health component, having developed additional competencies and experience. This will benefit not only the families themselves but professional and voluntary colleagues, who are confronting these challenges for the first time.

Quotes

‘A man had the right to recourse to public funds, but his wife was an asylum seeker. They were separated because of her situation and he travelled up and down from London to see his pregnant wife and child and liaised closely with our team. He was hugely reassured by the fact that we could support her as she spoke no English and was alone and terrified.’

‘Today Michelle came. We went to Merstham hub. We had coffee, then I got the two classes, one on Thursday and a second class on Monday - art and knitting. I am so happy to meet the peoples - so lovely and nice people. I had a very good time with them and I learn it from a computer class. I am very happy well done you are helping so much. Thanks a lot.’

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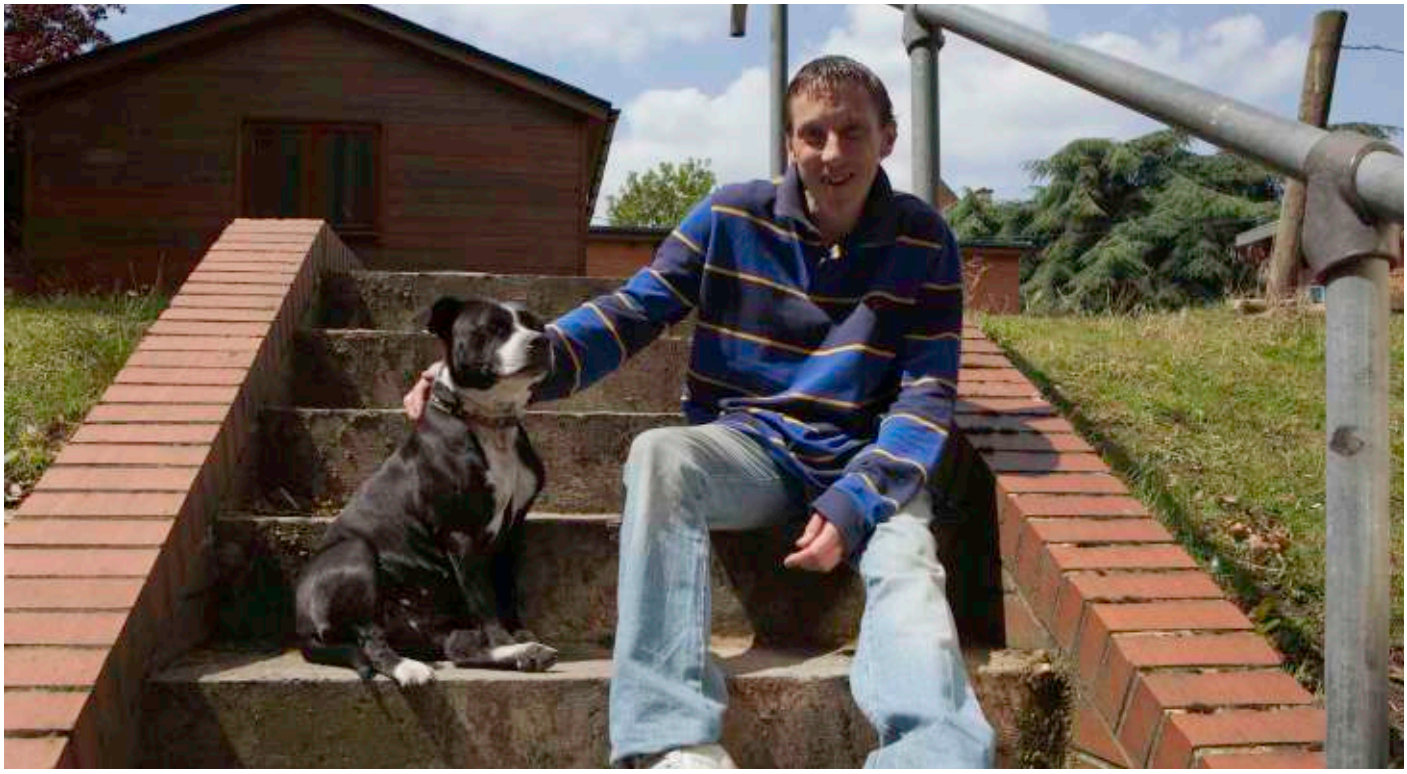


Case Study 2

Title Mental Health Nurse: Rough Sleeping Project

A project working with an identified cohort of people who have been rough sleeping for long periods of time and accommodation and health services have not been successful at engagement with accommodation and health services; the assumption being that it is emotional distress/mental health problems that underly their situation**.**

By Mental Health Outreach Nurse

Context

A cohort of people, mostly known to services but whom services have failed to engage.

- Sometimes the people identified are very visible, well known and supported by the public (often being provided with food, drink and other support).
- Sometimes the people concerned are very hidden due to a high level of distrust of services, (Kings Fund 2020).
- Research shows that the longer people stay in their situation of distress, the harder it is for them to find a way out of the situation.
- It is also commonly known that rough sleeping is incredibly detrimental to physical and mental health and reduces a person's life span.
- Prior to this intervention, services were not able to spend the time necessary to build engagement with people who are so mistrustful. Services have not traditionally had the flexibility or the longevity or the understanding to carry out this highly specialized work.
- People have been discharged for 'non-engagement' and left in their situation, often due to the belief that they

> The highly experienced nurse, who has worked in homelessness services for over 14 years, will work flexibly, over a long period of time, to get to know the person who they are hoping to work with.

are actively choosing this way of life; without anyone having been able to truly understand that very pro-active intervention is often necessary and can have very positive outcomes.

Solution

Proposed change: the provision of services for this specific group of people and and an enhanced understanding and ability to support people to change their situation.

Action

This service is set up using a person-centred, trauma and psychologically informed approach.

A highly experienced nurse, who has worked in homelessness services for over 14 years and who is registered in both general and mental health nursing, works flexibly, over a long period of time, to get to know the person they are hoping to work with in an entirely person-centered way.

The time spent together is client led and focused on the client's priorities; this can be as wide ranging as buying a new pair of shoes, liaising with asylum seeker services, support to set up a methadone prescription.

This period of extended engagement is also an extended assessment period, allowing for gentle interventions where appropriate such as harm reduction suggestions, anxiety management strategies, physical health advice and referral to the secondary mental health services if deemed appropriate.

This approach means that people who have previously been unable to benefit from any services will have their needs better understood and will be supported to access what they need to achieve for a more meaningful life by a professional advocate who will be alongside them as they negotiate the systems that are currently in place.

This may mean accessing supported accommodation or mental health inpatient stay followed by supported accommodation.

The amount of contact a client needs varies during the different stages of their 'journey' but the client will not be discharged from the service until the nurse is satisfied that they have adequate and appropriate support to continue to work towards their goals.

In the future it is hoped that the client will be able to contact the nurse when necessary in the hope that periods of crisis can be avoided or resolved promptly.

Outcome and Impact

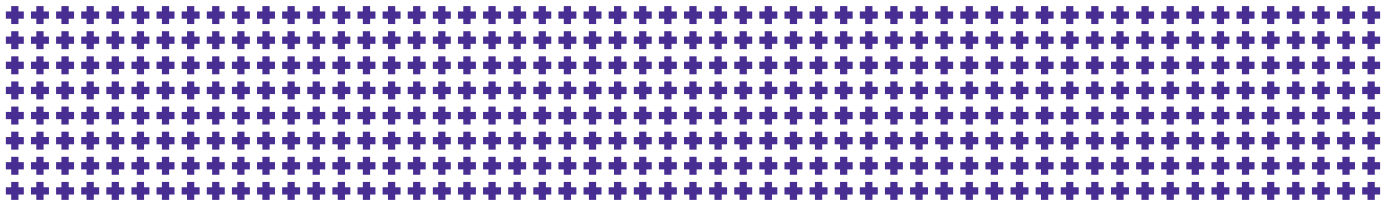
Actual Outcome:

- People have been helped out of their rough sleeping situation.
- People are being supported/treated by the mental health services
- People are now receiving benefits, attending to their physical health needs and have re-established contact with their families
- Reduced A&E admissions.

Actual Difference:

- People are now accommodated and/or receiving treatment/support for their mental health
- Services are working better together, better understanding of the breadth of need for this client group.

Quantitative:
10 people on initial caseload



- 2 people are in supported accommodation following mental health inpatient stay
- 3 people are in their own flats with visiting support services
- 1 person in a hostel has funding for supported accommodation but a reduced drug use is required for this, with intensive support in place to achieve this goal and to attend assessment with the mental health team
- 1 person is in emergency accommodation who has attended assessment with the autism service and is now being supported to achieve a goal to live in their own flat
- 1 person actively decided to stop working with the nurse but the understanding gained during the initial assessment has enabled the nurse to continue to liaise with other services and has been able to suggest other support that could be offered
- 1 person has left Bristol – presumed to have returned to Wales
- 1 person was supported to engage with immigration services and is currently in London, doing so.

Two years later; 28% of outreach service clients required MHN input.

Qualitative
Feedback:
A client with learning difficulties, who did not communicate with anyone apart from attending A&E, now regularly texts several individuals from different services.

A client, currently in mental health supported accommodation, received support from the Early Intervention with Psychosis team for a total of 3 years. He also turns up to the office of this service if he has any concerns, because he feels safe and understood.

Financial:
Of the initial caseload of 10 people, this project enabled 6 former rough sleepers to move successfully into their own accommodation, with appropriate support. Cost data from Pleace and Culhane (2016) estimated the total public sector costs of a person experiencing homelessness to be as much as £38,736 per person per year in England (based on 2019/20 prices).

This included NHS costs (£4,298), mental health services (£2,099), drug and alcohol services (£1,320), criminal justice sector costs (£11,991) and homelessness services (£14,808).

On average, they estimated that preventing homelessness for 1 year would reduce the public expenditure by approximately £10,000 per person.

With the complex history and health and social care needs of these clients and the inputs from the team, it is reasonable to assume that this project has potentially avoided similar costs: 6 x £10,00= £60,000 for 6 clients. This success can be scaled, with indications that more clients are likely to achieve similar positive housing outcomes over the next year.

Further significant cost avoidances are indicated:
As a result of the project's actions, it can be asserted that a client in specialist housing with long term engagement with Early Intervention with Psychosis Team is likely to avoid in-patient mental health admission(s). These have not been modelled or quantified, but we can suggest a potential cost avoided for treatment - Longer Term - Psychotic Crisis (Medium / High Risk) at a unit cost of £600.40

Avoided presentations at A&E, where the average unit cost for A&E Mental Health Liaison Services, Adult and Elderly is £239 (National schedule of NHS cost 2019/20) which frees up capacity for urgent cases.

> A client, currently in mental health supported accommodation, received support from the Early Intervention with Psychosis team for a total of 3 years. He also turns up to the office of this service if he has any concerns, because he feels safe and understood.

Lessons Learned and Recommendations

Worked well:

- Flexibility, longevity, stickability (reference from UCL inclusion health module)
- Supervision from psychologist
- Access to budget for drinks, I.D, bus passes etc.

Could be done differently:

- Being part of a multi-disciplinary team
- Closer links with secondary mental health services

How to sustain change over time:

- Collection of evidence in order to prove necessity of long-term funding to secure this service
- Continued liaison with related services to share understanding
- Continued liaison with commissioners to highlight the difficulties that this client group have in navigating the system and accessing services; provide evidence to support system change.

Quotes:

'I thought I was going to die in that tent.'

'She's the only person who has ever believed in me.'

References

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Case Study 3

Title **Supporting families seeking asylum residing in contingency hotels**

By Debbie Fawcett, Specialist Health Visitor

Context

Current Situation

- Whilst asylum claims are considered, families are placed in contingency hotel accommodation. Families remain in a hotel room with hotel catering, until self-contained settled accommodation is found
- Families may have presented as asylum seeking after being in the UK for several years or having just arrived via boat or plane
- Families have no recourse to public funds
- Families may have fled 'dangerous' situations and experienced trauma or have unmet health needs, with their efforts having been on survival
- Parent's focus may be on the asylum claim
- Government recommendation is that health visitors offer five mandated contacts: antenatal, new birth visit at 10-14 days, developmental reviews at 6-8 weeks, 10-12 months and 24-30 months. Contacts were virtual during the Covid pandemic.

Current Issue

- Health outcomes for both adults and children can be poor
- Families are at risk of poor physical and mental health, isolation, and the impact of poverty

Photo courtesy of Elina Fairytale from Pexels

> ‘Positive working relationships have been established, through face-to-face contacts, and continuity of care, which reduces the need for families retelling their story and avoids further trauma.

- Families lack knowledge of services which could support their needs
- There is no accurate notification system for new arrivals or effective communication pathways between professionals across health, education, and social care.

Reason for change

- Responsive health visiting to assess, identify, advise, and refer as needed
- Trusting relationships can support positive change
- To create professional links to create opportunities for collaboration and improvement
- To improve the health and wellbeing outcomes for families seeking asylum living in hotels and temporary accommodation
- Reduce barriers to accessing services, including health, education and social services
- Ensuring children are safe, thrive and can fulfil their potential.

Solution

The proposed change

- Incorporate into the homeless families caseload. The team consists of two specialist health visitors (working 37.5 and 30 hours per week) who visit temporary accommodations
- Increase visibility by visiting hotel for 2 days per month
- Network with statutory and voluntary services to raise profile and advocate where gaps in provision occur
- Offer initial contact within 2 weeks of notification of arrival
- Use specialist knowledge and skills to undertake an initial health and needs assessment for all families (children under 5 years of age and pregnant women)
- Universal five mandated contacts
- Explain health services and signpost to both statutory and voluntary services, supporting access and engagement
- Use screening tools, share evidence-based health messages, and support positive parenting
- Offer telephone interpreter where English is a second language
- Assess and support family’s mental health and refer to specialist mental health services where appropriate
- Offer face to face contacts and continuity to build trusting relationships
- Ensure children are safe from harm and make appropriate safeguarding referrals
- Complete verbal handover to receiving health visiting team.

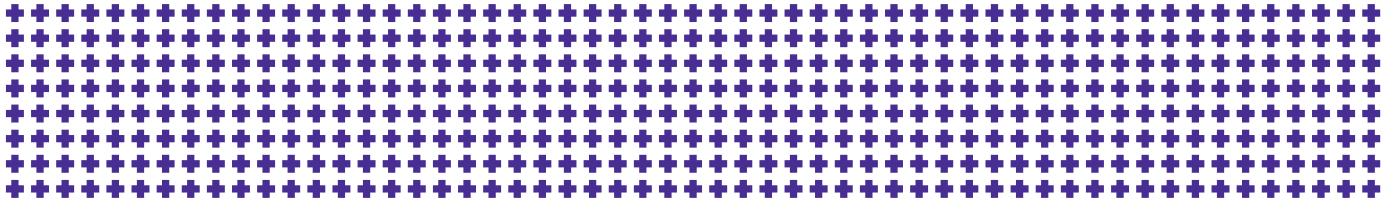
How will this improve the situation

- Specialist health visitors bring assessment, safeguarding and knowledge skills
- Positive professional relationships increase uptake of health reviews and engagement
- Effective communication and partnership working
- Children remain in focus.

Action

What has been done?

- Transfer in contacts offered
- Specialist health visitors offer an enhanced service alongside the mandated contacts, in their home
- Established links with statutory and voluntary organisations, including fortnightly multi-professional borough meetings
- Verbal handover to receiving health visitor.



Case study
Occupancy is currently 240 (women and families), having risen from 180 which were 90% men, since our involvement began in August 2020.

Parents spoke little English, so a telephone interpreter was used to communicate. Parents, and children, (11 months and 6 years) arrived in the UK having crossed the channel in a small boat and were placed in the hotel as emergency accommodation, whilst their asylum application is processed. The families journey took almost 2 years, having fled Iraq, and honor-based violence. Father was assaulted by his brothers-in-law, which resulted in a catastrophic head injury.

The hotel offers free Wi-Fi, weekly room clean, laundry services, formula milk, commercial baby foods and pre-cooked meals are provided. During the covid pandemic, families were restricted to their hotel rooms, for meals, play and everyday family life.

Parents engaged with an initial contact for a holistic assessment of family health and wellbeing, but they focused on their children's practical needs, such as clothes and a school place, and frustrations with hotel food, lack of money and unknown timeline for the next move.

Over the 9 months residency, Covid restrictions increased the family's isolation, a further pregnancy was announced, and a disclosure of domestic abuse made. A referral was made to social care for assessment of safeguarding risks and the father's health and learning needs. The mother felt unable to leave her husband, so a safety plan was created. Numerous contacts were completed, alongside liaison with services, including education and the children's centre, maternity unit, charities for baby items, toys, and fresh food.

Parents were pleased to be moved to self-contained accommodation, but this also brings more change.

Outcome and Impact

Outcomes:

- Parents were engaged in the holistic assessment of family health and wellbeing, to identify needs and concerns
- Using a telephone interpreting service enables communication
- Advised on health visitor role and NHS services, including GP, dentist, A&E and 111 to support access
- Signposted to a local charity for clothes, toys, and fresh food items
- Linked with hotel staff to register for GP and early years, school space
- Shared health messages including, immunisations, healthy diet, physical activity and safety, dental and vision screening
- Discussed positive parenting, including boundaries and routines, play activities to support development. This supports a feeling of security, builds independence skills and models positive behaviour
- Children were reluctant to eat the hotel food, preferring formula milk. Advice was given, additional food items were provided by a charity and the health visitor advocated with the hotel for child friendly provision. Distributed healthy start vitamins
- Mother felt able to disclose domestic abuse
- Parents described feeling anxious and low, so they were supported to self-refer to mental health services
- The 1 year review was used as an opportunity to explore a child's health and development with the parents. Needs were identified and strategies to support their progress discussed
- The parents consented to referrals to physiotherapy and were offered a referral to children's centre activities. This raised awareness of safety, both home and stranger risks as living in a multi-occupancy building
- An antenatal contact was completed when the mother shared she was pregnant. She was assisted to self-refer to maternity services for antenatal care.

> The mother was able to disclose a domestic incident which had resulted in police attending the hotel. Using the Domestic Abuse, Stalking and Honour Based Violence risk assessment tool the risk was explored and with consent liaison with social care.

- The mother was provided with information on preparing for the new baby, breastfeeding, safe sleeping, baby's development to support attachment and healthy lifestyles, including covid vaccine.
- A referral was made to a charity for baby items.
- Current guidance on safe sleeping and formula feeding was shared with the hotel to ensure cots, steriliser and formula were provided.
- The mother was able to obtain a maternity grant of £300 to purchase a buggy and additional baby items.
- The mother felt isolated and lacked English to enable access to services, so a referral was made to the Happy Baby Community.
- The mother was able to disclose a domestic incident which had resulted in police attending the hotel. Using the Domestic Abuse, Stalking and Honour Based Violence risk assessment tool the risk was explored and with consent liaison with social care.
- Completed verbal handover when new address identified.

Staff outcomes:

- Health visitor was able to use screening tools to assess the child's development and make appropriate referrals.
- Specialist skills enabled a full holistic assessment of the family's health and wellbeing needs, recognising financial, social, emotional, and practical needs.
- Specialist health visitors can be responsive to changing need, offer face to face contacts and advocate for services where there is a gap in provision.
- This specialist role allows for multi-agency working to ensure appropriate support for families placed in the contingency hotel.
- Specialist health visitors can share their learning and knowledge with peers.

Lessons Learned and Recommendations

What worked well?

We offer transfer in contacts to all new arrivals and the increased visibility supports engagement with approximately 90% of families.

Positive working relationships have been established, through face-to-face contacts, and continuity of care, which reduces the need for families retelling their story and avoids further trauma.

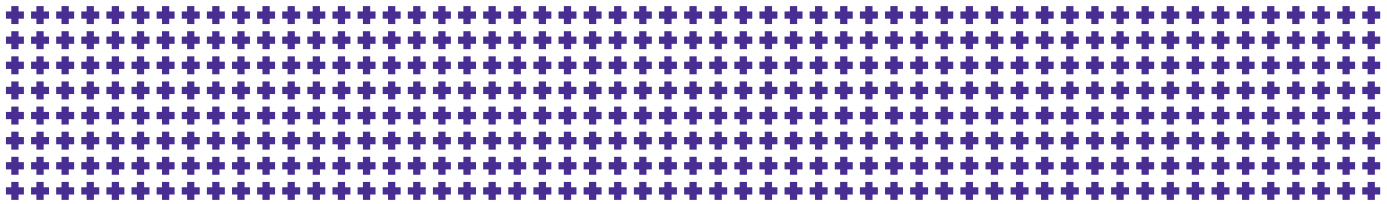
Liaison (with family consent) can help professionals understand the daily lives and challenges so further support can be provided. School for example offered free school meals, notebooks and pencils, laptops, oyster cards and emotional support sessions.

Partnership links have been created with midwives, early years, education, voluntary organisations, community services, housing hotel staff and their management. This has led to an understanding of services, appropriate liaison, and referrals.

A verbal handover to the receiving team, ensures continuity of care for families moving to more settled accommodation. In 2021 approximately 100 verbal handovers were completed once a new address was identified.

Partnership working has created opportunities for service development, and advocacy for families and children as well as reducing service duplication. For example:

- Use of telephone interpreter for health visitor contacts
- Mothers are offered enhanced midwifery postnatal care for 28 days



- Under 2 year old children are provided with a crib or cot and steriliser
- 1st stage formula milk is provided for babies under 12 months on request, with cows' milk, additional fruit, and snacks for all children
- Female hotel staff are employed by the hotel and support discreet access to sanitary items
- Healthy start vitamins distributed
- Direct liaison with GP practice which register residents of the hotel
- Provision of holiday activities, stay & play sessions, and toys
- Local charity offers ESOL classes and drop-in sessions to collect fresh food and clothes
- Local authority agreed to fund early spaces for 2 year old children who would not be eligible for funding, due to their no recourse status
- Stay & play group being established
- Specialist health visitors have highlighted safeguarding risks, and safety hazards to reduce the risk of harm. For example, unsupervised children, faulty window catches
- Specialist health visitors have created a workshop session for students to share learning and experience of families experiencing homelessness
- This has raised the profile of health visitors working with families seeking asylum in contingency hotels
- This has high-lighted the issue of duplicate NHS numbers, locally and nationally.

Specialist health visitors can offer a responsive enhanced health visiting service, to meet the needs of this vulnerable group, sharing health messages and monitoring children's progress, whilst recognising their individual needs and circumstances. National standards should be created from best practice and specialist expertise.

Quotes:
'I am a new asylum seeker and I have 3 children also my wife is pregnant. I have a letter from you and need support'.

'I didn't realise there were people like you, who could support us and tell us what we need to do to be ready for our baby'.

'We've given up everything to get here. We are always happy to see you as we know you will help us'.

'Thank you for getting me the tickets. My son enjoyed the play so much'.

'Thank you so much for your help and advice. We have been moved to Liverpool. If you visit, please come and see us'.

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Case Study 4

Title Health Needs Assessment for the travelling community

After identification of unmet health needs for the Travelling communities passing through Bath and Northeast Somerset, a pathway was devised to enable all encampments to be offered a health needs assessment. Any health needs identified are then addressed. Multi-agency working with the council enforcement team enables camps to be tolerated whilst health needs are met if deemed appropriate by the council / courts.

By Lorraine Dooley, Health Visitor, Practice Teacher

Context

Current situation:

An unauthorised encampment arrived in Bath and Northeast Somerset in 2018 setting up camp on the official Traveller site. I visited with an outreach worker from a charity that is commissioned to provide services to the Gypsy, Roma, Traveller, Boater (GRTB) community. There were many unmet health needs that required health and care intervention. I was able to assess and get appropriate medical help, but it posed the question of what would have happened if this group had stopped somewhere else within Bath and Northeast Somerset. The outreach worker helped with other matters and Gypsy Traveller education services managed to find school places for the younger children.

Many positive outcomes were made for this encampment: access to medical services, appointments and treatment as required for health / developmental reviews and interventions as required for children. Midwives were able to provide care to pregnant women, an outreach worker provided support with financial and benefit matters and Traveller education

> A Traveller, when asked how health care professionals could encourage uptake of health services from the community, answered, 'We need people prepared to break the rules'. His answer was insightful as the approach currently being offered was not improving health outcomes.

were involved. This camp demonstrated that we needed to consider ways of helping all Travellers passing through Bath and Northeast Somerset and not just those on official sites.

Problem / Issue:
Travellers have some of the worst health outcomes amongst all ethnic and socio-economic groups and so in the search for health needs this group was identified as needing a different approach (McFadden et al. 2018).

Reason for change:
At a Traveller conference in November 2019, a Traveller, when asked how health care professionals could encourage uptake of health services and interventions from the community, answered, 'We need people prepared to break the rules'. His answer was insightful as the approach currently being offered was not improving health outcomes. Referral processes can be slow, and the transient nature of this population make access and engagement with services to improve their health problematic. They do want access to health care, but system level barriers are in place to prevent access. Since the health visiting profession provides services across the life course it was decided that we should look at how to make health services more accessible to improve health outcomes for those who experience challenges in accessing the right care at the right time.

Solution

Proposed Change
Investigation showed that encampments were usually discovered after members of the public called the Council to report that Travellers had arrived at a local location. This results in the local Councilors and Council Enforcement Team being informed of the encampment. Health and the local Traveller services were not part of this information distribution list and therefore were not informed in a timely manner, hence some encampments were dispersed before any health interventions or support could be offered. The change was to include health and Traveller services at the time of notification so that timely assessments and support could be provided.

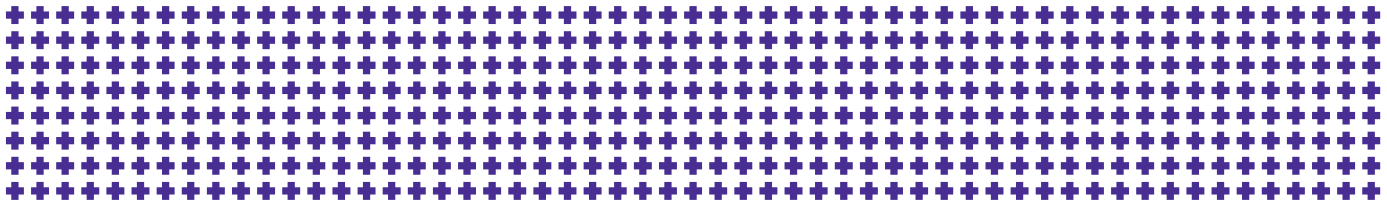
How will this change improve the situation?

- It will no longer be the responsibility of the Council Enforcement Team to provide the health assessment questionnaire, on which the decision to tolerate or enforce a camp would be made and which they stated was rarely completed in full, it would be a health professional's responsibility
- The setting up of a new multi-agency working group to improve health needs assessment with appropriate interventions and better outcomes.

Action

What was done?
A Pathway was developed and agreed by the health / council enforcement team and the GRTB outreach service that ensured encampments were visited by health and outreach workers prior to a decision of enforcement or to tolerate a camp being made. All individuals were offered a health needs assessment / health support/ signposting to other services i.e., education/ benefits. The Pathway has been tested and is now in use. It has also been ratified by the HCRG Care Group governance committee. New outreach workers have been employed and have all found the pathway to be useful.

How was it be done?
Health needs assessment is offered to all Gypsy and Travellers stopping in Bath and Northeast Somerset and interventions are offered. There has needed to be amendments made due to some problems that emerged. For example, patients needing to see a GP are registered as temporary patients. Initially families were registered with local GP's, but some found re-registration challenging with their previous GPs if their lists were full. Some families did not re-register elsewhere which had a detrimental impact on GP statistics in Bath and Northeast Somerset such as immunisation rates.



Why was it done?
Agencies who are responsible for assessing encampments do not usually engage with other agencies who support GRTB populations e.g., health care providers. This has allowed a pathway to be developed that enables Travellers to be offered health needs assessments and be given appropriate care. The aim is to help them achieve the best possible health outcomes and enable access to health care services and advice while they are residents in Bath and Northeast Somerset.

Outcome and Impact

What is the actual outcome?
It was recognised that after speaking to the Travellers they had often not accessed health care or completed immunisation schedules for their children because the barriers to access local services inhibited them rather than them not wanting to access care.

Immunisation provides protection to all communities and is an important public health intervention; a local GP practice was happy to provide services to families as temporary patients.

- They offered immunisation out of usual clinic times so they could be completed quickly before the camps moved on
- They were also prepared to see any patients needing primary care and medication, as it is not unusual to find that medications has run out for conditions such as asthma and preventative treatment may help prevent unnecessary Emergency Department presentations.

I was able to carry out developmental reviews for children and from there if required developed a relationship with both audiology and speech and language therapy that enabled these children to be seen quickly so they could be assessed, and treatment offered locally, or I would hand over if the camp moved before any treatment was completed. I have handed over to Health Authorities throughout the UK and the Republic of Ireland; this provides some continuity of care rather than having incomplete care or having to start again.

What is the actual difference made?
There has been a significant impact from this new process:

- Access GP services whilst in Bath and Northeast Somerset
- Medication prescribed and collected
- Individual health reviews
- Child developmental reviews
- Access antenatal and postnatal care
- Access immunisations
- Receive referrals and consultations with secondary care
- Hand over care to agencies in the next destination, which allows continuity of care and ensures that health needs continue to be met
- Reside on safe sites - working with the Council Enforcement Team means that toilet, sanitation, and additional refuse collection is organised to help keep the Travellers healthy and enable them to maintain a clean and organised site.

During the COVID pandemic:

- I was able to provide public health information, as well as deliver self-tests and support to access COVID vaccinations
- Many people were unable to access their GPs and all encampments that passed through needed some support or intervention to help with their health
- Social media appeared to be the main source of information regarding COVID-19 and there were many inaccuracies that I was able to discuss and explain to enable them to keep safe and stay healthy

> ‘Thank you, it’s so hard to get anyone to listen, and impossible to be seen by anyone. (New age Traveller in COVID-19 pandemic).

- During the first lockdown many were frightened and bewildered at the speed with which the world had closed down and had difficulty accessing basic necessities such as water as their usual establishments had closed their doors due to lockdown
- For the settled sites and Boater communities, drop-in vaccination clinics were held on site for flu and Covid-19 vaccines.

Data:
We have accessed all unauthorised encampments within the Bath and Northeast Somerset area over the last 4 years and offered health advice and support to all. We had an increased number of encampments during Covid-19. On average we have 4-5 per annum but we recorded 9 during the first year of the pandemic. Many were moved on despite legislation to protect them and they were frightened and looking for a safe place to stay. The plan this year is to improve data collection so that real numbers are collected for people that have had positive outcomes.

The impact is that all Travellers passing through Bath and Northeast Somerset are offered:
- support to improve their health outcomes
- advice around minor injuries and illness and signposting to appropriate agencies, reducing inappropriate use of the Emergency Department.

The camps vary greatly with their health needs, many will have static pitches and will have prepared for travelling and have sufficient medication etc. Some will be more roadside and will have many unmet health needs. We plan to collect hard data for the next year but on average there will be 5-6 health interventions for each camp, with some having a greater need than others. It is not unusual to have 10 different health referrals / needs / signposting for each camp.

Lessons Learned and Recommendations

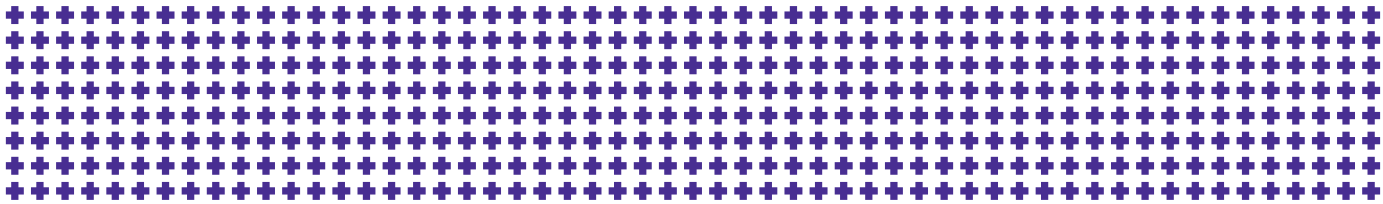
What worked well?
Reaching out to organisations that the health visiting service does not usually work with, enabled this pathway to be developed and embedded into practice. Commissioners had already recognised this group as having poor health outcomes and 15 hours a week was set aside within the health visiting service as being dedicated to supporting the health needs of the Gypsy, Roma, Traveller and Boater Community. This dedicated time has allowed work to continue with the groups and further accessibility to health enabled.

What could have been done differently?
- Initially there were no dedicated hours to improve outcomes for this group and it was challenging to juggle hours within the existing health visiting service
- Initially I registered all people needing to see a GP with a local surgery, however this posed two problems. The first problem was that if the Travellers did not re-register elsewhere when they moved on then it negatively affected the performance of the Bath and Northeast Somerset (B&NES) GPs for health-related targets such as immunisation rates. Secondly some Traveller patients when they returned to their local area found it difficult to re-register at their old surgery if the surgery list was full. For this reason, all patients are registered as temporary patients unless they gain a permanent pitch within the B&NES area.

How will the change be sustained?
- The change is already embedded into practice and is established. Further work is being done with other services to ensure people are seen in a timely manner for conditions that would normally be associated with a long waiting list. There are challenges for this work, but links are being made to ensure success.

Quotes
‘Thank you, it’s so hard to get anyone to listen, and impossible to be seen by anyone.’ (New age Traveller in COVID-19 pandemic).

‘…because I need support with drugs everyone thinks I’m an addict but I’ve been clean for a while now and need help to stay that way.’ (New age Traveller needing drug and alcohol services).



'No-one cares about us; they just hope we will go soon… I've been so worried about ..x.. but didn't know what to do.' (Irish Traveller worried about speech and language development).

'They keep sending letters, but I never get them because I'm not there, so I did not even know I had an appointment.' (Irish Traveller with permanent pitch but travelling).

'I want them to have their needles, but no-one will ever do it.' (Irish Traveller with part immunisation history for all the children. The children were less keen)!

'We were told you would come.' (Traveller who had been told by a family who had previously pitched in the Bath area that a nurse would visit them and had a list of concerns).

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Case Study 5

Title **Community Street outreach supporting a patient with cancer with no recourse to public funds**

By Nurse Practitioner Health Inclusion

Context
X is a 60-year-old Romanian gentleman who was street homeless, spoke no English and was having some urinary symptoms which he had ignored as he had no access to health care services.

Solution
Having street outreach teams, actively identifies those at risk and in need and reduces inequalities in healthcare provision. Having one person who builds a relationship with a client can encourage engagement with appropriate health services rather than crisis ones.

Action
As a community nurse specialist practitioner in the street outreach team, I support people experiencing homelessness in one of the London Boroughs.

People who live on the street and who are homeless, many of whom do not have recourse to public funds or speak English are not registered with GP's and do not access health care provision when it is needed.

The street outreach team bridge this gap by identifying those in need and carrying out appropriate action to address these inequalities.

The team visit known places where those who are homeless and living on the street tend to sleep and engage with them to find out if they are known to relevant services and to signpost them appropriately, carry out health and social care assessments and help them to navigate the systems required.

> ‘I have made a difference to this gentleman’s life, and I can provide ongoing support and signposting throughout his illness journey so that he knows that someone cares.

The team can access resources quickly due to the nature of the clients they support and are able to transport and accompany those clients in need.

Outcome and Impact

I met X as part of an outreach visit. He was invited to come for a health assessment which Identified that he did not have a GP, or any recourse for public funds, but had been suffering from some abnormal symptoms which warranted a GP referral. As he spoke no English, I accessed language line to carry out the health assessment and to explain what was required, and what investigations would take place and what would happen. After investigations he was diagnosed with prostate cancer.

As a direct result of my intervention of assessing him and referring to the GP, he was able to engage with health care professionals so that he could receive appropriate treatment.

I attended many appointments with him in the hospital and I was able to advocate on his behalf insisting that he had access to an interpreter (due to the pandemic this was very difficult to achieve face to face, but I had access to language line) so that he could fully understand what was happening.

I was able to access appropriate teams to assist in an application for housing due to his health needs, which he still has, and he is still engaging with all health services as he is now in receipt of regular injections and follow up appointments.

Lessons Learned and Recommendations

- Having access to language line and, being aware of how those who do not have recourse to public funds can be helped
- Being able to attend appointments and advocate on his behalf has built up a trusting relationship which he really values
- Without having been identified and assessed he could possibly have been dying on the streets, or been admitted to A&E for crisis care
- He has said that he trusts me and continues to engage in health services to stay well, although his cancer is not curable
- I have made a difference to this gentleman’s life, and I can provide ongoing support and signposting throughout his illness journey so that he knows that someone cares, as well as reducing some of the inequalities that would have meant that he may not have received treatment, not just for his physical health but also his mental health.

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Case Study 6

Title **Delivering outreach primary health care to rough sleepers in the City of London**

By Samantha Dorney-Smith, Nursing Fellow, Pathway

Description

Doctors of the World delivered a nurse led street-based health outreach service on Tuesday evenings between 15th September 2020, and 1st June 2021. All sessions were undertaken in partnership with the Thamesreach City Outreach team.

The purpose of the service was to work alongside the Thamesreach City Outreach team and other partner services e.g. East London Foundation Trust, Rough Sleepers Mental Health Project (ELFT RAMHP) team and Turning Point (addictions) to ensure that people who are rough sleeping in the City of London were able to access primary health care, and were adequately safeguarded. Shifts were undertaken by bike. Relevant equipment was taken in bike paniers.

Context

Aims and objectives:

- to ensure people rough sleeping had a GP
- to facilitate access to primary health care and any other health care as needed
- to identify and raise safeguarding issues.

The City of London is a geographical area of 1.2 square miles, in which 350 individual rough sleepers were identified in 2020-2021, and night time street counts are generally between 20-30 individuals. (Greater London Authority 2021).

Photo courtesy of project lead

> One client with long term mental health and addictions issues was housed and received their elective hip operation within 8 weeks ('I just feel like I am flying now').

Rough sleepers often suffer from the tri-morbidity of physical health, mental health and addictions, and this results in poor outcomes. The Office for National Statistics report that the average age of death of people experiencing homelessness is 46 (men) and 42 (women).

Even where specialist primary care services exist, people experiencing homelessness have difficulty accessing primary care (University of Birmingham 2019, Doctors of the World 2019) due to:

- a reduction in drop-in and walk-in services during Covid
- having no credit, or no charge on their phone
- communication and language difficulties
- mental health and addictions
- poverty (having no money to get to appointments)
- mobility / ill health
- stigma
- lack of trust.

Method

Experienced Practice Nurse Practitioner Samantha Dorney-Smith went out every Tuesday evening between 19.30 - 00.00 or similar with a Thamesreach City Outreach team worker. Outreach team workers are commissioned to go out in the mornings and evenings to engage rough sleepers, and to try to resolve their rough sleeping situations. They know where sleep sites are, are experienced in managing risk, and understand which clients have the poorest health.

Shifts were generally undertaken by bike - the most effective way to move quickly between sleep sites.

8-10 people were seen per shift.

Activities undertaken included:

- Engagement work
- Holistic health assessment, observations / covid screening if needed
- GP registration and liaison with GPs over treatment
- Referral and liaison with mental health and addictions and a variety of other providers including safeguarding and hospital discharge teams
- Prescriptions, dressings, vaccinations (although this has not been frequent)
- Taking people into accommodation when this is available, and they agree to this
- Case management for longer term clients.

The nurse also attended the twice monthly 2-hour City of London 'Task & Action' meetings on MS Teams.

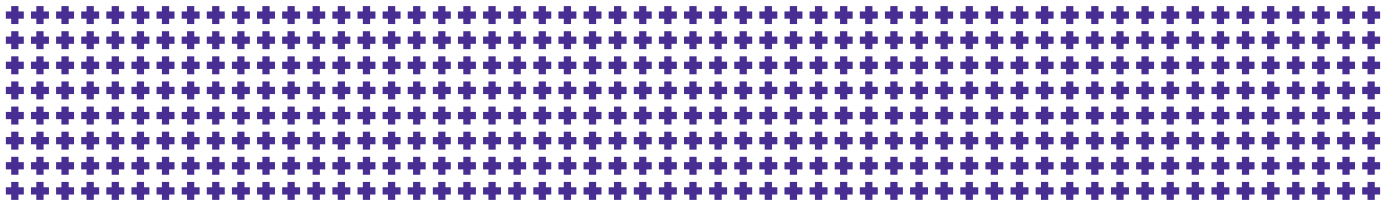
In total 8-12 hours work per week was devoted to the role, made up of 4.5 hours clinical practice and up to 7.5 hours follow-up including meetings.

Outcomes

Summary outcomes and activity were aggregated on an Excel spreadsheet.

34 sessions were delivered over 8 months:

- Clients seen: 100
- Client contacts: 289
- Contacts per session: average of 8.5
- Additional 2.6 'missed' contacts per session (contacts that were attempted, but client was not there)
- Total of attempted and missed contacts per session: average 11.1



Patient impact:

- Full health assessment achieved: 76 clients
- Health advice: 65 clients
- New GP registration facilitated: 27 clients
- GP appointments booked (sometimes multiple appointments): 28 clients
- Liaison with mental health: 28 clients
- Liaison with addictions: 14 clients
- Liaison with other health services: 38 clients
- Clients brought into accommodation during a shift:19 clients
- Safeguarding referrals: 6 clients
- Cognitive assessments: 11 clients
- Expert input given at Task and Action meeting: 22 clients
- Case conferences organised: 11 clients
- A&E visits avoided: 11 (Cost of A&E visit = £188 (Crisis UK 2016) so savings are 11x £188 = £2,068)

As a result, some great individual outcomes were achieved – e.g. several clients were engaged in primary care from their accommodation, one client with long term mental health and addictions issues was housed and received their elective hip operation within 8 weeks ('I just feel like I am flying now'), and another client moved into mental health supported accommodation after a long period living on the streets.

Another client with cerebral palsy agreed to come in after 17 contacts and was then reconnected to their own country and family.

Rough sleeping is said to cost £20,128 per year (NHS England 2020) and this person had been rough sleeping for three years, so this intervention was better for the client, and has also saved money.

In addition, there have been benefits for partner staff as outreach staff have been better able to connect with health services and understand health issues, with a resultant reduction in stress, and development of new approaches for clients where things have been 'stuck'.

Key Learning Points

Operational details for shifts:

- Undertaking shifts by bike is very effective in terms of accessing the maximum number of clients – better than walking, or by car (it was difficult to park near sleep sites)
- Paniers enable all necessary equipment to be brought directly to the client
- Uniform is not needed (and would indeed not be recommended), but wearing a visible ID is essential
- Having contact cards, brief simple information about the service to leave with clients is helpful
- Shift times should be varied, possibly evening and morning shifts. This would enable the practitioner to escort people to appointments to enable engagement.

Complexity of work / seniority of nurse:

Many of the clients seen were highly complex, with presentations complicated by a variety of communication challenges including:

- Language
- Literacy / learning difficulties
- Mental health problems
- Complex Psychological Trauma

> ‘Having you in the City has been revolutionary in so many ways – and this goes beyond health impacts. You have invigorated so many professionals to do a better job for people - I genuinely cannot overstate to you how thankful I have been.

- Brain injury / learning disabilities / cognition issues
- Neurodiversity
- Addictions
- Cultural needs.

As evidence of this:
- 47% of clients were EEA (European Economic Area) national or other non-UK national
- 18% needed an interpreter for all communication
- 8% were from a Gypsy, Roma or Traveller backgrounds
- Mental health problems - 70%
- Alcohol or drug problem - 68%
- Concerns regarding self-neglect - 24%.

On numerous times clinical assessments were being made with clients who had multiple intersecting health conditions and safeguarding concerns. As such this work needs to be done by a nurse with:
1. direct previous experience of working with rough sleepers
2. an advanced assessment course and / or significant experience of clinical triage in an A&E department
3. a proven ability to assess and manage clinical risk independently
4. a good knowledge of safeguarding in a homelessness context (including an understanding of self-neglect).

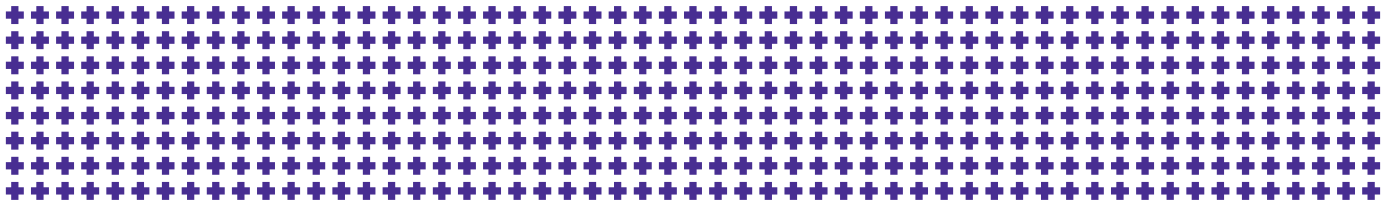
Essential partnerships with other teams / professionals:
Partnership working is vital due to the clients’ complexity, and the existing Task and Action (T&A) meeting enabled constructive, positive, active discussions and care planning.

Attendees to these meetings included:
- Local Authority Rough Sleeping Pathway Lead
- Thamesreach Outreach team
- City Assessment Service – 60 beds (Providence Row)
- East London Foundation Trust Rough Sleepers Mental Health Team (RAMHP)
- East London Foundation Trust Outreach team
- Turning Point (Addictions)
- City of London Social Worker
- City of London Police.

However, the addition of a primary care / physical health opinion for this project was vital, and helped to move things on.

‘Having you in the City has been revolutionary for the City in so many ways – and this goes beyond health impacts (ignoring the wider determinants of health). You have invigorated so many professionals to do a better job for people – you have provoked so many different approaches to working with so many people I genuinely cannot overstate to you how thankful I have been.’
Rough Sleeping Coordinator, City of London

Clinical recording and data sharing
The effective recording of clinical activity and safe sharing of clinical insights between partners is a familiar challenge. A particular challenge in this case was that the service was delivered by a voluntary sector, non-NHS service, which generated some challenges.



Things to consider:

- Clinical notes should be available to access for reference during outreach shifts
- Clinical notes should be easily sharable with other health providers
- Clinical records should ideally be coded to support quarterly or annual reporting

Prescribing medication, dressings/ bandages and vaccines

Simple medications are often required during this work, so there is a benefit if the outreach health practitioner is able to directly prescribe or to provide drugs by Patient Group Direction – although the ultimate purpose of an intervention like this should be to engage clients with mainstream services.

Common stop-gap prescriptions were needed for dressings and bandages, antibiotics such as Flucloxacillin (wound infection) and Amoxicillin (dental infection), Paracetamol, asthma inhalers, skin emollients, and treatments for allergy and infestation.

In this pilot only 5 Covid-19 vaccines were facilitated on the street, but there was potential to deliver more. However, there are considerable order / supply challenges and cold chain issues inherent in delivering vaccines in the evening during outreach that need exploring further.

NHS Spine Access

An ability to check NHS Spine easily is extremely useful to support this work, and would reduce the amount of detective work involved in confirming GP registration where this is needed.

This role has been commissioned by the NHS going forward and further outcomes are awaited.

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Case Study 7

Title **Gypsy, Traveller Drop-In**

By Shaynie Larwood, Inclusion Nurse

Description

Multi agency open access drop-in for local people of Gypsy, Traveller ethnicity. The focus of the drop in is to be responsive to attendees needs while providing a safe space for discussion and advice about health and wellbeing.

Context

The Traveller Health Team (THT) was formed 12 years ago with a focus on improving health outcomes for Gypsy & Travellers. Gypsy & Travellers are one of the local authorities' largest ethnic minority communities. Nationally it is recognized that Gypsy & Travellers have the worst health outcomes across multiple measures of any ethnicity (McFadden et al 2018). As the members of the THT became trusted by members of the community our workload increased and we would be opportunistically flagged down by clients when entering sites for a scheduled appointment. This opportunistic work became unmanageable both in terms of time and lack of digital connectivity. As more and more services became digitally based the need for connectivity became imperative.

Method

Having recognized that our delivery model was not able to meet the expressed needs of our clients, a service development was proposed. As a team with wider partners input we looked at developing a drop-in clinic as a safe space for clients to attend proactively for support with matters in all areas of their lives. Partners and colleagues already working with our clients were keen to participate in this project.

- A suitable building was identified at the local church hall that was within walking distance of one of the larger sites. A reduction in room hire costs was agreed as the parish church recognized the vulnerability of our clients.
- A trial period of 8 weeks was initially planned.
- The drop-in clinic was advertised by word of mouth amongst the community and by informing professional clients.

> People vote with their feet and so the fact that clients continue to attend regularly and even come to the building when we are not open (school holidays) means that clients value this resource.

On the first week the teams' expectations were low but clients came and we were able to support clients with various issues that were troubling them, causing anxiety and distress. Since that first week we have continued to run the drop-in on a weekly basis (term time only) and clients always attend, sometimes small numbers but with complex issues sometimes larger numbers but still with complex issues.

Throughout the pandemic we continued to run the drop-in whenever we were allowed but on an appointment only basis. As the drop in became more established, more partner organisations became involved.

The drop-in is now regularly staffed by the Traveller liaison officer from the local District Council, Family Workers from the Early Help Team, Adult Education Tutors and Education support consultants. We also have occasional professional and third sector colleagues who attend to discuss health issues and service developments with clients. The drop-in is occasionally used as a forum for capturing the voice of Gypsy Travellers.

Outcomes

The trust established between staff and clients means that clients that attend with highly complex health and social issues requiring multiple expert interventions can be seen in one visit rather than multiple home visits.
By enabling needs to be dealt with in one visit means that staff time is maximized, reducing operational costs, but more importantly using the clients time more efficiently and the opportunities to respond to their current needs are also maximized.

By encouraging and enabling attendance at the drop-in, clients experience a sense of agency.

Clients also meet other community members which can reinforce community bonds and develop peer networks that are mutually supportive.

Members of the community can access the support they need in a timely, pro-active manner.
The Church Hall has Wi-Fi connectivity, so some attendees are able to access the internet independently.

Staff are also able to assist with services requiring the use of a digital platform e.g., Universal Credit, etc.

The drop-in has also proved to be very useful for professional colleagues to provide appropriate targeted public health information and advice. People vote with their feet and so the fact that clients continue to attend regularly and even come to the building when we are not open (school holidays) means that clients value this resource.

Key Learning Points

Key learning points of this service development are the need to ensure that sufficient trusted and skilled staff are at the core of those professionals present. These staff can then introduce other professional colleagues to the community who can then access their expertise in a safe therapeutic space. This means that the drop-in can only open in term time as the core staff in the THT are only 4 part time workers. Any drop-in needs at least 2 members of the THT to be present. Ideally the drop-in would run all year but staffing precludes this. The THT would like to build on the success of the drop-in and develop links with local schools. We now have a notice board in the hall which I would like to use to display children's work and newsletters as well as health information. I would also like to increase the opening hours and use the afternoon to offer wellbeing events to clients. I would also very much like to have dedicated mental health support at the drop-in. Mental Health is a significant health issue within the community. I am in touch with leaders within the Mental Health Trust to look at ways of facilitating this.

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Case Study 8

Title **Cervical Cytology screening for non UK nationals, residing in initial accommodation.**

By Homeless and Inclusion Team

Description
Females facing multiple disadvantages, who may be unaware of the importance of cervical cytology screening, or who have not been able to access this in their home nation, will be able to access health education and performance of cervical cytology.

Context
Non-UK national women entering the UK and residing in initial accommodation are either not aware of the UK's national cervical screening programme, have never had cervical cytology and / or are unaware of the information and resources for accessing cervical cytology screening.

The issues can be that a large majority of the non-UK national women arriving have been trafficked and will continue to be used for sexual exploitation, which could increase their risk of developing cervical cancer (RCN 2020). The reason for the change is to ensure that non-UK national women, living in initial accommodation, have equitable access (Matthew, et al 2014).

Providing on-site cervical cytology clinics means that they are easily accessible, culturally sensitive and provide a wider understanding for the clients to make informed choices about their bodies and their health (Jo's Cervical Cancer Trust 2018). The change will improve the situation, as the women will have access to information in their home language. It will support their informed decision to be a part of the screening programme. It will support with early detection of any serious health issues.

> ‘ The time spent is flexible to adapt to each woman and whether there are any other problems/issues or matters that arise and can be addressed. By doing this the clients feel at ease and the consultation is meaningful, as their cultural needs are met.

Method

An already employed band 7 nurse, who has worked within inclusion health for almost 14 years, completed a cervical cytology City University module, including practical sign off and an exam. Initially clinics were held 1 afternoon per week for 3 months. This then increased to whenever the band 7 nurse would run her usual clinic.

Each appointment is 30-45 minutes. This allows for the time spent needing to use language line to provide health promotion and education and explain and perform the cervical cytology procedure once this has been consented to. The use of female interpreters is utilised on all occasions (unless none are available – whereby consent will be sought to use a male interpreter). There is an opportunity to have a booked appointment or if the client is being seen for something else, this can be booked as a drop-in but allowing for the same amount of time depending on the circumstances. It also allows for any questions the women may have. The time spent is flexible to adapt to each woman and whether there are any other problems, issues or matters that arise which can then be addressed. By doing this the clients feel at ease and the consultation is meaningful, as their cultural needs are met.

The consultation takes place in the clinic room within the initial accommodation. Female clients who are newly arrived at the accommodation and are of screening age have a discussion about cervical cytology in their initial health assessment, which should take place within the first week of their arrival. This is also discussed with any women of eligible age, being seen by any of the other team members (clinical nurse specialists, health visitors, GP's), so that they can be booked in for an appointment.

Outcomes

Actual outcome

- Improved access for non-UK national women for cervical cytology screening
- Increased uptake of cervical cytology

Actual difference

- Increased trust with patient group and healthcare professionals and services
- Able to address other health needs / concerns during the consultation – e.g. mental wellbeing, smoking cessation

Quantitative

- There are now 2 other nurses who have undertaken the cervical cytology module and are able to offer the service to other disadvantaged female clients (experiencing homelessness, sex workers)

Qualitative

- Good feedback received from clients
- The clients can be provided with written information in their home language about cervical cytology (questions will be asked to glean an understanding of the level of literacy – other forms of communication such as pictures may be used).

Key Learning Points

What worked well

- Using the already existing clinical space
- Being on site, which allowed for opportunistic encounters
- Nurse job satisfaction, at being able to support clients to access information about the national screening programme
- Meeting a previously unmet need for the client group

What could be done differently

- Having a space and childcare provision
- Having a pathway with colposcopy hospital services for those women who were referred
- Better link up with the GP practice, with regards to courier service and QOF targets

> ‘In my country we check this for cancer. You explain here in UK what the test checks for. This is useful for me, and I will tell my mother and sisters.

How will the change be sustained overtime?

- It is sustained currently but more on an ad-hoc basis

Quotes:
‘Thank you for explaining what this is. I will make sure to do this every time’.

‘In my country we check this for cancer. You explain here in UK what the test checks for. This is useful for me, and I will tell my mother and sisters.’

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Case Study 9

Title **A Male with Cancer Supported by Outreach Team**

By England Outreach Team Nurse

Context

This gentleman was an emergency admission to hospital in October 2020. He was admitted with abdominal pain and required emergency surgery which resulted in the formation of a colostomy. He also underwent further surgery for a washout of the wound and had a CT scan of his head which identified an old right sided ischaemic change. An emergency endoscopy was also performed due to a gastric bleed. He required on going input from Occupational Therapy and Physiotherapy.

He had input from the Mental Health Team as he was on monthly depot injections for schizophrenia. It was known that he had an amphetamine drug habit which also impacted on his mental health. He had a catheter in situ due to urinary problems. He was discharged in January 2020 to new accommodation and we were going in to assess his medicine management and stoma care.

Our first visit was outside as he was Covid positive and had to isolate, but at this time he stated he was ok and had food and was managing his stoma bags.

Action

Our subsequent visits identified multiple issues:

- No food at the property
- Used stoma bags on the floor
- Evidence of drug use
- Requirement to register with a GP
- Faeces and urine on the bedding and carpet
- Prescription required for regular medication
- Required follow up with the Stoma Nurse
- No washing or cleaning done at the property
- Required follow up with the Catheter Nurse

Photo courtesy of Timur Weber from Pexels

> ‘ If the gentleman had not had input from the team who built up this trusting relationship, his needs would have escalated.

- Required follow up with the Mental Health Team for depot injection
- No evidence of self-care
- Struggling to cope
- Concerns that drug dealer / friend has his bank card
- No support in the accommodation

Actions taken by outreach team:

- Referral to safeguarding team and referral to social care
- Discussion with the Stoma Nurse regarding bags and a joint visit arranged
- Discussion with the Catheter Nurse regarding removal and a visit arranged
- Support given with cleaning the property, shopping and washing
- Discussion with the Homeless Health Team who felt it would be beneficial to register with them there as they knew him
- Support with collecting medication
- Liaison with the Mental Health Team regarding his depot injection
- General health and wellbeing checks
- Discussion with housing, the suitability of accommodation and would a more supported environment be appropriate
- Liaison with care agency when a care package had been agreed.

Outcome and impact

The team had input with this gentleman from January until April 2021 and when all the appropriate services were in place, we were able to discharge him. In this time, we built up a good rapport, trust and an understanding of his health and wellbeing needs.

If the team had not been involved, it could have resulted in re-admission to hospital due to:

- Infection / sepsis – from poor catheter care and hygiene
- Malnourishment – no food in the property, very poor dietary intake, underweight at first meeting
- Eviction – due to environmental, health and fire risks, used stoma bags left all over the floor, carpet used as an ashtray
- Mental health – escalation in mental health when not receiving depot injections
- Medication – not taking regular prescribed medication as not collecting from the pharmacy
- No support or input from other agencies would have resulted in a decline in his physical and mental health.

If the gentleman had not had input from the team who built up this trusting relationship, his needs would have escalated. Cost data from Pleace and Culhane (2016) estimated the total public sector costs of a person experiencing homelessness to be as much as £38,736 per person per year in England (based on 2019/20 prices).

This included NHS costs (£4,298), Mental Health Services (£2,099), Drug and Alcohol services (£1,320), Criminal Justice sector costs (£11,991) and Homelessness Services (£14,808).

Lessons learned and recommendations

- Since we have discharged him from our service he continues with a care package from social services, he has moved into supported accommodation and engages with his GP.
- He has visited A&E twice since January 2021, once with catheter concerns and the second visit due to shortness of breath and these were both out of hours or the weekend. This is a significant decrease in 2020, when he visited A&E at least 6 times the last resulting in a hospital admission for 3 months. (Cost of A&E visit = £188 (Crisis UK 2016).

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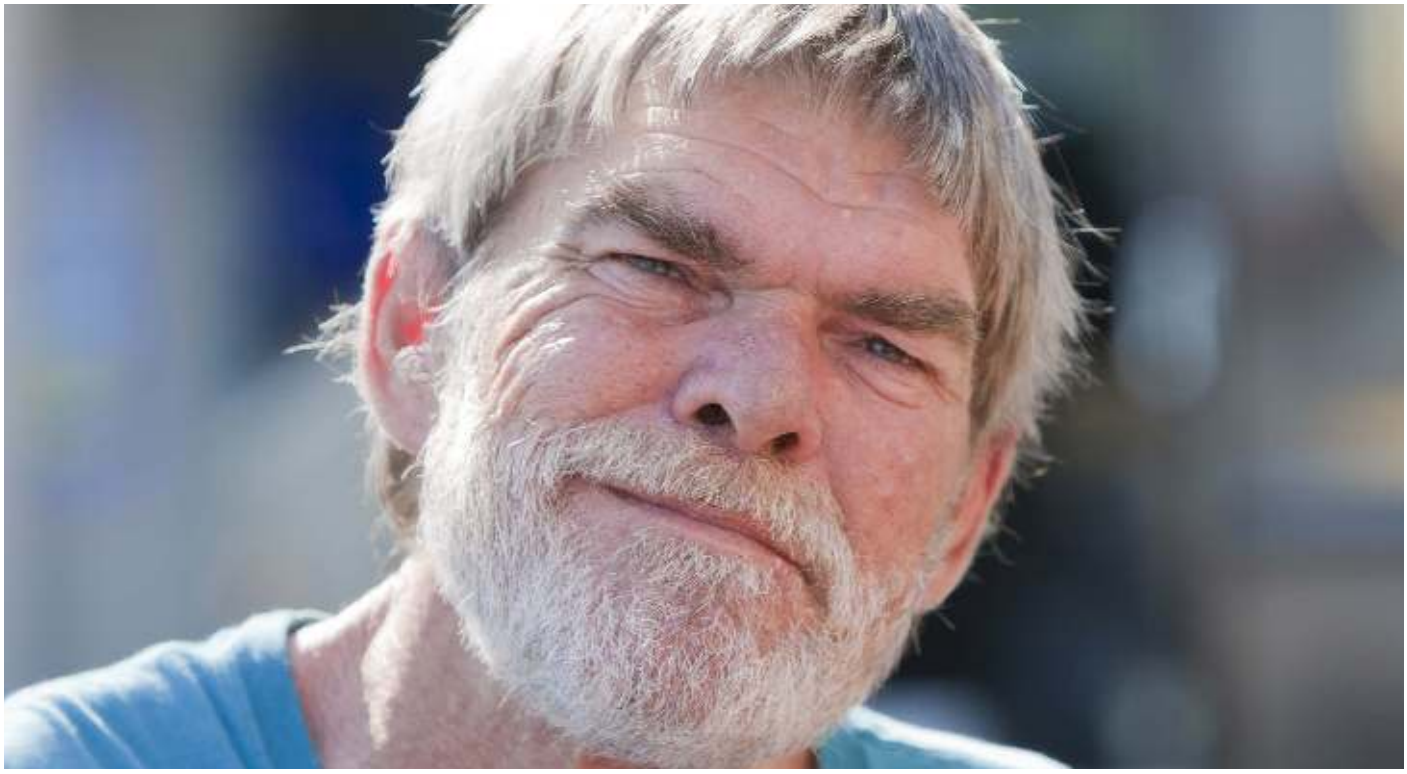

Case Study 10

Title **A Male Supported by Outreach Team**

By England outreach team nurse

Context

First meeting with A in June 2021. He was rough sleeping, sometimes in a tent and sometimes on a bench. He stated that he was often nibbled by rats down by the river in his tent. On the first occasion I met him he had been incontinent of faeces in his trousers and was very sunburnt. His medical history included diabetes, alcohol dependency and was an ex intravenous drug user. He had been homeless for the best part of 10-15 years. Banned from a lot of areas due to aggressive begging, he spent most of his days on the bench by the river. At that time he was bouncing in and out of A&E with severe intoxication and / or having been assaulted. Not long after I met him his tent was burnt down by some youths. A few weeks later he was burnt by some other youths whilst intoxicated.

Action

At the first visit we checked his blood sugar level, took some blood samples, gave him clean socks, gave him wet wipes so he could clean himself where he had been incontinent, and bathed his feet – which we noticed had some blisters and wounds due to the shoes being too small. Wounds to the feet and poor footcare are serious issues for people with diabetes and can escalate into ulcers and necrosis. We also provided him with water and suntan lotion.

Subsequent visits included:

- Diabetes management
- Providing new shoes that fitted
- Sun protection
- Dressing and healing his foot wound
- Dressing and healing his thigh burn which occurred due to the assault
- Liaising with St Mungos homeless hostel to help him have a shower
- Welfare checks

> In 5 months, they had gone from a long term rough sleeper being nibbled by rats as he slept, to having their own accommodation & registering with a GP where he has access to a diabetic nurse & drug workers.

- Covid vaccine
- Regular footcare - and consequently a monthly outreach podiatry service has been set up for other clients who are homeless and who have diabetes or who need footcare
- Nurturing a relationship and gaining trust with someone who up until then had had poor relationships with health care professionals, did not trust people and therefore did not engage.
- Bringing him food and clean clothes and socks at each visit.

We have also liaised with shared care workers – whilst he was sleeping out we helped him get in contact with the drug and alcohol team, he was started on subutex and has now started on buvidal injections. He is asking about alcohol detox.

Outcome and impact

- Prior to our input A was a regular attender of A&E. In 2020 he had over 11 attendances to A&E (Cost of A&E visit = £188 (Crisis UK, 2016)
- We fostered trust and engagement with health and social professionals
- Diabetes management which stabilized his condition
- Wound care was managed and therefore prevented the wounds from becoming infected, and they all healed
- Covid vaccine was given
- Opioid Substance Therapy was recommenced
- Support with nutrition and fluids
- Welfare checks

Lessons learned and recommendations

In 5 months, this gentleman had gone from a long term rough sleeper being nibbled by rats as he slept, to having his own accommodation and registering with a GP where he has access to a diabetic nurse and drug workers, who he telephones on his new mobile phone if he is going to be late. He is also requesting an alcohol detox. There have been no hospital admissions for past four and a half months.

If this individual had not had input from the team who built up this trusting relationship, his needs would have escalated. Cost data from Pleace and Culhane (2016) estimated the total public sector costs of a person experiencing homelessness to be as much as £38,736 per person per year in England (based on 2019/20 prices).

This included NHS costs (£4,298), Mental Health Services (£2,099), Drug and Alcohol services (£1,320), Criminal Justice sector costs (£11,991) and Homelessness Services (£14,808).

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