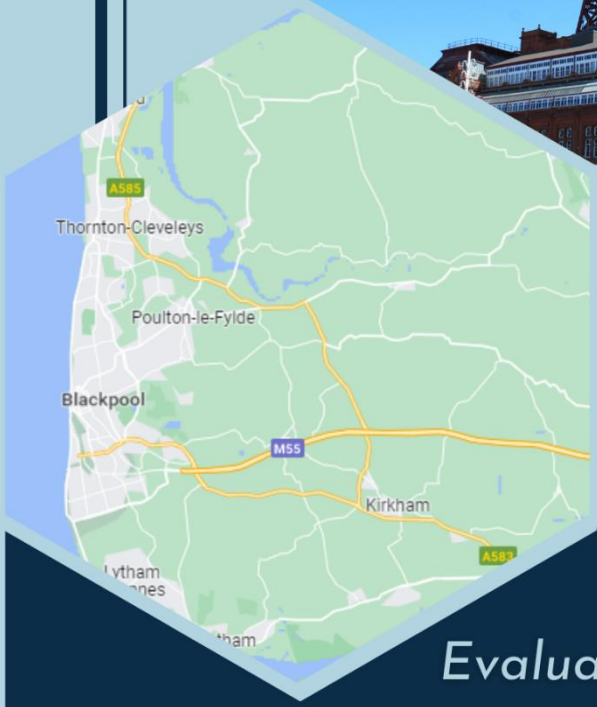


Evaluation of

FYLDE COAST HOMELESS HEALTH HUB

October 2022

NHS
Lancashire and South Cumbria
Integrated Care Board

Blackpool Council
BUILDING A BETTER COMMUNITY FOR ALL

healthwatch Blackpool

Contents:

1. Introduction

This evaluation was carried out by two GP trainees, Dr Furqan Sattar and Dr Olumide Adebambo, whilst undertaking a placement with Public Health Blackpool. Supervision was provided by Dr Judith Mills, Public Health Blackpool and Tracy Whitfield, Population Health Project Manager, Lancashire and South Cumbria ICB, Fylde Coast. Engagement with service users was led by Healthwatch Blackpool and supported by stakeholders of the wider Homeless Health Hub.

The aim of this project was to evaluate the pilot of the Homeless Health Hub covering Blackpool Fylde & Wyre, based at the Salvation Army (The Bridge), Blackpool. Those who are homeless/rough sleeping often face barriers in accessing local services and experience difficulties in interacting with multiple service providers. Due to the high numbers, transience, and the growing need for wound care of this client cohort, particularly in Blackpool, the hub offer was developed to address this.

In this report we begin with background information of homeless health problems generally and expand on the local context. This is followed by a description of the Homeless Health Hub and how it started and evolved, briefly describing the service specification as well as the outcomes set out when the service began, focusing on the key elements of the Nurse-led homeless clinics. We discuss findings from a quick literature search to show similar models in the UK, followed by the evaluation of the service with our service users and stakeholder's questionnaire and key recommendations.

2.0 Background

2.1 Health problems in people facing homelessness

The population of people who are homeless have multiple and complex needs, including severely poor health, deep social exclusion, and early death. Poor health is often both a cause and an effect of homelessness, and the two tend to interact in complex and mutually reinforcing ways.

In 2020, there were an estimated 688 deaths of homeless people registered in England and Wales, which even though this showed a decrease of 11.6% from that in 2019, the figures were not statistically significant and identified to be potentially underestimating the actual numbers[1]. Drug-poisoning is the leading cause of these deaths (accounting for almost 38.5% of all these estimated deaths), followed by alcohol-specific causes and suicide (accounting for 12.1% and 10.8% of the deaths respectively) in these. Northwest had the second highest number of deaths registered, with 126 (18.3% of the total number) estimated deaths of homeless people in 2020. However, considering the size of the population, Northwest of England has the highest rate, with 23.3 homeless deaths per million people.

Populations facing homelessness have complex physical and mental health needs, with 78% of homeless people reported having a long-term physical health condition compared to 37% of the general population, and 44% of homeless population having a mental health diagnosis compared to 23% of the general population[2]. They are also far more vulnerable to issues relating to alcohol and drug use, violence, and abuse.

Alongside their high and complex needs, people who are homeless commonly face a range of barriers to accessing health and care services (Gunner et al., 2019)[3]. These can include:

- Difficulties navigating the health and care system, due to a range of different factors including low literacy skills, language barriers, complex administrative processes and the lack of transport

- Reluctance to engage due to expectations of rejection or stigmatisation, or distrust of institutions, often based on negative past experiences

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2020registrations

[2] https://www.homeless.org.uk/our-work/resources/homeless-health-needs-audit

[3] Gunner, E., Chandan, S. K., Marwick, S., Saunders, K., Burwood, S., Yahyouche, A., & Paudyal, V. (2019). Provision and accessibility of primary healthcare services for people who are homeless: A qualitative study of patient perspectives in the UK. *British Journal of General Practice*, **69**(685), e526. https://doi.org/10.3399/bjgp19X704633

- "Chaotic' lifestyles, in which health and care needs are often not an immediate priority – service users can have difficulties keeping to appointments and can be difficult for services to contact

- Attitudinal issues within services and among some staff, including the stigmatisation of people who are homeless (Rae & Rees, 2015)[4], a lack of confidence and a lack of understanding around working with this population group, including being sufficiently trauma informed.

Some of the physical health problems seen in homeless population is shown in the image below (Figure 1):

Figure 1 Adapted from Health needs audit – Homeless.org

[4] Rae, B. E., & Rees, S. (2015). The perceptions of homeless people regarding their healthcare needs and experiences of receiving health care. *Journal of Advanced Nursing*, **71**(9), 2096–2107. https://doi.org/10.1111/jan.12675

2.2. Local context

The Fylde Coast has a population of 352,000 people living in a mix of urban, suburban, and rural communities. These areas include Blackpool, Fleetwood, Thornton-Cleveleys, Poulton-le-Fylde, Garstang, Great Eccleston, Over Wyre, Lytham St Annes, Kirkham, Wesham, and the surrounding villages.

During July 2021, the Chief Medical Officer's Annual Report, Health in Coastal Communities, was published, highlighting that coastal communities, the villages, towns, and cities of England's coast, include many of the most beautiful, vibrant, and historically important places in the country yet have some of the worst health outcomes in England, evidencing low life expectancy and high rates of many major diseases. For example, Blackpool, although one of the country's favourite holiday destinations, has some of the most deprived communities in England with significant levels of health inequalities resulting in people experiencing a range of preventable diseases which affect quality of life and lead to increased morbidity.

There are many reasons for poor health outcomes in coastal communities. The pleasant environment attracts older, retired citizens to settle, who inevitably have more and increasing health problems. An oversupply of guest housing has led to Houses of Multiple Occupation which leads to concentrations of deprivation and ill health. The sea is a benefit but also a barrier: attracting NHS and social care staff to peripheral areas is harder, catchment areas for health services are artificially foreshortened and transport is often limited, in turn limiting job opportunities. Many coastal communities were created around a single industry such as previous versions of tourism, or fishing, or port work that have since moved on, meaning work can often be scarce or seasonal.

The need for a new approach to supporting homeless health in Blackpool was identified, following a Public Health England led outbreak control response to Group A Streptococcal (GAS). GAS is a notifiable infection. A one-off non-NHS wound management clinic was held in response to the outbreak. This was successful in engaging with the patient cohort but failed to encourage patients to complete follow up treatment within generic health services.

The patient cohort is split into two demographic age cohorts. Those 45 – 60 and those 20-30. The latter is a concern as it would suggest that Blackpool is following the recent trend in Glasgow and Dundee with an increase in heroin use. In Glasgow there has been an associated increase in HIV diagnosis within the drug using community.

Blackpool has the highest rate of drug related deaths in England, with a rate of 22.1 per 100,000 which is four times higher than the England average of 5.0 per 100,000. Figure 1 shows we compare to other areas in the North-West. There were 122 drug poisoning deaths in Blackpool in 2018-20, 86 of these were categorised as drug misuse, with males accounting for almost two thirds of these cases.

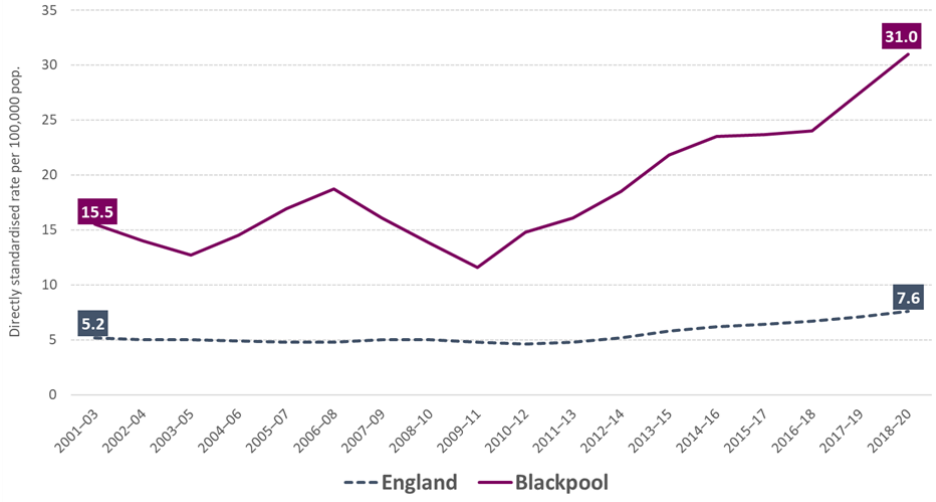
Rates of hospital admissions in Blackpool for conditions that are related to drug misuse mirror this increase in deaths. IV drug users have been identified nationally and locally as high users of emergency services.

Figure 1: Deaths from Drug Misuse – North-West Region 2018-20

Area	Recent Trend	Count	Value
England	–	8,185	5.0
North West region	–	1,476	7.1
Blackpool	–	86	22.1
Liverpool	–	168	12.9
Wirral	–	92	10.1
Cumbria	–	126	9.7
Blackburn with Darwen	–	39	9.1
Manchester	–	120	9.0
Tameside	–	58	8.8
Knowsley	–	35	8.4
Bolton	–	62	7.7
Salford	–	53	7.6
Bury	–	40	7.3
Rochdale	–	45	7.1
St. Helens	–	34	6.7
Sefton	–	49	6.5
Wigan	–	62	6.4
Stockport	–	47	5.6
Oldham	–	35	5.4
Cheshire West and Chester	–	51	5.4
Lancashire	–	161	4.8
Halton	–	18	4.8
Trafford	–	32	4.5
Warrington	–	27	4.3
Cheshire East	–	36	3.3

As seen in Figure 2 below, there has been a 167% rise in rates since the low of 2009-11 and the number of deaths has increased from 48 in that period.

Figure 2: Trend in deaths related to drug poisoning: 2001-03 to 2018-20, England and Blackpool



Deaths related to drug misuse are lower in both Fylde and Wyre over the same period, showing a rate per 100,000 for Fylde 8.06 and Wyre 6.59.

Blackpool is ranked the 1st worst district nationally for alcohol related deaths and 13th for hospital admissions for alcohol related conditions. Both Fylde and Wyre are both above the national average for alcohol related hospital admissions.

Health Foundation data 2019/20

		Blackpool	Fylde	Wyre	England
Alcohol-related mortality (all persons)	2019	65	36	50	36
Hospital admissions for alcohol related conditions (all persons)	2019/20	772	571	551	519

The overall need for the Homeless Health Hub is estimated as 600-1000 patients per year with multiple and complex needs (nursing, mental health, and substance misuse support) including 60+ clients requiring complex ongoing wound care. Again, Homeless people have been identified nationally and locally as high users of emergency services.

Rough sleeping and homelessness have increased dramatically over the last 5 years and in Blackpool numbers remain consistently high. In Fylde and Wyre the overall figure is much lower however, due to the cost-of-living crisis, housing shortages and the lifting of the eviction ban posed on Landlords during the Covid 19 pandemic, they are now seeing an increase is numbers either homeless or at risk of becoming homeless.

Blackpool

For the year 1st April 2021 – 31st March 2022 Blackpool Housing Options 2804 applications were taken for individuals who were either homeless or at risk of homelessness or in housing need. Of this amount 1,411 people were owed duties under homeless legislation to either Prevent or Relieve homelessness. During this period, we arranged placements of temporary accommodation for 547 households. In total we arranged 900 temporary accommodation placements.

For year 1st April 2022 – 31st October 2022 Blackpool Housing Options 1769 applications were taken for individuals who were either homeless or at risk of homelessness or in housing need. Of this 937 people were owed duties under homeless legislation to either Prevent or Relieve homelessness. During this period, we arranged placements of temporary accommodation for 432 households. In total we have arranged 655 temporary accommodation placements.

Fylde

For the year 1st April 2021 – 31st March 2022 Fylde Council had 727 presentations from individuals who were either homeless or at risk of homelessness. Of this amount 376 homeless applications were taken. Of these applications 133 households were placed into temporary accommodation

For year 1st April 2022 – 31st October 2022 Fylde Council have had 503 presentations for individuals who are either homeless or at risk of homelessness. Of this amount 287 homeless applications have been taken. Of these applications 117 households were placed into temporary accommodation.

Wyre

For the year 1 April 2021 – 31 March 2022 Wyre Borough Council received 1090 homeless applications. Over the same period, 447 initial assessments were carried out and 102 of these were homeless at the point of assessment. 335 households were threatened with homelessness.

From 1 April 2022 – 30th October 2022 Wyre Borough Council have received 757 homeless applications 52 households were placed in temporary accommodation.

3.0 Description of Homeless Health Hub

3.1 Historical development of Homeless Health Hub

To support the growing health needs of the homeless population, a multi-disciplinary homeless health team was established during the 1990's through a Department of Health Grant which was then mainstreamed by North-West Lancashire Health Authority. Historically, the team included two senior nurses, primary health nurses, dental care, and mental health provision. Over time the numbers of rough sleepers reduced and in response to the need for efficiency savings, the team reduced to a core of primary health nurses based at the Bridge Project, which is managed by the Salvation Army and is the main day centre in Blackpool for homelessness.

Before the COVID-19 pandemic, plans were underway to develop a homeless health hub, however as the pandemic hit, it presented a huge challenge, threatening to make the access of homeless population to basic health services, food, and shelter even more difficult.

In response to the growing concerns of the impact of COVID-19 on the homeless client group, Government guidance was issued during March 2020. Based on this guidance, the Fylde Coast Integrated Care Partnership (ICP) implemented a local Homeless Health Response Cell which included partners from Fylde Coast Clinical

Commissioning Group, Blackpool Borough Council, The Ashley Foundation, Blackpool Teaching Hospitals, Lancashire & South Cumbria Foundation Trust, Lancashire County Council, Fylde Borough Council, Wyre Borough Council, Fylde Coast Medical Services NW Ltd, Substance Misuse Services, Mental Health Services and Her Majesty's Prison, Probation and Police Services.

From 9th April 2020 this 'local response cell' was co-ordinated and co-chaired by the Clinical Commissioning Group and Blackpool Borough Council, with the main objective of reducing the spread of COVID-19 among the homeless client group and the wider community, and to ensure that the basic needs of this community were being met during the period where usual services were being affected by the pandemic and the subsequent lockdown. This was further morphed into a formal Homeless Health Hub, piloted from January 2021.

Since the introduction of the hub pilot, other initiatives have been developed (ADDER and Changing Futures) which are described in more detail under section 3.5. The diagram in this section illustrates how each of the teams work as a 'system' to ensure the most effective use of resource to maximise the benefit to the client.

3.2 Service Description

The service specification document for the Homeless Health Hub, described it to be a multi-disciplinary service, part of a wider wraparound homeless support service delivered on the Fylde Coast, based at the Bridge Project, Salvation Army Citadel, Blackpool. This included nurse-led homeless health clinics, mental health support and liaison with other agencies and organisations to provide other aspects of healthcare as described below.

The health team provides appropriate clinical decisions around the health and wellbeing of individuals; this will frequently include direct intervention. The team provides specialist guidance on the interventions identified through an initial health needs assessment on a planned and drop-in basis. The purpose of the service is to provide a joined up, holistic approach to improving health and care outcomes for rough sleepers and homeless people.

Importantly the service is not intended to be an urgent care service but rather support improving outcomes for ongoing complex needs. The purpose of the drop in element is to provide a flexible entry point to the service, not address urgent care needs. Urgent care needs will still be addressed using urgent care pathways, as appropriate to the individual's needs.

The initial areas of need to be supported by the Hub model were:

- Mental health
- Substance misuse
- Wound care and treatment

- Blood borne virus screening and treatment
- Circulatory conditions
- Respiratory conditions

3.3 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill-health or following injury
Domain 4	Ensuring people have a positive experience of care
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm

3.4 Locally Defined Outcomes and Objectives:

The overarching outcomes of delivering a wraparound homeless support service on the Fylde Coast were identified as:

- To ensure an effective and equitable use of resources
- To ensure that the health and or care needs of the homeless population, who require clinical and care interventions, are safely met by offering an environment where they receive care that is appropriate for their needs and provided by people with appropriate knowledge and skills
- To work closely with CCG and wider partners to ensure that there are no gaps in service

Key performance indicators were identified at the start of the pilot, and it was always envisaged that the model would continue to evolve once delivery started. Some of the service outcomes in terms of evaluation and reporting were as below:

- Engagement with a minimum of 150 people from the target cohort in order to ascertain their views in relation to effective service model
- Production of Health Needs Assessment
- Co-production informed model with venues identified for roll out of service including capacity requirements
- Determination if model requires specialist GP input

3.5 The Nurse-led Homeless Health Team

The nursing team consists of 1 WTE Nurse Prescriber, 0.5 WTE Nurse, 0.3 WTE Nurse Practitioner (Clinical Lead) and 0.6 WTE management support, all funded by the Lancashire & South Cumbria Integrated Care Board. In addition, Blackpool Public Health have provided short term funding for a non-clinical Care Navigator (18 hours per week).

The nursing team carry out holistic health assessments, see and treat minor aliments/minor injuries, provide wound care assessments/treatment and, chronic disease reviews. They also support the triaging of patients who find it difficult to navigate or will not access mainstream services, for example, urgent care whilst helping them navigate wider healthcare provisions etc.

The team is based at the Bridge on Mondays and Fridays to provide drop-in and appointment-based clinics. On a Tuesday the team undertakes outreach work and visits local hostels using a specially equipped van. Thursday is used to focus on the drop-in session delivered by the ADDER Team, where there is a clinic for opportunistic siting. Wednesday is flexed to support additional outreach, MDTs etc.

3.6 Other Organisations Involved:

Teams from partner organisations work closely with the nurse led team. A dedicated Mental Health Service is now operational and through a dual pathway and referral form with the nurse led team, they are easily able to identify which team is best placed to offer initial support, facilitating onward referrals and signposting to other parts of the system, as appropriate.

These include the following teams:

- Probations and Prison services HMPPS
- Homeless Mental Health Team
- ADDER
- Lived Experience Team
- Renaissance UK Ltd
- Blackpool, Fylde and Wyre Housing Teams
- Delphi Medical
- CGL Inspire
- Changing Futures

These teams were part of the stakeholder feedback, and a summary of their feedback is described later in the report. Teams and their roles have been described below:

a) Lived Experience Team:

The Lived Experience Team (LET) are a key collaborative force within the Hub. The LET are an outreach-based team that, through its network of volunteers who themselves have personal experience of issues such as homelessness, mental health, offending and substance misuse.

They are skilled in building trust with and advocating for people facing multiple disadvantage. Taking the form of going to speak to people where they are and where needed, convincing them to attend the service. In addition, the LET will actively bring people to appointments and attend with them to support them and encourage completion of care plan goals. Within this role the LET deliver a wraparound service. In addition to advocacy support the LET will also guide the development of the service, working with homeless people to tailor the service to their needs.

b) Renaissance UK Ltd

The Renaissance Team, as part of the Horizon Drug and Alcohol Service in partnership with Dephi Medical, provide community focussed assertive outreach for drug and alcohol harm reduction and engagement into treatment, together with health screening for sexual health and blood borne viruses, and support into Housing. We also coordinate the needle exchange services within Blackpool and the Naloxone distribution. Outreach workers can also assess service users for entry into treatment and then offer motivation and advice until a keyworker is allocated. We specialise in empowering individuals through specialist support and interventions.

Renaissance is a Blackpool based charity, founded in 1986, and is a dynamic and innovative service offering quality, community focussed sexual health and substance misuse services. We specialise in supporting individuals to reduce harm, we offer specialist support and we aim to move people forward in their lives by means of empowerment. Currently we work across three local authorities delivering harm reduction, assertive outreach, specialist support and moving forward opportunities such as volunteering and training, all strands of our work support a sexual health or substance use local need.

c) Delphi Medical

Delphi provide treatment and recovery support to over 1400 people across Blackpool. In partnership with Renaissance and Acorn Recovery Projects, they deliver the Horizon Drug and Alcohol Service. Supporting clients with clinical and holistic psychosocial interventions, as well as assertive outreach. The team comprises of General Practitioners, Non-Medical Prescribers, Nurses, Recovery Practitioners and Support Workers – as well as a dedicated therapy team, providing mental health support to their clients.

Operating from various locations and in a wide range of community settings, Delphi work closely with local partners in Health and Social Care to ensure our service users receive a care plan that places the person at the centre of their care. Our delivery model includes specialist support for those with Multiple Complex Needs, Safeguarding Needs and those who are experiencing problematic and/or dependent drinking. We provide a range of clinical interventions, including Opiate Substitution Therapy and were early adopters of the long-acting Buprenorphine (Buvidal) treatment options.

Delphi are a values led organisation which, as part of the Horizon Partnership, harnesses the value of lived experience to provide a safe, effective, response, well led and caring service to the people of Blackpool.

d) CGL Inspire (Change Grow Live)

CGL provide all aspects of drug and alcohol treatment for residents of Fylde and Wyre including open access to their services, structured treatment, and referral to tier 4 rehabilitation. Their aim is to promote recovery from addiction and dependence, supporting clients to make positive changes to their life. Range of services include:

- Needle exchanges
- Advice on Harm Reduction
- Psychosocial Interventions
- Substitute Prescribing
- Group Work
- Access to Counselling
- Referral to Residential Detoxification and Rehabilitation

e) Housing Options (Part of Blackpool Housing):

Blackpool Housing options has a range of services available to offer support and prevent people from becoming homeless, this includes finding them somewhere to live they have nowhere to stay.

They have a dedicated outreach service that engages with rough sleepers to help them off the streets. Offers of help to rough sleepers may include help accessing emergency accommodation, referrals to supported accommodation (such as The Ashley Foundation) or help finding private rented accommodation.

f) Fylde Borough Council

Fylde Borough Council support customers who are either homeless or threatened with homelessness. In these circumstances the Housing Advice and Homelessness Service will conduct the appropriate enquiries and determine if either a Homeless Prevention Duty or a Homeless Relief Duty is owed. If it is determined that a customer is Homeless, Eligible and in Priority Need then temporary accommodation will be offered at this point.

Housing Advice and Homelessness Officers and Housing Services Officers will support the customer through their homelessness journey until they secure settled accommodation. To support this, referrals may be made into other Fylde Council Services.

Range of services can include:

- Referral to our Domestic Violence Outreach Service
- A "Help to Rent" scheme to help with deposits to enable access to the Private Rented Sector
- Help and advice negotiating with Private Rented Sector landlords including mediation
- Referral to budgeting and debt advice services
- Referral into our Rough Sleeper and Ex-Offender Specific Service
- For those facing Multiple Disadvantage we can refer into our Changing Futures Service
- Help and advice if you are having problems with your mortgage and face repossession
- A Floating Support Service

g) Wyre Borough Council

Wyre Borough Council support to those who are homeless or are concerned they may become homeless. In these circumstances the Housing/Homelessness Team will provide help and assistance, and if necessary, arrange temporary accommodation for the client whilst they carry out an assessment and conduct investigations to why they have become homeless. We provide support to gain accommodation and signpost to a range of services relevant to our client's needs.

A range of services can include:

- Referral to domestic violence outreach worker.
- A scheme to help with deposits /rent in advance to enable access to the privately rented sector.
- Support to gain access to social housing
- Referrals into supported accommodation
- Help and advice negotiating with private sector landlords.
- Referral to debt and other support services.
- Referral to ex- offender support worker
- Referrals to changing Futures programme
- Help and advice if you are having problems with your mortgage and face repossession.

h) Homeless Mental Health Service:

The homeless / rough sleepers (RS) mental health team is part of a multidisciplinary, co-located service based at Winstone House, Blackpool. The team is attached to the Primary Intermediate Mental Health Team, Blackpool Teaching Hospitals NHS Foundation Trust, which enables swift access to the Single Point of Access Mental Health Duty Team, onward referral to adult autism spectrum disorder (ASD) services for assessment and educational support, and for signposting to the attention deficit hyperactivity disorder (ADHD) assessment and follow-up clinic.

The aim of the team is to provide a holistic, flexible, and non-judgmental approach that encourages clients to engage in mental health and social care provision, with the intention of providing clients with social support and a trusting relationship that leads to ongoing engagement on a therapeutic pathway. They work in partnership with other homeless services including housing, physical health nurses, substance misuse and sexual health services, and peer support outreach workers with lived experience.

By reducing pre-existing barriers, the team offer easy access to mental health intervention with an objective of improving the mental health and care outcomes for clients who have multiple disadvantages within the local community via:

- A trauma informed workforce
- Person Centred Approach through a multidisciplinary team
- Assertive outreach
- Joint working with individuals with lived experience
- Joint funding to add value, robust staffing and improve effectiveness
- Collaborative working, pathways, and protocols

The homeless / RS mental health team consists of:

- Consultant psychiatrist (clinical lead for the service)
- Clinical psychologist
- Mental health practitioners (band 7 Team Leader, band 6 mental health nurse, band 6 mental health nurse who will specialise in mental health transition work, band 5 allied health professional)
- Nursing Associates (band 4 x 2)
- Peer support worker
- Mental health social worker (AMHP)
- Team Administrator

Referrals to the mental health team are accepted either via the dedicated team in-box, through discussion at the Fylde Coast Changing Futures MDT meeting or at the request of other colleagues within the wider homelessness services. Referrals are discussed at the weekly allocation meeting, but the team do offer same day input if a member of the wider homeless services requests support.

i) Homeless Link Worker (HLW):

To support links between Blackpool Teaching Hospitals and the partners from the Hub, 2 Homeless Link Workers were appointed during November 2021 embedded within the Discharge Team at Blackpool Victoria Hospital. They both work closely with Local Authority leads and wider homelessness services to facilitate safe, timely secondary care discharges, supporting any on-going care needs through onward referral and signposting. Prior to the implementation of these posts, clients were referred/sent directly to the local authority housing teams.

Their role is to assess homeless patients admitted to the hospital with a view to support a safe discharge from hospital. The main functions of the role are liaising with housing teams to secure suitable accommodation and housing support, facilitating any necessary onward referrals to the Homeless Health Hub teams to provide any identified community support to prevent re-admission, this can also include supporting people to access wider services for example transport services, food parcels and clothes banks.

j) HMPPS (Probation and Prison Services)

The Probation service supervises all men and women who are subject to supervision either on Community Orders or on release from custody on licence. Key to release planning is robust multi agency working, partnerships and good information sharing. Poor health issues amongst men and women in the Criminal Justice system are high and homelessness adds to their vulnerabilities.

k) Changing Futures

Changing Futures consists of 15 nationally funded partnerships aiming to improve outcomes for people experiencing multiple disadvantage. Changing Futures Lancashire is a county-wide programme with 4 localities. Blackpool is the lead authority for the Fylde Coast Locality, which includes Fylde and Wyre Boroughs.

The Programme has aims at three levels:

1. **Individual level aims**
   - To increase the likelihood that people experiencing multiple disadvantage will remain connected to support
   - For people experiencing multiple disadvantage to be more empowered, informed and resilient and able to manage their recovery in ways that work for them.
2. **Service level aim**
   - For local services to become more person-centred, coordinated, flexible and trauma-informed and to support people make lasting positive change
3. **System level aims**
   - For the Lancashire system to implement long-term sustainable changes to benefit people experiencing multiple disadvantage

- To sustain the benefits of the programme, beyond the lifetime of the funding.

For people to enter the programme they must be over 18 years of age and be facing barriers to engaging with services they need. They also must be currently experiencing multiple disadvantage. Access criteria has been defined as a combination of at least 3 of the following:

- Homelessness
- Substance use (drugs and/or alcohol)
- Mental health issues
- Domestic abuse
- Contact with the criminal justice system

The core Changing Futures offer for individual beneficiaries is a named peer mentor from the Lived Experience Team who will build a trusted relationship with them, connect them to their coordinated multiagency plan of support, advocate on their behalf when the plan/system is not meeting their needs and help them to recognise their own assets and build resilience so that, over time, they can become independent.

l) ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery):

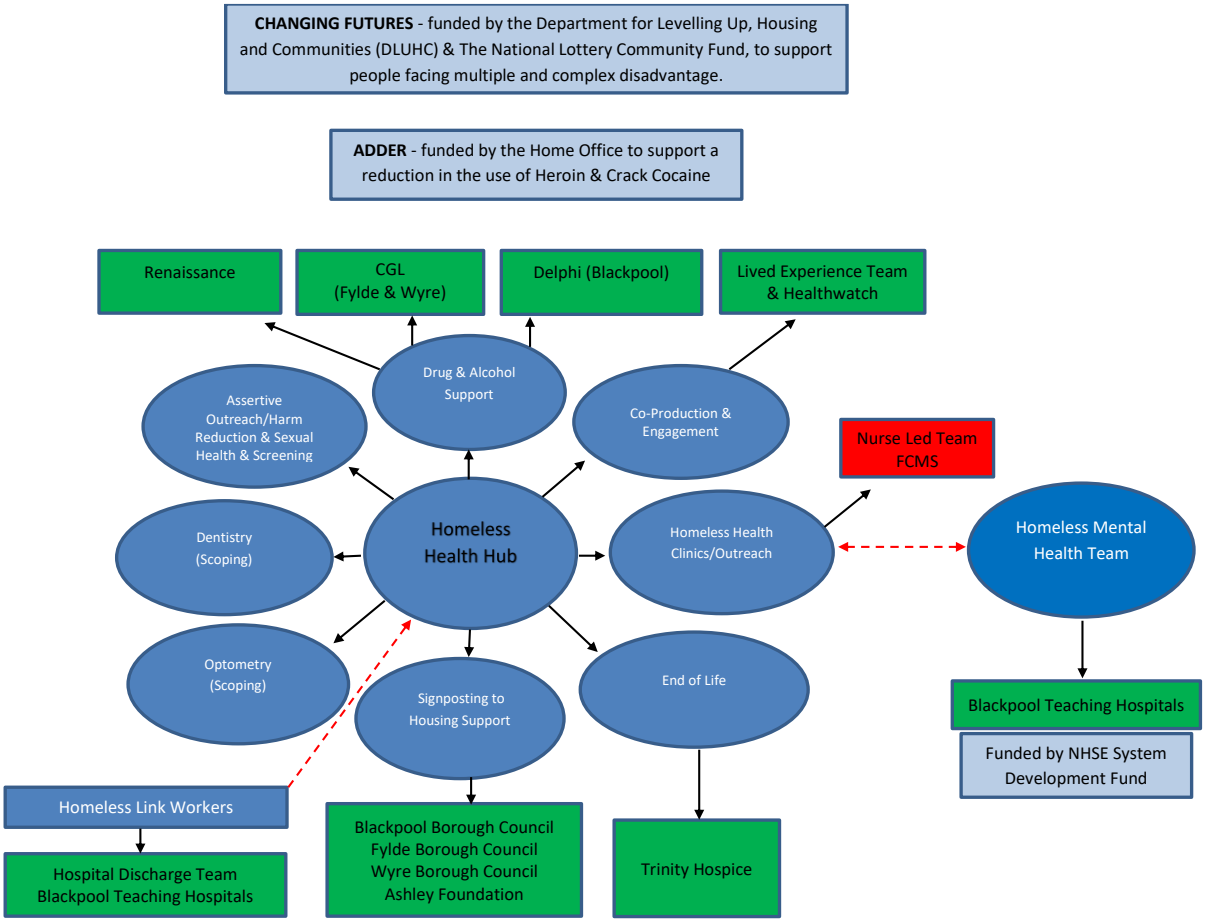
ADDER is a Home Office funded pilot in Blackpool supporting an intensive whole system approach to tackling drug misuse in select locations worst affected by drug misuse, whilst working alongside other agencies around national activity to disrupt the middle market supply of drugs.

The project involves co-ordinated law enforcement activity alongside expanded diversionary activity and treatment/recovery provision in the chosen pilot areas. This pilot has been built on existing work expanding multi-agency partnership working in the Blackpool area to drive sustained health and crime related outcomes.

The ADDER pilot Blackpool officially started in January 2021 and is based at Winstone House in Blackpool, it consists of a therapist, psychologist, non-medical prescriber, harm reduction nurse and a Criminal Justice Team. The team has a steady client caseload of approximately 10 clients, experiencing multiple disadvantage, at any one time. This focused caseload is aimed at keeping a close contact with the clients in order to deliver effective care planning and management.

Clients supported by ADDER are from Horizon, from the Renaissance outreach team and from the Lived Experience Team (LET) who work collaboratively with housing options, probation, police and the adult social care in order to deliver effective and all-round care to their clients.

A pictorial representation of the Homeless Health Hub, linking with both ADDER, Changing Futures and a dedicated Mental Health Team is shown below.



Each of the initiatives identified in the diagram work together as a 'system' to ensure the most effective use of resource to those who often find accessing care quite difficult. This also supports the building of strong and consistent relationships with individuals and helps prevent any barriers to them accessing health and social care services.

The nurse led team, highlighted in red, are an integral part of the system delivery and although sit within the Hub model, they are now supporting clients identified through ADDER and Changing Futures. Liaising with other partners to address their immediate health and social care needs, supporting links with primary and secondary care, with the long-term aim of reintroducing individuals back into mainstream services.

4.0 Methodology

For this evaluation, we did a quick literature search to look for evidence for the utility of homeless health clinics, especially the nurse-led services. We also looked at their outcomes and what key challenges they faced.

Furthermore, we developed a questionnaire for the service users with questions focusing on their main health-related problems, experiences with the mainstream health services as well as the homeless health clinics, as well as their perspectives on how things could be improved. Multiple sessions were arranged, supported by Healthwatch Blackpool, Lived Experience Team and colleagues from the NHS Lancashire and South Cumbria Integrated Care Board. Sessions were delivered cross various sites in Blackpool including, the Ashley Foundation Hostels (Oak House, Holly House and Elm House), The Bridge Project, Claremont Community Centre and individual conversations with clients being supported by ADDER and the Lived Experience Team.

We also included case studies to help get a clear picture of how these services are impacting on individuals.

We also spoke with various key stakeholders from a variety of backgrounds, including the nurses leading the homeless health clinics, homeless mental health team, drugs, and alcohol services as well as the housing teams.

Finally, the summary of findings and key recommendations were drawn based on the information gathered whilst undertaking the evaluation.

5 Literature Search

Health-related outreach has generally shown to improve health outcomes for people experiencing homelessness (Ungpakorn & Rae, 2020)[5]. Furthermore, literature search showed many examples of nurse-led homeless health services in various parts of the UK. Queens Nursing Institute (QNI) published an evaluation of 10 nurse-led homeless health pilot projects that were funded in partnership with the Oak Foundation charity in 2018 (Byar, 2020)[6]. The projects were based across 10 different locations in England, each received funding and an assigned community nurse lead who undertook the work alongside their normal jobs. They found that overall, involving the nurses resulted in

[5] Ungpakorn, R., & Rae, B. (2020). Health-related street outreach: Exploring the perceptions of homeless people with experience of sleeping rough. *Journal of Advanced Nursing*, **76**(1), 253–263.

[6] Bryar, E. R. (2020). Homeless Health Innovation Funding Programme: Evaluation Report. The Queen's Nursing Institute, https://www.qni.org.uk/wp-content/uploads/2020/08/HH-Innovation-Funding-Programme-Evaluation-2020.pdf

improved engagement of the individuals and encouraged them to seek help for their health problems. 7 out of 10 projects continued beyond their original funded year. Accurate data collection, economic evaluation and lack of enough time/staff were found to be the main challenges in these projects.

People facing homelessness face problems like navigating the mainstream services. Bad experiences including facing stigma and prejudice has been reported (Hauff & Secor-Turner, 2014[7]; Rae & Rees, 2015)[8] compared to specialised nurse-led homeless services which have been shown to improve accessibility (Gunner et al., 2019; Su et al., 2015)[9] [10]

In addition to being more accessible, nurse-led clinics have also been shown to improve care by giving more personalised care and a more holistic care.

In our literature search, some of the challenges highlighted in similar nurse-led health clinics have been to do with the development of information-sharing and referral pathways between various agencies. Furthermore, capacity issues in terms of funding and staffing have been a recurring theme in terms of challenges as well (Bell et al., 2020)[11].

[7] Hauff, A. J., & Secor-Turner, M. (2014). Homeless health needs: Shelter and health service provider perspective. *Journal of Community Health Nursing*, **31**(2), 103–117.

[8] Rae, B. E., & Rees, S. (2015). The perceptions of homeless people regarding their healthcare needs and experiences of receiving health care. *Journal of Advanced Nursing*, **71**(9), 2096–2107. https://doi.org/10.1111/jan.12675

[9] Gunner, E., Chandan, S. K., Marwick, S., Saunders, K., Burwood, S., Yahyouche, A., & Paudyal, V. (2019). Provision and accessibility of primary healthcare services for people who are homeless: A qualitative study of patient perspectives in the UK. *British Journal of General Practice*, **69**(685), e526. https://doi.org/10.3399/bjgp19X704633

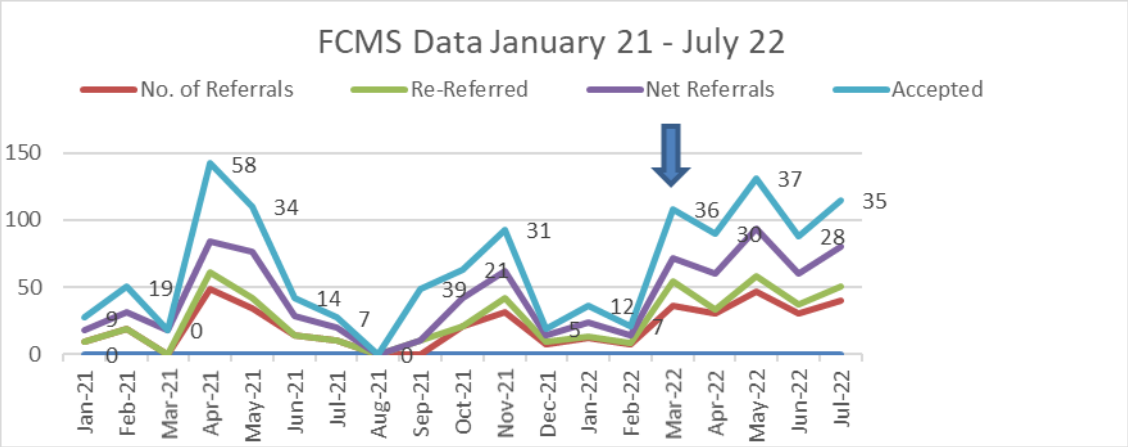
[10] Su, Z., Khoshnood, K., & Forster, S. H. (2015). Assessing impact of community health nurses on improving primary care use by homeless/marginally housed persons. *Journal of Community Health Nursing*, **32**(3), 161–169.

[10] Bell, L., Whelan, M., Fernandez, E., & Lycett, D. (2022). Nurse-led mental and physical healthcare for the homeless community: A qualitative evaluation. *Health & Social Care in the Community*, 00, 1– 10. https://doi.org/10.1111/hsc.13778

6 Quantitative Results

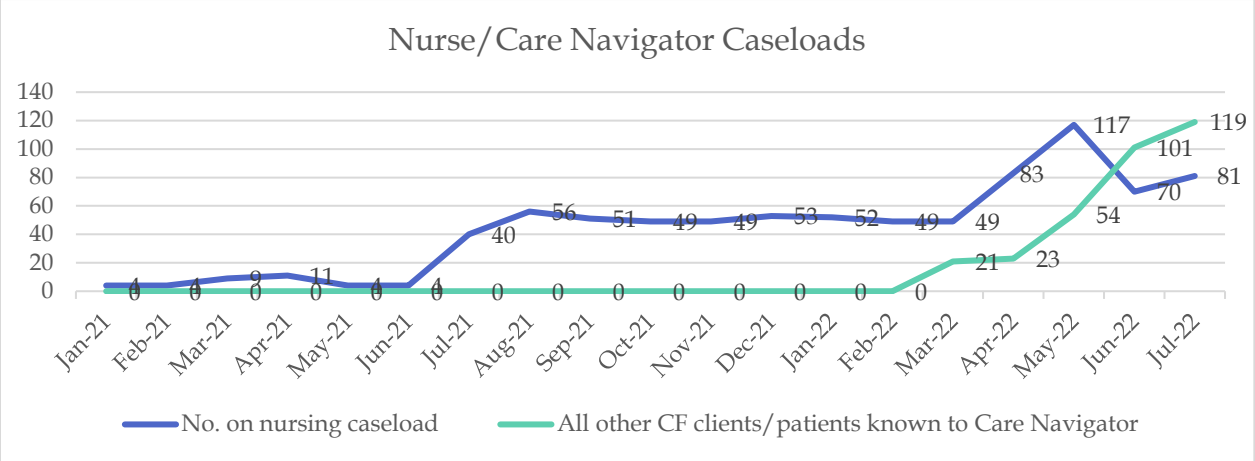
FCMS (Fylde Coast Medical Service) Nurse Led Team

The initial review of data from the nursing team looked at the 12 months period from January 2021 to January 2022 (249 referrals accepted) however, this was later expanded up to July 22 to evidence the increased demand on current capacity due to the introduction of other initiatives.



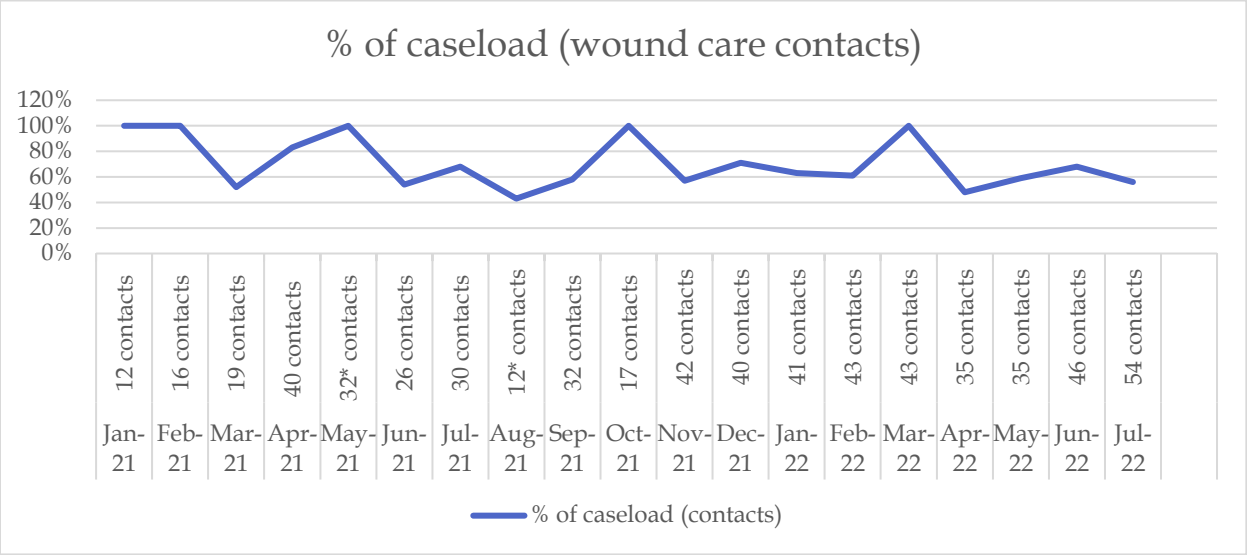
The above information shows us the total number of referrals received each month, the number of re-referrals, the number accepted and the net total. The arrow points to the start of a marked increase in referrals accepted into service during March 22 and, although we cannot directly identify the Changing Futures clients in the data, there is a direct correlation between this increase and the Changing Futures initiative going live at this time.

The following data provides further evidence of a link between increase in caseload and the establishment of Changing Futures. It shows caseload numbers remaining relatively static between August 21 and March 22, with April showing a marked increase at 83, peaking during May to 117. Prior to April 22 the Care Navigator didn't hold a caseload but from the start of Changing Futures this became necessary.



The position at the end of July 22 shows 81 cases on the Nursing caseload with a further 119 clients known to the Care Navigator, a total caseload of 200. In contrast, during July

21 caseload numbers were much lower with 40 cases being managed by the team in its entirety.

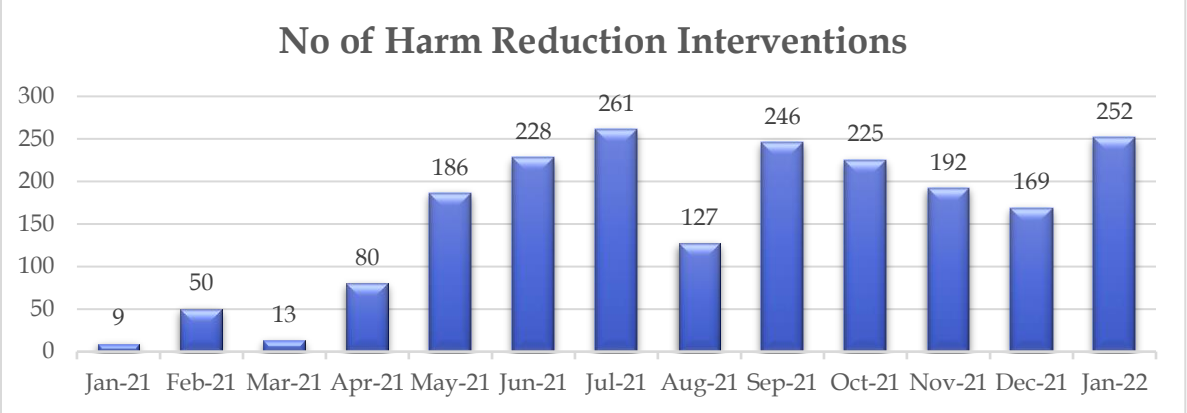


Whilst developing the nursing offer, it was apparent that the predominant need was to address the increasing demand for wound care as demonstrated in the data above. For clarity, other issues may have been addressed in these contacts, but the main presentation was wound care.

The data collected also evidenced that long term conditions care is not being picked up with only 17 clients having had a chronic disease review during the reporting period, although it is important to note that this is very much due to nursing capacity and not capability within the team. Due to capacity the team have had to respond and react to presentations and as demonstrated above, this is predominantly wound care.

Renaissance UK Ltd – Assertive Outreach/Harm Reduction & Sexual Health Screening

The data collected January 21 to January 22 shows the number of harm reduction interventions per month. The reduced numbers during January and April 21 directly correlates with Covid restrictions being in place at The Bridge, Salvation Army restricting access to clients only.



The Assertive Outreach team support clients into treatment but also help to retain people in treatment who are at risk of disengaging. They provide harm reduction advice, needle exchange equipment and Naloxone to clients for use in the event of an overdose. Naloxone training is also provided to partner organisations through their Harm Reduction Champion.

The team undertake welfare checks on clients, as requested by the drug and alcohol keyworkers, whilst also ensuring clients know when their appointments are and can attend. They deliver opiate substitute treatment in the homes of clients who are immobile, taking prescriptions from the drug and alcohol service to the pharmacy if a client is unable to collect direct from the service.

The team continue to work closely with Blackpool Victoria Hospital, taking alcohol referrals directly from the Alcohol Liaison Nurses, assessing clients and holding them, offering brief intervention and harm reduction advice, whilst they are awaiting allocation to a drug and alcohol keyworker. There is also a pathway in place with the Homeless Link Workers at the hospital, directly into the Assertive Outreach Team.

During the reporting period, 58 individuals were tested for blood borne viruses, 12 referred for treatment and 8 seen in clinic completing treatment for Hepatitis C. The Hepatitis C Outreach Worker continues to work closely with the FCMS nurse led team, providing drop-in clinics via the Renaissance 'Big Sexy Bus' and works in the community, regularly testing at the ADDER drop in, the substance misuse service buildings, Hotels, Probation, and the Women's Centre. The offer includes referring for

treatment and supporting them throughout their treatment journey, making hospital appointments for the clients and accompanying them to the appointments if they require support.

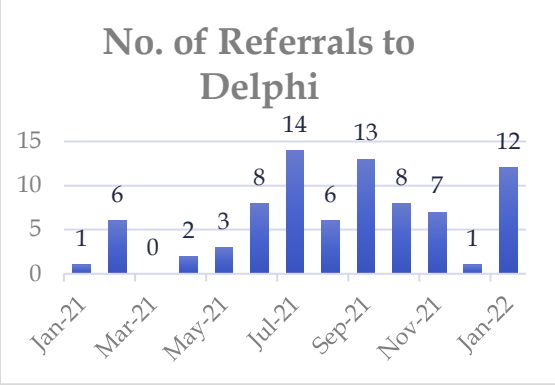
The Big Sexy Bus has a timetable of homeless health clinics and community clinics, parking up in priority wards where there is high prevalence of drug related deaths, offering drop-in services for drug and alcohol information and advice, entry into treatment and blood borne virus testing. The homeless health hub nurses support this provision offering advice and wound care in the clinical area of the bus. The Big Sexy

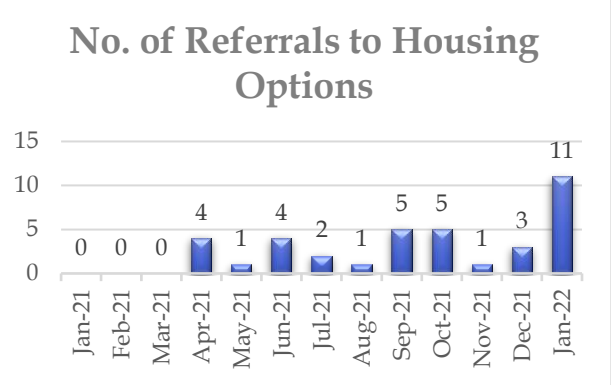
Bus also provides provision across key locations in the town to support local and national campaigns such as HIV Testing Week and World Hepatitis Day.

As described earlier in the evaluation, the homeless hub provision works closely with other initiatives such as ADDER. The ADDER team provide outreach key-working support, in a trauma informed way, to people at risk of drug related death and who are heroin and/or crack users, homeless or at risk of homelessness, people with poor physical and mental health, have offending behaviours, have had a recent non-fatal overdose and who do not historically engage well with services.

The outreach workers provide a tailored support package to each ADDER client, working closely with clients and hostel staff to ensure they can be managed in their accommodation.

Further data shows us that onward referral between teams is effective, facilitating 37 referrals to Housing Options and 81 referrals to Delphi Medical who provide drug and alcohol support.



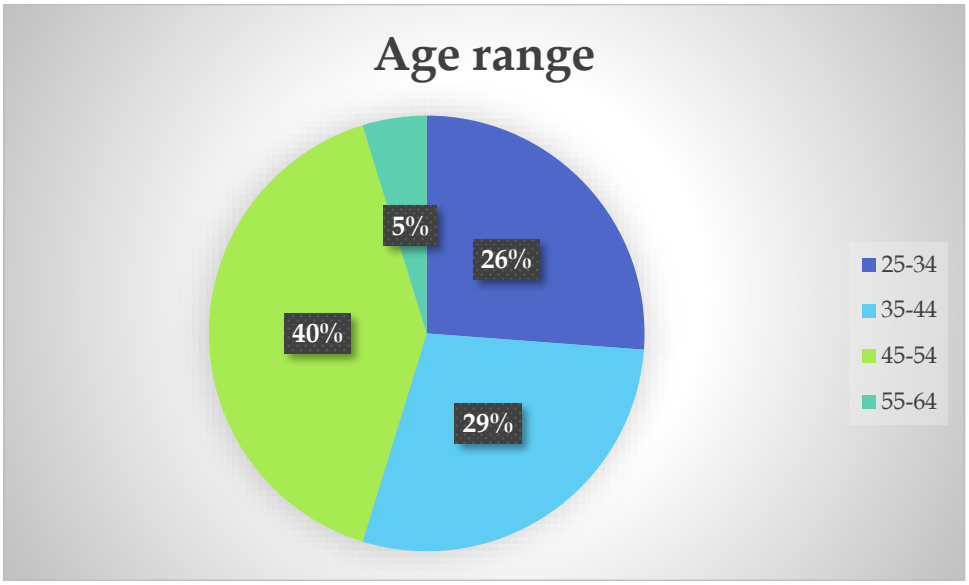


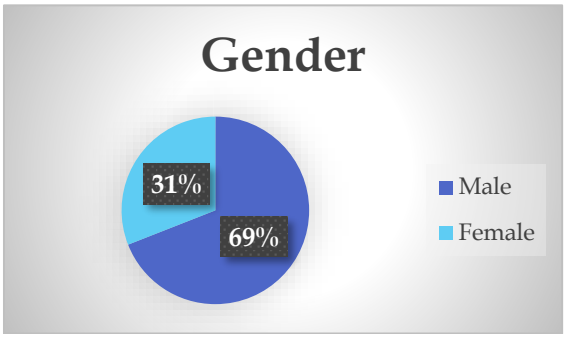
7 RESULTS - Service User Feedback:

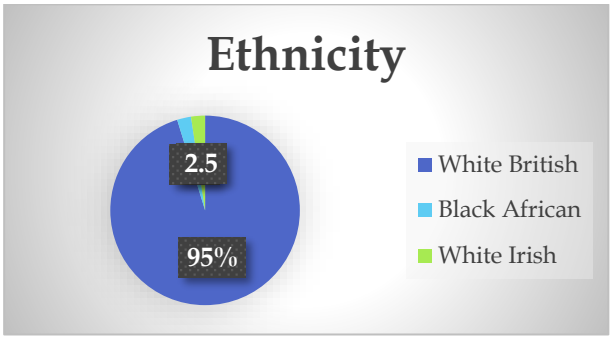
To support obtaining feedback from service users, a questionnaire was developed. Multiple sessions were arranged, supported by Healthwatch Blackpool, the Lived Experience Team and colleagues from the NHS Lancashire and South Cumbria Integrated Care Board. Sessions were delivered cross various sites in Blackpool including, the Ashleigh Foundation Hostels (Oak House, Holly House and Elm House), The Bridge Project, Claremont Community Centre and individual clients being supported by ADDER and the Lived Experience Team.

Questionnaires were completed in a conversation style within a group setting to encourage participation. Healthwatch Blackpool supported obtaining feedback from Holly House, Oak House and Elm House, with further engagement being carried out by the team at the NHS Lancashire and South Cumbria Integrated Care Board.

There were 42 respondents in total. The demographics of the respondents has been summarised in the chart, as follows:







Health problems

Service users who attended the engagement sessions or completed the questionnaires, suffered from a variety of common health problems. Predominant issues were anxiety, depression and other mental health problems, drug and alcohol-related issues and dental problems.

In addition, service users described issues including ADHD, hernia, diabetes, ulcers, asthma, club foot, wound care issues, respiratory conditions such as COPD, PTSD, liver problems, anemia and deep vein thromboses.

Experience with GP practices

Thirty-three of the service users confirmed they were registered with GP practices and knew their named GPs. Most however said that getting an appointment was difficult and they struggled to get the support they required. It was also reported that their appearance could be a limiting factor in getting the appropriate care for their needs when attending their GP practice.

A small number reported positive experiences, especially from St Paul's Medical Centre and another with Marton Medical Centre in Whitegate Health Centre.

Main issues with GP practices were:

- **Accessibility**:
  Service users said they found it difficult to get an appointment, although in the main it was easier to get an appointment to speak to someone over the phone. However, it was especially difficult to access a face-to-face consultation. Having to phone in the morning and wait on the line for a long time posed a problem for some.
- **Filling Forms**
  One respondent pointed out that registering with practices requires filling forms and are not considerate of those who are unable to read and write.
- **Having to divulge information to the receptionist**
  Some of the respondents pointed out that in order to get an appointment the receptionists ask personal questions which they'd rather not discuss with them.
- **Not being taken seriously**
  A couple of respondents felt that their problems especially the mental health issues were not taken seriously and felt 'fobbed off' by the practice.
- **Fear of being sectioned by the healthcare professionals**
- **Perception of being judged by practice staff**
  Some service users reported feeling judged based on their physical appearance and felt they were not treated with the same compassion as other patients. They found it uncomfortable going into a GP practice and said people move away from them and reception staff can be unhelpful.

Experience with urgent and emergency care services:

"When you go through A&E, you are shunned"

Most of the service users said they did not usually get help from urgent and emergency care services and the common issues for them were not addressing or acknowledging their problems effectively and fear of being stigmatized.

Some described feeling hesitant in accessing urgent health services as they felt they were wasting resources. This often stopped them from seeking help.

"You feel like you're moaning, and you don't want to make a big deal out of it"

Experience with homeless health clinic at The Bridge

"You cannot improve on perfection"

Fourteen service users confirmed they knew about or had used the homeless health clinic and all of those had positive comments. It is seen as a good starting point for homeless people that can signpost to appropriate services as required. Some reported

"They don't judge us"

that the clinic provided quicker and easier access when compared with GP practices.

"Lovely girls who are always friendly and supportive"

"Very happy with it now, everything else is just a bonus"

The clinic provides service users with the treatment they would otherwise perhaps not access, such as wound care, which in turn helps them to see the importance of regular ongoing healthcare support.

When asked about areas for improvement, dental support was raised – as many of the service users feel they would be treated better if they had better-looking teeth – and access to medications via the clinic.

Feedback on the outreach bus

Around 30 of the service users were aware of the outreach bus. Although they did not necessarily understand the term initially, once it had been described to them, they knew about it. Again, most of those who had used it were positive and said it was a good service. On occasion clients had attended The Bridge on days the health clinic wasn't running and had been re-directed to the outreach bus to access the service.

Experience with mental health services

"You had to commit a crime to get fast-tracked (for the mental health services)"

Most of the service users found it difficult to access mental health services. This was a recurring theme in all of the sessions.

Of those who had accessed the service, the negative comments seemed to focus more on the long waiting times or difficulties in having their referral accepted. Once in the service, several service users provided positive feedback and said they had felt supported.

Comments were made that the service lacked continuity and/or follow-up and that service users in some cases felt as though they had been dropped by the service and not provided with sufficient ongoing support once the intervention had concluded.

Most respondents did not know about the homeless mental health service.

"If you're not in crisis they (mental health team) don't help. And by the time you're in crisis, it's too late"

"They (mental health team) told me straight away you will have to wait a year. A year is a lifetime!"

Experience with drug and alcohol services:

The feedback relating to drug and alcohol services was mixed. The experience of those who had accessed these services depended a lot on the team that they had received care from.

ADDER received a lot of positive feedback, where service users felt this service was extremely comprehensive, and everything was well co-ordinated. Some of the people who received care from Horizon did not speak as positively and one respondent was trying to switch over to ADDER.

"I can't speak highly enough about ADDER"

Interestingly, those with positive experiences were primarily those who had sought support for drug abuse issues, while the negative experiences came from those with alcohol addiction.

"ADDER is a very good model for how things could work well for all aspects of homeless support"

"Horizon keep saying it's your mental health and mental health team say its addiction"

Signposting to other services

"You need one place to go where you find all the information"

Service users have been signposted to support for various issues, including housing/benefits support, smoking cessation, HIV testing and sexual health services and optometry.

Difficulties were raised in accessing dental services.

Service users pointed out that services were disjointed and one place that deals with all problems would be ideal.

Impact of homeless health hub

"They do some very good work, but the major problem is that they are overwhelmed and simply cannot cope with the volume of people needing their help"

Feedback from the Homeless Health Clinic team:

The nurses involved in delivering the care in the homeless health clinic were enthusiastic about their work and was evident that they go an extra mile in this job especially in trying to build trust with the people who are going through difficult circumstances and being able to bring about change. One of the nurses said the following about her role:

I have been working as the lead nurse in the homeless health nurse-led service since its inception in January 2021 and am so proud to see us go from strength to strength. We began the service by identifying our patient cohort and seeking them out in the community to find out how best to approach their needs and we have adapted the service delivery accordingly.
Every day is a learning experience, and it is a privilege to meet so many dedicated and interesting people who work with our patients. The patients themselves all have their own unique stories to tell, and it is an honour to work with them & empower them to value their health. Our key priority and what we do well is to deliver much needed healthcare where these patients might have missed out, where mainstream care does not effectively meet the needs of those most marginalised. I look forward to seeing where we can take this going forward. ***Kelly Gorrie – Lead Nurse***

As the Care Navigator for the Homeless Health Hub, I work alongside the Nurses to provide ongoing support to meet the holistic needs of the patient. This includes providing practical and emotional support which enables the nursing team to provide the vital clinical care. The service starts with the need of the patients and works outwards, ensuring everybody has access to care and support. The team works effectively with partner agencies and constantly goes above and beyond to provide a safe, welcoming, and supportive service to some of the most vulnerable members of society. I am extremely proud to be part of such an innovative, compassionate service where providing a high quality service remains at the heart of all we do.
Sarah Moran, Care Navigator

I have the privilege of working as a nurse within the Homeless Health team, a team so unique to any in which I have worked due to the fierce commitment to providing a voice for those who aren't being heard or seen. As a result of becoming marginalised, the homeless community experience lack of equality to service and health outcomes, barriers which we as a team try to remove. This may look different for each patient therefore we take the time to understand their needs and sensitively and compassionately include them in finding a way forward to meet their needs. This way of working has proved extremely successful, and we have now established trusting relationships and have been able to make a true impact in our patient's quality of life. ***Marie Day, Nurse***

Positive aspects of the service according to them:

- The intervention of the homeless link workers in the hospital has greatly contributed to the care of the homeless
- Ability to do fast track referrals for suspected cancers, opportunistic cervical screen, and smears.
- Ability to build trust with the people
- To work with the homeless mental health team although there is a delay in accessing that service.
- To do wound dressings; those requiring more frequent dressings would be referred to the district nurses.

Challenges faced:

- **Lack of staffing** there aren't enough people to work with and funding is still quite a challenge.
- **Lack of funding** funding is received from the Lancashire & South Cumbria Integrated Care Board with additional monies identified and sourced through the Blackpool Drug Strategy, Local Authority Rough Sleepers Grant, ADDER and other Public Health Grants which fund the Care Navigator post.
- **Housing** other challenges have been with housing and getting people into suitable accommodation. It was suggested that having a kick bed/nursing step down bed, (in use in London), would be beneficial and would support a timely discharge from hospital, preventing bed blocking when a client no longer needs hospital care.

Suggestions moving forward:

- Maybe a proper GP practice to be commissioned to include a GP, a Nurse and a Social Prescriber
- Increased funding and staffing
- Hostel with nursing step-down bed to support clients following discharge

7.1 Summary of the Feedback from other stakeholders:

We spoke with Fylde Coast Housing Teams, Homeless Link Workers (HLW), ADDER, Renaissance UK Ltd, Probation/Prison Service and Delphi to get their feedback about the nurse-led homeless health clinics and general health needs of the homeless population of the Fylde coast.

Fylde Borough Council advised that although they do support and value the Homeless Health Hub, the central Blackpool location of the hub does create a barrier to their clients accessing the offer. It is acknowledged that Blackpool have a much higher prevalence of homelessness/rough sleeping but highlighted concerns in terms of their own increasing number of clients being housed in temporary accommodation. Recent figures show that this number has doubled when compared to the number of clients being temporarily housed during the first Covid lockdown during March 2020.

Wyre Borough Council continue to see very low numbers and have not, in the past, required the support offered by the Hub. Throughout this evaluation it has been clear that the initial focus of the model has been on delivering in Blackpool and does not afford equity of access to the Fylde and Wyre localities. Based on the original commission, dedicated outreach in Fylde and Wyre was not required. However, since the introduction of Changing Futures, referral numbers are increasing therefore a dedicated outreach model is now needed.

HMPPS - strong partnership working at the outset of the Covid 19 pandemic led to positive interaction with the Homeless Health Hub to address the issues and ensured that people who were being released from the prisons had a place to stay. Through partnership working we were able to identify risk, vulnerability, and homelessness on time at the point of leaving the prison.

HLW feedback - The team relies mainly on the housing option systems to which they have limited access.

Key health related issues in homeless population highlighted in this feedback:

- patients aren't engaging with their respective GPs because they have had previous negative experiences with their GPs
- Delays and difficulties around housing makes dealing with health-related issues more challenging
- Problem of regression and requiring constant/long term support
- Access to mental health services is a problem
- Unable to access dental services

Positive things about the nurse-led homeless clinic:

- General feedback was that this service does provide more holistic care to individuals with complex needs
- Able to liaise with other teams working with homeless population and closely linked with them
- Based at the Bridge which is a convenient location for the service users in Blackpool

"This model (homeless health clinic) is more comprehensive and holistic (compared to usual services); it feels like real investment in Homeless Healthcare"

Things that can be improved upon:

- Create more pathways and protocols on how to effectively manage health related issues in homeless individuals
- Dental care to be prioritised
- One suggested that an alcohol and/or drug misuse service attached to primary care would improve responsiveness
- Better access for Fylde and Wyre clients

"Dental Problems are huge, and the impact is massive on homeless individuals. It results in poor diet. It is a huge social barrier for them and reduces their confidence."

8 Conclusion:

Housing and health are very closely tied together and as demonstrated from the data presented above various physical and mental health related problems have been shown to be present amongst this population group. Skin infections and wound care, mental health problems, drug and alcohol issues, and dental problems were the most commonly identified themes in our study. It is important to view these issues in the wider context of these individuals where barriers to accessing healthcare further complicate the matter. These barriers were not only due to the difficulty navigating the health services, reluctance of these individuals to seek help and lack of trust, but also exacerbated by stigmatization they face when they do seek help from the usual healthcare services like GP practices, walk-in centres and the emergency department. This may partly be because these services are working beyond capacity and already under a high-pressure and as such may not be able to give bespoke trauma-informed care to these individuals with complex health and social needs. There is however, a case for doctors and staff working in these areas to be trained in trauma-informed practice.

Having a dedicated Homeless Health Hub bridges this gap in providing health care to these individuals, in the main limited to the reactive needs of the individual, rather than being able to take a proactive preventative approach, and to also support them in seeking help from other health services when they need to, as well as signpost them or refer them to other services including drugs & alcohol services, housing teams etc. All the feedback from the service users, and the stakeholders show that the nurse-led health clinics have been successful where they have been able to provide care which, as noted above, has been limited by capacity compared to demand. Some of the case studies have been attached at the end (Appendix A) to show this. The nursing team is able to form strong relationships with these individuals over time, and this seems to be an important factor in the effectiveness of this service, something which cannot be easily quantified and shown in data.

Based on the key performance indicators for this service, and whilst reviewing the feedback, it has been evidenced that the nurse-led clinic has been able to provide the holistic care to the clients, by closely collaborating with other partner teams in the community. In terms of the numbers, there were 81 cases on the Nursing caseload with a further 119 clients known to the Care Navigator, a total caseload of 200, which seems to be increasing. It is important to note that the focus has primarily been on wound care. While the nurses are fully capable of doing chronic disease reviews, this is something that is done on an as needed basis, depending on presentation, and has mainly been limited due to the limited capacity of the staff.

While the service, especially the nurse-led clinic has been operational for some time, there does seem to be lack of awareness of this service in the wider community. However, the service users who have used these services, as well as the case studies and the feedback from stakeholders, all suggest that this service has had a huge impact on many individual lives. Promotion and further development of the proposed Homeless Health Hub generally and the nurse-led clinic especially needs to be prioritised in order to meet the healthcare needs of people facing homelessness on the the Fylde Coast. Key recommendations based on the feedback we received have been provided on the next page.

10 Key Recommendations

1. Agree minimum data set with hub providers for implementation by January 2023
2. Undertake a financial evaluation to identify the amount of funds utilised and the amount saved by not utilising the mainstream healthcare services, to aid future decisions
3. Seek additional funding from the Changing Futures initiative to support an increase in nursing capacity to address the increased demand, and facilitate chronic disease reviews
4. Once mental health support is stabilised in Blackpool further develop service to allow integration of resource into Fylde and Wyre aligned with the Changing Futures Hubs
5. Develop communications to raise awareness of the homeless/rough sleeper mental health service
6. Work with partners to develop an outreach offer for Fylde and Wyre aligned with the Changing Futures Hubs
7. Establish more robust referral pathways between primary and secondary care to support the reintegration of clients into mainstream services
8. There is a case for a dedicated GP support to be made available to support the nurse-led clinics
9. Work with partners to address the gap in dental services
10. Work with partners to develop an Optometry offer

Appendix A: Case Studies

8.1 Case Study A

The team were asked to outreach and try to engage client A as many services were concerned about his welfare due to him being on end of life treatment for stage 4 cancer. A member of the team found him sleeping in a Public toilet on Gynn Square he engaged well as he has grown up with the majority of the team. The team supported him to housing and managed to get him a room at the Emergency Bed Unit. The team supported him to the GP and to the Health Bus to get his legs dressed.
On the bus the team supported him to sit in on a Multi Agency Meeting that had been arranged to try and support him with a Care package, he had not been invited. The Care Package was for him to go into a Hospice he did not want to do this. He was encouraged by the team to speak up and to state what he actually needed. He was addicted to drugs and alcohol and did not wish to end his life in a Hospice.
It was agreed he could go into a care home. This went well for a while but he was accused of stealing off another resident and left the premises. The team supported him again, got him back on his methadone prescription and supported him to Housing where he was placed in a Hostel.
Client A, was quickly starting to deteriorate and decided he wanted to stop drinking alcohol. We arranged for the Adder staff to support him with a detox, which he completed in the Hostel. He had a birthday coming up so the team arranged a birthday lunch at Empowerment knowing this would probably be his last. Client A's last few days were spent with the Team around his friends he passed away in the Hostel but in the Knowledge, he was safe and looked after.
The team found his family and supported with funeral arrangements and his favourite song was played that he always wanted on when he was in a Team member's car.

8.2 Case Study B

Client B is an entrenched Rough Sleeper and Substance Misuser and lacks trust in services. Client B has been on the streets on and off for years has excepted support on a number of occasions from housing and drug services but has always failed due to the rules he finds himself unable to engage with.

Client B has a dog, which is on the dangerous dogs register and has been removed on a number of occasions but has been given back to him in Court. The dog is his protected factor and the one thing that gives him some stability and love in his life. Client B struggles to do any appointments due to being unable to leave his dog outside services.

Even though Client B is not with any of the Lived Experience Teams services, they always speak and engage with him when seen on the Streets and ask if there is anything, we can do to help. The answer has always been no I do not need any help from services.

One day Client B turned up at the offices with no appointment and said he needed help. A Police Officer had told him she had found him a flat and he needed to go and see the Estate Agent. Client B had done this and was informed he needed references and he had not been promised a flat.

The Team knew the importance of him coming and asking for our help and the importance of not sending him away with an appointment. A Housing First worker was in the office at the time who called housing and the Estate Agent to find out what was happening regarding the flat. Unfortunately, there was no flat for him and he had been given the wrong information.

At this time, Client B was in poor health, and we suspected he had Sepsis. The Team worked with the Homeless Health Team and went with the Nurses to see him in the Public Toilets where he was staying. The Housing First worker went in search of a flat. The Team and Housing First visited him in the Toilets for the next couple of days. Time was Crucial and we needed to get him into Hospital, however he would not leave his dog.

Housing First found him a flat and he agreed to engage and go to the Hospital as soon as he moved in as long as we found somewhere for his dog. He moved in the following week and Housing paid the dog to go into Kennels whilst Client B went into hospital.

The Team supported Housing First with the move picking him up from the toilets and moving him along with the dog into the flat. The next day we picked him up, took his dog to the Kennels and Client B to hospital. Client B was treated for Sepsis and on discharge; we picked his dog up and returned it straight to him. Client B and dog are both now settled in the flat and visited daily by Housing First. Client B is still refusing any support from Drug Services but the day he accepts support we will make that referral.

What worked different this time with Client B?

- An open-door policy at our office no appointment needed.
- Rapid Response to what Client B needed not what services say he needs.
- Joint working with the Team and other agencies to meet his needs without barriers.
- Relationship with the Team already there to enable him to ask for help when he needed it.
- Taking the services to him not expecting to attend appointments and assessments.

8.3 Case Study C

Client C 47-year-old gentleman in a hostel in Blackpool. He was diabetic with previous broken leg that got infected. He was not compliant with Diabetes medication.
Mentors went to visit C one day at the Hostel and found him sat on the step outside in the rain waiting for an ambulance, the Mentors were informed the wait would be a few hours. Mentors placed him in their car and took to A&E.
Client C was admitted, and the hospital needed to operate and amputate the leg.
The Mentors supported whilst in hospital for a good few weeks' and moved on to a Rehab. Client C was moved into Gorton Street Hostel into a first-floor room. On release the Mentors Visited Client C who stated that no one has been to see him to dress his leg and he has no support at all since he had left hospital.
The Mentors contacted the Homeless Health Team who visited Client C regularly in the Hostel, dressed his legs and liaised with the District Nurses to support Client C. An Adult Social Care Assessment was also put in place to support Client C with Getting in the shower and daily chores.
Client C has been taken to the hospital and supported with fittings for his new prosthetic leg.
Client C is now living independently in a Coastal Housing Flat with support from the Team. Abstinent from all drugs and complying with his Diabetic Medication.

8.4 Case Study D

Female 40's Mental Health, Substance Misuse and Homeless. The team first starting engaging female when she was sleeping in a doorway on Abingdon Street.
The Team built a relationship and encouraged to the Health Bus and ensured she always had Naloxone.
Client moved into Gorton Street and has been there 9 months. Client attends the office regularly on one occasion attended and had fallen and had infected knees.
The team called the Homeless Team who came straight away to dress her legs. When they were here both ladies said they were concerned they could be pregnant. The Homeless Team tested them then with the help of the Mentors discussed and organised for them both to have LARC. Both ladies had implants that were still in from a couple of years ago.
The Team also worked closely with Horizon and have now supported the lady who is currently in detox and will be going on to rehab and moving into her own accommodation when she returns home.

8.5 Case Study E (from Housing options)

An IVDU gentleman, had dangerous strep bacterial wound infection, some said he will manage, others had concerns. So, the housing options team liaised with the nurse-led homeless clinic who advised that he may not be able to manage and if he doesn't it can be life threatening for him. So, the Housing options team took him out of his accommodation and found a place at a hostel where there was more direct supervision.

Appendix B: Service User's Questionnaire

1. Age: (Please tick one box from the options below)

□ Under 18 □ 18-24 □ 25-34 □ 35-44 □ 45-54 □ 55-64 □ 65+

□ Prefer not to say

2. Sex: (Please tick one box from the options below)

□ Male □ Female □ Non-Binary □ Prefer not to say

□ Other_____

3. Ethnicity: (Please tick one box from the options below)

□ White □ Black □ African □ Caribbean □ Asian □ Mixed

□ Other_____

4. What is your current address?

   a) When did you move here?

   b) What were the reasons?

5. Are you registered with a GP?

   a) If yes, what's the name of the practice?

   b) Do you find it difficult to get help from your GP practice?

   c) What are the barriers you face when getting help from GP practice?

   d) If not, were you ever registered before? And what are the reasons for not doing so?

6. Do you have any health problems? Y/N

a) What concerns you the most about your health?

b) Were your health problems addressed by any healthcare provider?

7. Have you attended the homeless health clinics at the bridge? Y/N

a) What impact has it had on your life?

b) What do you particularly like about the service?

c) How can the service be improved?

8) Do you know about the outreach bus used by the homeless health clinic? Y/N

What do you think about it?

9) How is homeless health clinic different from the usual GP/OOH services?

10) Have you ever been referred to or used the homeless mental health service? Y/N

a) Did you find it helpful?

b) What did you like the most about the service?

c) How can we improve it?

11) Have you required any support from the homeless health hub in terms of your housing? Y/N

a) Did you find it helpful?

b) How can we improve this?

12) Have you accessed Drug and Alcohol services? Y/N

a) Did you find it helpful?

b) What did you like about it?

c) How can we improve it?

13) Have you been signposted to or supported to access any other services by homeless health hub? Y/N

a) What services were they?

b) Did you find them helpful?

14) How has the homeless health hub impacted your life overall? Any other comments.

Nurse-led homeless health clinic

"...it (homeless health clinic) feels like real investment in Homeless Healthcare"