Homeless and Inclusion Health Programme
Evaluation Report 2021

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Introduction

This report consists of the findings from an end of project evaluation of elements of the Oak Foundation/Queen’s Nursing Institute (QNI) co-funded Homeless and Inclusion Health Programme (HIHP). The programme, formerly known as the Homeless Health Programme was recently renamed (during the analysis and writing up period for this report) as the HIHP. Hence some comments from respondents on the importance of highlighting the term ‘inclusion health’ within the title of programme activities in order to flag up the range of services and provision, have been overtaken by a pro-active decision on renaming made by the QNI.

Inclusion Health is here taken to refer to four (primary) categories of potentially particularly vulnerable service users who over the last decade have been the focus of Government health inclusion strategies under the ‘inclusion health’ rubric1: Gypsies, Roma, Travellers; people experiencing homelessness; Vulnerable Migrants and Sex Workers. Additional communities of interest recently included in updated definitions, include those in contact with the criminal justice system, substance misusers and victims of human trafficking or modern slavery.

The HIHP consists of a number of activities: in particular, convening a national network of nurses and other practitioners who work to improve the health of marginalised and inclusion health groups, as well as running professional events and conferences focused on Homeless and Inclusion Health practice.

For ease of reference, the HIHP will be used as the overarching term to describe all activities undertaken and reviewed in this evaluation. Mentions of the ‘Network’ in quotations typically refers to the broad range of activities undertaken by and to support the community of specialist HIHP nurses and other practitioners who are signed up to online Network activities, who (for example) attend meetings undertaken under the auspices of the HIHP, access specialist HIHP resources and participate in a range of professional development activities. Further, there are ‘special interest groups’ of HIHP practitioners who meet to explore and focus on particular aspects of their work, or in relation to specific client groups such as Gypsy, Roma, Traveller, Boater, Showmen communities, service users with mental health needs or families experiencing homelessness (albeit there is inevitably at times an overlap in ‘special interest group’ membership or communities of interest with whom practitioners work). Activities convened by special interest groups within

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the Network, under the overall auspices of the HIHP are discussed below in the body of the report.

This evaluation focuses on the following core elements that respond to the overall objectives of the funders as specified in Oak Foundation Grant agreement OCAY-16-524):

- To evaluate the breadth, take-up and professional value of the HIHP established by the QNI for nurses, allied health professionals and others working across sectors to improve the health care for people experiencing homelessness and other excluded groups, e.g. sex workers, Gypsy, Roma, Traveller, Boater and Showmen communities, refugees and asylum seekers, and other vulnerable migrants.
- To explore the added-value, accessibility and use of QNI resources by members and associated professionals who have participated in the HIHP.
- To identify the potential impact on specialist homeless and inclusion health professionals who are members of the HIHP should the programme be discontinued, or offer be truncated, as a result of lack of continuity of funding.
- To identify recommendations and scope for growth and sustainability of the HIHP, e.g. potential for enhanced collaboration and strategic partnerships with other specialist organisations and professional bodies.
- To identify (in partnership with HIHP members and associated policy professionals) the potential for commercial support and/or funding of specific elements of the HIHP.

To fully illustrate the overall impact of the Oak Foundation/QNI funding provided across the HIHP, and to further evidence how a suite of programme objectives has been met, this report is to be read in conjunction with the associated (2020) evaluation undertaken by Professor Emerita, Rosamund Bryar (QNI Fellow), of nurse-led innovation projects in inclusion health seed-funded by the QNI/Oak Foundation2.

**Methods**

This evaluation report consists of four distinct elements supported by a short scoping *literature review and review of existing materials* (including analysis of HIHP membership) pertaining to activities and outputs from the HIHP.

Key analysis consisted of a review of HIHP *membership* and analysis of responses to a detailed *survey* sent to the 1315 (as of September 2020) members of the HIHP (N.B. as of June 2021, the number of members stand at 1534). A total of 55 completed responses to the survey were received. (4.18%), While this is unlikely to

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be a representative response to the questions asked, nevertheless, the detail gained from these responses is useful and valid, representing around 14% of the 400 network members who regularly open HIHP/QNI emails and respond to interactive activities.

(See further, Appendix 5 of this report for a more in-depth discussion on survey responses than are provided in the main body of this report).

In addition to the survey, a series of 12 interviews (n=13 respondents as one interview took place with two strategic health lead respondents) took place supplemented by a focus group with frontline health care practitioner HIHP members with various levels of seniority and experience, (n=7) and a second group discussion with strategic health leads working in this area of practice (n=9).

Finally, we compiled three example case studies that illustrate the impact, range and geographical spread of the reach of the HIHP and the support of the QNI more generally.

The topic guides and interview schedules for use in focus groups and individual interviews were devised by the independent evaluators and discussed with the commissioners to ensure that full data capture would occur to meet the requirements of this evaluation. In the case of the interview which took place with two senior strategic leads who had not been able to attend the focus group for experts, a lightly edited version of the topic guide used within that focus group was utilised with insertion of some additional probes as appropriate to smaller group/individual interviews.

Appendices 1–4 consist of the topic guides/interview schedule operationalised for the qualitative data collection.

Appendices 5–7 provides details of demographics of survey respondents and interview and focus group participants.

The evaluation activities reported upon herein were undertaken between September 2020 and December 2020.

Ethics approval was not required for the purposes of feed-in of additional questions to the annual QNI survey distributed to members, but was gained to enable interview and focus group elements of the evaluation to be undertaken. Ethical approval was provided by Buckinghamshire New University in October 2020 (reference number: UEP2020Oct01).

Brief literature and documentary/resource review

To support the primary empirical research elements of the evaluation (interviews and focus groups) a literature review and analysis of pre-existing documentation was undertaken to support understanding of the primary (professional) beneficiaries of the HIHP, as well as to identify potential scope for expansion and development of
activities which may generate additional income or impactful workstreams for the QNI and collaborators.

In the main, these elements consist of reviewing the demographics of the HIHP membership, consideration of the main subject areas of resources available via the QNI’s website, as well as materials pertaining to evaluations of the nurse-led projects delivered as part of the HIHP. A full evaluation of the nurse-led projects has been undertaken in 2020 by Professor Bryar (op. cit.) and as such we only briefly touch upon the key elements of that report within our discussions. A number of our recommendations for future developments do however have close synergies with discussions and findings within the Bryar evaluation report (op. cit.).

Literature

To underpin the research elements of the evaluation and to contextualise the work of the HIHP, a literature review was carried out utilising the following search terms:

<table>
<thead>
<tr>
<th>Search Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusion Health; Homelessness; Training; Education; Leadership; Burnout; Nurse Training; Professional networks; Clinical networks; Barriers; Facilitator; Education; Training Prison; Gypsies, Travellers and Roma; Asylum Seekers and other terms associated with the populations in question.</td>
</tr>
</tbody>
</table>

In total 160 relevant papers were initially identified, although these were refined down to 46 documents within the literature review which follows.

Summary of relevant literature

Inclusion health aims to prevent and redress the harms of extreme inequity among the most vulnerable and excluded populations, through advocacy, policy, research, education, practice and service provision (32) Inclusion Health Groups (IHGs) include overlapping populations experiencing homelessness, prison, people who sell sex and people with substance use disorders (32, 33). IHGs are characterised by complex health and care needs (34) often including ‘tri-morbidity’ – the combination of physical illness, mental illness, and substance use disorders (35, 36). Frequent contacts with unplanned emergency care are characteristic of IHG healthcare. Such care focuses on the presenting problem but often fails to address broader health and social needs resulting in missed opportunities to prevent poor health outcomes and financial cost to the NHS and public services (37).

Poverty and adverse life experiences (37, 38) often underpin exclusion and extreme disparities in health. In recent years, the UK has seen rapid increases in homelessness (39), high imprisonment rates, increasing drug-related deaths and sustained year-on-year cuts in local authority services supporting these groups. Previous research has described the overlaps between these populations (37, 40,
41), and noted that individuals move between exclusion ‘states’. Due to barriers such as discrimination and difficulty registering with a GP (42, 43) all IHGs have significantly higher rates of hospital attendance and under-utilise scheduled and primary care (43, 44, 45).

**Educational interventions to address inequity in healthcare**

Interventions in training can have a positive impact on nurses, particularly as students. Studies show that innovative placements in prisons and custodial settings, service-learning approaches in homeless foot clinics, substance misuse settings and hostels and shelters, are effective at dispelling stereotypes, increasing empathy and addressing negative preconceptions (3, 4, 5, 10).

There are still considerable gaps in training and ongoing negative perceptions due to varying experience and knowledge of working with inclusion health groups and issues affecting them such as addictions, mental illness and chronic pain (1, 2, 6, 7, 8, 9, 11).

Education can decrease negative attitudes and promote confidence to take action to address barriers and improve care (12, 13, 17). Addressing knowledge, skills, attitudes and behaviours needs different modes of education. Educational programmes included interactive workshops, case studies, online modules, targeted lectures and workshops, simulation sessions, real-time coaching, and in-service training (17, 15, 16, 19). Innovative models typically use multi-modal education. The ‘baccalaureate concept-based curriculum’ used team-based learning strategies, which can be incorporated into traditional curricula (15). The TOLERance model (Theory, Observations, Learning from patients, Engagement, and Research) enabled students to understand interrelationships between the individual clinical level and the socio-political structures by actively engaging in social, political and policy issues that impact their patients and advocating for change (18). Another example of culturally competent substance misuse training included cultural competency education, simulation, and educating students to use screening, brief intervention, and referral to treatment for alcohol and other drug use (22). A key barrier to incorporating inclusion health related content in nursing curriculum include an already crowded curriculum (23). An Inclusion Health Board-commissioned review of the extent of relevant training in professionals qualifying programmes found that inclusion health is an area of practice that is generally underdeveloped by healthcare regulatory bodies, suggesting that “without clear regulatory bodies’ standards and guidance about Inclusion Health, which in turn enforces the education sector to incorporate this topic in the curricula, there is no guarantee that aspects of Inclusion Health will be taught and assessed” (47:i).
**Need, role and use of professional nursing networks to prevent burnout and promote retention**

Many nurses experience isolation but those caring in complex needs in community settings are particularly impacted, which can result in reduced retention in roles, risk of burnout and stress (24, 25). Nurses at all levels are affected, including those in leadership roles, and they often rely on their own networks for support (25). Interventions that can support staff effectively include sharing best practice and promoting safe and high-quality care, but these rely on organisations or services to support nurses to build their own networks or organise professional networks for them (24, 25).

Professional networks can include peer-to-peer support, specialist training, continuing professional development (CPD), mentoring, networking, clinical supervision and clinical leadership (18, 29, 30, 31). A recent article (46) on the impact of Covid-19 on families experiencing homelessness by Domey-Smith, QNI HIHP Nurse Lead (and colleagues), emphasised the importance of the specialist QNI convened network for Health Visitors working with families experiencing homelessness in identifying national trends, facilitating rapid information sharing and capturing data on health visitor provision of practical support to mitigate the impact of Covid-19 on vulnerable families, e.g. recording activities undertaken outside of the clinical role such as “facilitating access to food, toys and digital support to those in need”. Crucially, they also found that “despite recognition of the negative impact of coronavirus restrictions on homeless families in both the short and long term, many specialist health visitors have been under threat of redeployment” (46: 193). As explored in the interview data, the provision of peer support to professionals working in particularly challenging community settings and circumstances is seen as an especially valuable aspect of such networks.

**Documentary review and associated resources (e.g. engagement with Special Interest Group meetings)**

There is a certain degree of overlap between some materials cited in the literature review and QNI documentary evidence.

A review of existing resource materials uploaded under the heading of Homeless and Inclusion Health, which are available on the QNI website (some of which were mentioned in considerable detail within interviews and focus groups as a particularly valuable element of specialist HIHP outputs), demonstrates a wide range of accessible, open-access, free to download materials on Inclusion Health topics, with new documents being added regularly.

These fall into the following key categories:
• **Newsletters** which were emailed out approximately fortnightly to all members of the HIHP (1180 recipients in England, 56 in Wales, 28 in Scotland, 18 in Northern Ireland, as of December 2020).

• **Reports** (e.g. evaluation reports; findings from surveys of homeless health specialist nurses; impact report of the HIHP 2014–17).

• **Guidance and recommendations for health professionals considering a career in Homeless/Inclusion Health.**

• **Case-studies** of initiatives or specialist roles, e.g. integrated mental health practitioners working with individuals experiencing homelessness delivering flu vaccines to people who are homeless; supporting people in hostels during the pandemic.

• **Specialist resources** such as factsheets on homeless health statistics.

• **Short films** – linked to the role of specialist health professionals and the QNI’s role in supporting holistic learning and providing networking opportunities; inter-agency knowledge and working to support people experiencing homelessness; impactful interventions supporting families who are homeless.

• **Relevant documentation** (e.g. Pathway Draft Standards for Education and Practice for Inclusion Health Nurses).

• **Practice Tools** such as the Health Assessment Tool (2015) which was mentioned repeatedly in interviews and focus groups undertaken for this evaluation as a particularly well used and appreciated resource.

**Homeless Health Newsletters**

As of Autumn 2020, at the date when the survey was distributed, there were 1315 current HIHP members.

**Table 1: Recipients of the Homeless Health newsletter by date of joining Mailchimp list**

<table>
<thead>
<tr>
<th>Length of engagement on Mailchimp list</th>
<th>Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Since 2016</td>
<td>13</td>
</tr>
<tr>
<td>Since 2017</td>
<td>39</td>
</tr>
<tr>
<td>Since 2018</td>
<td>751</td>
</tr>
<tr>
<td>Since 2019</td>
<td>326</td>
</tr>
<tr>
<td>Since 2020</td>
<td>186</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1315</strong></td>
</tr>
</tbody>
</table>

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Table 2: Engagement with newsletter (rate of individual opening of emails) in autumn 2020

<table>
<thead>
<tr>
<th>Opening rating</th>
<th>Opening rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - rare</td>
<td>15</td>
</tr>
<tr>
<td>2 – less than half</td>
<td>836</td>
</tr>
<tr>
<td>3 – around half</td>
<td>138</td>
</tr>
<tr>
<td>4 – more than half</td>
<td>179</td>
</tr>
<tr>
<td>5 – nearly all</td>
<td>147</td>
</tr>
<tr>
<td><strong>1315</strong></td>
<td><strong>36%</strong></td>
</tr>
<tr>
<td>3, 4, 5 – half or more</td>
<td>464</td>
</tr>
</tbody>
</table>

As can be seen, the majority of recipients open and engage with the HIHP newsletters 2–3 times per month with approximately 300–400 opens per email. This equates to an average open rate of 25–30% (which is higher than the average national mailshot email open rates in the UK, which is calculated at 16.4% (2020 data)). Sector-specific information (not accessible for the UK) suggests that only 21% of health-related newsletters are opened in the US, which overall has a slightly greater open rate than the UK when email newsletter metrics are compared between the two countries.

In total, in 2020, 464 HIHP members open 50% or more of emails received, suggestive of high levels of engagement. This ‘open rate’ is broadly similar to performance of other QNI email lists, and also those sent out by the London Network of Nurses and Midwives and the Faculty of Homeless Health.

Table 3: Geographical spread of HIHP members across countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1180</td>
<td>89.6%</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>18</td>
<td>1.4%</td>
</tr>
<tr>
<td>Scotland</td>
<td>28</td>
<td>2.2%</td>
</tr>
<tr>
<td>Wales</td>
<td>56</td>
<td>4.4%</td>
</tr>
<tr>
<td>Isle of Man</td>
<td>3</td>
<td>0.2%</td>
</tr>
<tr>
<td>Jersey and Guernsey</td>
<td>3</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other (in order of numbers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Ireland, Australia, France,</td>
<td>27</td>
<td>2%</td>
</tr>
<tr>
<td>Spain and Holland</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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4 [https://www.campaignmonitor.com/resources/guides/uk-email-marketing-benchmarks/#two](https://www.campaignmonitor.com/resources/guides/uk-email-marketing-benchmarks/#two)
Table 4: Geographical spread of HIHP members across England

<table>
<thead>
<tr>
<th>Area of England</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>East</td>
<td>54</td>
<td>4.5%</td>
</tr>
<tr>
<td>London</td>
<td>196</td>
<td>17%</td>
</tr>
<tr>
<td>Midlands</td>
<td>114</td>
<td>10%</td>
</tr>
<tr>
<td>North</td>
<td>274</td>
<td>23%</td>
</tr>
<tr>
<td>South</td>
<td>382</td>
<td>32%</td>
</tr>
<tr>
<td>National (unspecified or role covers large regions)</td>
<td>63</td>
<td>5%</td>
</tr>
<tr>
<td>UNKNOWN</td>
<td>97</td>
<td>8.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1180</td>
<td></td>
</tr>
</tbody>
</table>

As illustrated by Tables 3 and 4, there is a heavy geographical skew towards membership in England with a predominance of practitioners in the North and Southern areas of the country. There is a clear under-representation of membership in Wales, Scotland and Northern Ireland, and the South West of England was included in the South. Whilst the extremely active QNI Scotland will inevitably have closer contact with practitioners in that nation, further investigation could take place to explore whether and how Scottish practitioners are engaging with specialist homeless health resources with an emphasis in the specific national context. It is worth noting when considering the number of responses from Northern Ireland that there are only Homeless and Inclusion Health Services in Belfast and Derry, and moreover that the population of Northern Ireland is only 1.8 million people, hence there is a significantly lower level of demand for specialist services in that country.

Table 5: Professional role of HIHP members

<table>
<thead>
<tr>
<th>Professional status (taken from job title or other indication)</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>772</td>
<td>58.7%</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>39</td>
<td>2.9%</td>
</tr>
<tr>
<td>Nurse and/or Allied Professionals (this is where job title is Clinical Lead or similar)</td>
<td>302</td>
<td>22.9%</td>
</tr>
<tr>
<td>Allied Professionals</td>
<td>21</td>
<td>1.6%</td>
</tr>
</tbody>
</table>
As can be seen, 90.4% of the membership are health professionals with 61.6% explicitly identifying as qualified nurses, although this may increase to 84.5% based on internal data/roles.

Of these nurses, 268 (20.4%) had job titles consistent with specialist inclusion health roles. However, a large number of those identifying as nurses had mainstream job titles, e.g. Community Matron, Community Nurse, District Nurse, Advanced Nurse Practitioner, and did not appear to be employed within specialist inclusion health services, indicative of a high level of in-reach to mainstream nursing professionals and dissemination of inclusive/homeless health practice-based knowledge across the profession.

A total of 143 (10.8%) respondents had educationalist type titles, e.g. Lecturers, Course Leads, Practice Development Leads, Quality Leads, Researchers. A further 129 (9.8%) of HIHP members had job titles suggesting a strategic or policy-making role, with 76 (5.8%) identifying as Director/Assistant Directors, Heads of Service and CEOs.

Thirty hospice and/or palliative care services were also represented within recipient lists, suggesting considerable interest from this speciality in engaging with inclusion health, an issue supported by the QNI through a resource bank of links to guidance from Dying Matters/St Mungo’s on working with people who are terminally ill and also experiencing homelessness, as well as QNI HIHP member authored blogs and case studies on this subject⁵. We are advised that the QNI/HIHP Nurse Lead has received requests to consider setting up a special interest group to focus on end of life care impacting inclusion health groups and that this is under consideration subject to resource.

**Accessibility of resources**

For 2019 (most recent figures available), individual resource/page views on the QNI website, and numbers of unique users of materials, (shown in brackets), were as follows:

- Main Homeless and Inclusion Health page: 6276 (2668)
- Health Assessment Tool: 2196 (1185)
- Facts about HH: 1610 (743)

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[https://www.dyingmatters.org/sites/default/files/user/images/Resources/Promo%20materials/Staff_Homelessness_Leaflet%20WEB_1_.pdf](https://www.dyingmatters.org/sites/default/files/user/images/Resources/Promo%20materials/Staff_Homelessness_Leaflet%20WEB_1_.pdf)
Work of HH nurses: 1137 (547)
Transition to HH: 1074 (599)
HH resources general: 1047 (501)
HH practice in action: 1031 (535)
Leeds gypsy traveller blog: 1007 (610)
HH FFI projects: 934 (473)

Total QNI webpage views in the year 2019 totalled 706,000, representing 354,000 unique users.

The frequency at which access to reports and materials are cited in interviews and survey responses indicate that this element of the offer is highly regarded by health practitioners, as offering accessible, up-to-date information tailored towards the busy specialist nursing or homeless health practitioner.

Whilst there was an awareness of the range of resources and significant praise for the quality, a finding from interviews and focus groups was that the majority of practitioners and policy leads were either not fully aware of the extent of available materials (sometimes because a considerable number of additional documents had been uploaded since they last visited the website) or that they tended to search for particular items that they had used in the past, or which had been recommended to them, rather than more generally browsing. Pressures on time, that the website was relatively complex to negotiate or could be time-consuming to explore with so many resources available under ‘Blogs’ or ‘Case Studies’ emerged in several interviews:

“All the challenge is, well, do people know it is there, and do people know how to access it? Almost, there is so much information isn’t there?” (Strategic Health Lead)

One Specialist Nurse Practitioner based in London proposed that it might be helpful to enhance access to resources by having a searchable database that flagged up journal articles relevant to practitioners, whilst another commented on the fact that putting in a search term brought up blogs, films and guidance in a way that could be confusing. Whilst we are advised that the HIHP area of the QNI website has been revamped during 2020 to simplify search capacity, it is noted that there is scope to refine this further and that potentially a dedicated micro-site would be an appropriate way forward to most effectively showcase the HIHP materials.

Access to regular newsletters that flagged up new resources, or provided embedded links were seen as a particularly useful mechanism for distribution of information that would not otherwise necessarily have been seen by busy practitioners. Overall around two-thirds of all participants in this evaluation indicated that receipt of newsletters acted as a lead-in to awareness of specific new online materials relevant to their practice.
“It’s hard to remember specific tools or qualities but I think just the fact that you’re kept up to date with things. I don’t think you can even remember all of the links that you follow from the emails and the newsletters that you’re going into that then feed back into your practice.” (Clinical Homeless Health Practitioner).

When respondents (from a range of professions and roles) did access the QNI resource bank, the quality of materials was universally praised by front line practitioners, strategic leads and also other agencies working in the field of inclusion health or homelessness.

“Yes able to have guidance, and look at case studies, and look at blogs and seeing what other people are doing, or where other people are working, has been great.” (Clinical Practitioner, Homeless Health).

Certain practice-based tools such as the Health Assessment Tool for Homeless People (accessed by 1185 individual users in 2019 and thus the most ‘popular’ resource on the website), Safeguarding Toolkit for adults experiencing homelessness and exclusion, and information on transitioning to homeless health nursing’ were repeatedly cited by practitioner respondents in interviews and focus groups as being particularly helpful in their day-to-day practice, informing and underpinning their clinical knowledge. Whilst the focus group and interview data provide more detail on the most commonly utilised resources, the following comments are typical of those received from respondents:

“E-materials and the policies. That’s quite useful. There is new guidance coming in all the time.” (Clinical Practitioner, Homeless Health Service)

“I’ve often gone to QNI guidance first to build protocols and assessments around, so I have always found that particularly helpful.” (Strategic Health Specialist, Homeless Health Network Lead)

Resources available on the website may have been produced by external collaborators such as Groundswell, Dying Matters or Pathway, or directly by the QNI. Publications available via the website that are not directly produced by the QNI have often involved close collaboration and input from QNI colleagues and Queen’s Nurses who are active in research or policy areas, e.g. the draft standards for inclusion health nurses emanates from Pathway, the leading Homeless Health charity, for whom the QNI Lead supporting the HIHP works on a part-time basis.

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This overlap between the QNI and other specialist services and close working relationship between specialist homeless and inclusion health practitioners – as commented on within the strategic lead focus group in particular – has been noted as a major strength of the QNI given their leading role in, and their reputation for, the provision of high quality and well researched guidance.

“That resource with the QNI, which you know is quality assured, and that for us is really important that it has got that quality backing behind it, and often that work has been done in partnership with us anyway.” (Strategic Lead, Royal College of Nursing (RCN))

All 1315 members (as of December 2020) of the HIH Network who received fortnightly newsletters received a link inviting them to participate in a survey to underpin this evaluation. The survey distributed in the autumn of 2020 built and expanded upon questions asked in annual surveys issued to Network members in earlier years of the HIHP, however it is noted that as a result of lack of resource, this practice of routine survey of membership, had been discontinued in recent years.

Although key findings from the survey responses are presented separately, it is worth noting that 63.04% of respondents to the survey referred to accessing “guidance resources”, e.g. reports such as the thematic analysis of the responses of 206 specialist homeless health nurses to questions pertaining to major challenges to delivering nursing care in their specialist area of practice and recommendations for service improvement9; Homeless Families Toolkits, and resources including those on epilepsy, foot care and oral health specifically tailored to front line community nurses working in inclusion health10.

A total of 50% of respondents to the survey had made use of case study materials (e.g. mental health support for people experiencing homelessness during a pandemic, or outreach nursing to people experiencing homelessness with complex needs and co-morbidities11) and in addition, 23.9% referred to reading specialist blogs (such as those reflecting on the linkage between prison experiences, homelessness and health status; the experience of nurse-led engagement services for asylum seekers, or engaging with Gypsies and Travellers during a pandemic.12

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9 https://www.qni.org.uk/resources/nursing-care-for-people-experiencing-homelessness/;  
Approximately 21% of respondents reported that they had not directly accessed inclusion and homeless health resources from the QNI website and this may be reflective of less frontline clinical roles amongst some of those respondents, or limited time to explore the website and access materials.

Chart 1 illustrates the resources most commonly downloaded and read by respondents to the survey.

**Chart 1: Survey respondents use of Homeless Health specialist resources**

Overall, 96% of survey respondents rated the quality of newsletters and materials on homeless health available through the QNI as “Excellent” (42%) or “Good” (54%) with the remaining 4% stating that these were “Average”. No respondent indicated that they thought materials they had downloaded were of poor quality.

**Special interest groups**

A key initiative of the HIHP has been the development of online special interest group (SIG) meetings to provide mutual support and exchange of information for sub-groups of specialist inclusion health practitioners. These commenced in Autumn 2019 and have been online throughout 2020 and 2021 since the Covid pandemic commenced. We are advised that it is likely that these will now continue in on-line
format given the positive feedback from participants in relation to accessibility for practitioners in widespread geographical locations.

At the time of writing, these SIGs consist of a group for **health visitors supporting families who are homeless** (op. cit.), as well as one for health professionals working with **Gypsy, Roma, Traveller and Boater communities**. As of March 2021, a new ‘Street Outreach’ SIG has commenced, whilst a recent additional SIG with a focus on mental health has now commenced, run jointly with Pathway. As noted above requests have been received for the provision of an End of Life SIG. All groups are organised and led by the HIHP Nurse Lead Sam Domey-Smith within her 1-day a week role.

SIG meetings were anticipated to take place approximately every 2 months but in response to the pressures on frontline workers during the pandemic, potentially aided by the convenience of online meetings, and evidencing that practitioners feel the need for frequent touchpoints with colleagues to share information on good practice, developing trends, access to resources etc. it was noted by the HIHP Nurse Lead that some SIGs had been meeting more frequently. The Health Visitors SIG for professionals supporting families who are experiencing homelessness was having two full meetings within a month at one stage in 2020, whilst some sub-groups of this SIG have also met frequently in relation to certain themes, such as challenges of the Covid-19 pandemic on families experiencing homelessness, families in temporary accommodation, standards of emergency and temporary accommodation and notification of Covid positive status.

As of early 2021, the **Health Visitors for families experiencing homelessness SIG** had met on 10 occasions, averaging 10–15 people attending per meeting, although 25 health visitors are linked into that particular SIG. Activities that have emerged through these SIGs include (at the only face to face meeting to take place) hosting Australian researcher and practitioner Dr Yvonne Parry13 enabling health visitors working with migrant and vulnerable families to explore similarities and differences in the UK and Australian context, with particular reference to adverse childhood experiences. This SIG also acted as a conduit for collecting evidence which was fed into the Ministerial review of the health of Children and Babies launched in July 202014.

The Domey-Smith et al article (op. cit.) drew upon data submitted by members of this SIG. In turn, these findings fed into QNI resource development, enabling dissemination to wider audiences (footnote 7) and have been operationalised in policy and campaigning, e.g. in relation to letters to Ministers, and convening and coordinating a petition15 calling for a Government Inquiry into the situation of families

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15 [https://www.medact.org/2021/actions/sign-ons/healthy-housing-is-a-human-right/](https://www.medact.org/2021/actions/sign-ons/healthy-housing-is-a-human-right/)
experiencing homelessness, to enhance the rights of families who are destitute regardless of immigration status and to increase the numbers of health visitors and school nurses supporting families who are homeless. In addition, work has been undertaken with the All-Party Parliamentary Group (APPG) on Ending Homelessness and supporting health visitors to provide evidence in policy forums, e.g. Home Office meetings. In some SIG meetings (e.g. Gypsy, Roma and Traveller (GRT) health) there has been attendance from senior policy leads (i.e. the NHS England/Improvements lead on Public Participation, Ministry of Housing, Communities and Local Government (MHCLG) National Advisor on Homeless Health) has occurred, where these strategic leads have been interested in gaining insights into ‘on the ground’ experiences of health professionals working with particular communities of interest. Thus attendance by high level health policy specialists at such meetings is further evidence of both the reach of QNI networks and the value of the SIG activities in feeding into policy formation and information dissemination at the highest levels.

The HIHP Nurse Lead convenes a SIG meeting approximately every 8 weeks with health professionals, representatives of specialist non-governmental organisations (NGOs) and policy practitioners/academics supporting GRT health through the medium of a collaborative SIG developed with the leading NGO, Friends, Families and Travellers (https://www.gypsy-traveller.org). Approximately 20 participants attend each of the online sessions (although the distribution list goes to 45 members of the SIG). Ten sessions had taken place at the time of writing, including targeted sessions on vaccination hesitancy, impacts of discrimination and mental health issues amongst the communities. This group has provided evidence to Department of Health and Social Care (DHSC) work on the extent of Covid testing amongst these communities and engaged with the University College London (UCL) study to ensure that GRT and Boater communities are included in Covid surveillance.

Academic and policy engagement in this SIG is particularly strong, with three Professorial members, as well as the Head of Public Participation for NHS England and NHS Improvement, National Homeless and Inclusion Health Nursing Lead, NHS England and NHS Improvement, the Homeless Health lead at MHCLG and the Chair of the London Network of Nurses and Midwives (LNNM). Jane Cook who is also the National Advisor on Homeless Health and has extensive personal experience of working with GRT communities. International participation from experts and NGOs based in Dublin (Pavee Point) has strengthened networking and practice sharing opportunities amongst this group. In addition, a dedicated link has been created on the QNI website hosting information on working with GRT groups16.

Typical formats for SIG meetings (two of which were attended online as part of this evaluation) consist of a series of short presentations by practitioners or specialist NGO staff – e.g. on barriers to immunisation take-up amongst GRT community members or best practice in supporting mental health initiatives and signposting to services, followed by discussions amongst attendees of local practice, replicable initiatives, trends or emergent issues and recommendations, as well as networking opportunities.

Whilst the SIG for health practitioners engaged in Street Outreach is at an early phase of development, the launch of the collaboratively developed guidance (QNI, Pathway, LNNM Homelessness Group and others) on this subject\(^{17}\) in January 2021 had 170 participants, and 23 people took part in the initial meeting in March 2021.

Accordingly, the SIG activities hosted by the QNI encapsulate high value examples of activities undertaken within the HIHP demonstrating reach far beyond the resource dedicated to such activities.

Indeed, in interviews and focus group discussions the value of the SIG meetings were repeatedly mentioned by practitioners as immensely appreciated, as they facilitate regular opportunities for practitioners from around the country to share best practice and explore emergent concerns. Data from these meetings also support responsive intelligence led practice that can be fed back and shared with commissioners or strategic leads to support agile working and enable prioritisation of resources.

Examples of feedback received pertaining to HIHP participation include:

“\textit{The} HIHP has played an invaluable role in connecting me not only with a range of relevant training resources but also, crucially, with other homeless health professionals across the country, enabling us to share learning, ultimately improving client care and support at a local level. Examples of this include development of tools in relation to learning disabilities and homelessness; and improving homeless people’s access to specialist wound care. I very much hope to continue to share resources in these ways, in order to maintain the drive to address the clear gaps in service provision for this under-served and vulnerable group.” (Roger Nuttall, Nurse Co-ordinator, Hastings Homeless Service, St John Ambulance)

“\textit{The meetings are so postive and useful – thank you!}” (Sarah Sweeney, Policy and Communications Manager, Friends, Families and Travellers)

In recent months, these networks of practice have grown, facilitated in part by the accessibility and increasing familiarisation of specialist health staff in utilising online meetings. Importantly, in relation to enhancing international network development,

there is an increasing presence of Northern and Southern Irish inclusion health specialists, enabling sharing of information and exchange of knowledge (for example cross-border/international contacts between Irish Travellers; challenges experienced in self-isolation for an individual who is homeless with a positive Covid-19 test; or increasing resistance within minority communities to immunisation fuelled by concerns or false information distributed via social media.)

This newly developing internationalisation agenda that we identified within this evaluation, coupled with ‘word of mouth’ sharing amongst practitioners of the value of these online special interest meetings, appears to be fuelling the growth and development of emergent networks of practice that are supported by the QNI, despite considerable resource stretch to facilitate such activities.

(Interview data later on in this evaluation referring to QNI support in developing homeless health practice in Northern Ireland and the Case Study that reflects on the support provided by the QNI to the newly developing Nurses and Midwives for Inclusion Health professional practice network in the Republic of Ireland, further illustrate international reach and influence on practice).

**Survey key findings**

As noted earlier (see Methods), an online survey was devised by the HIHP Nurse Lead, with input from the Director of Nursing Programmes and evaluators to ensure relevant additional data was captured. This was distributed in September 2020 to all members of the HIHP. In total, 55 completed responses were received (4.18% response rate) and one additional partially completed survey, although reminders to invite recipients to complete the survey were sent out on at least five occasions. An initial tranche of responses was received in September, and a second wave in November. No responses were received after the end of November 2020.

The low response rate is likely to be associated with both heavy workloads and pressing professional tasks impacting recipients during a pandemic, and also importantly the length of the survey and estimated time to complete it, given that ultimately the survey comprised 75 questions.

Overall, 92% of those who completed the survey identified as full members of the HIHP and receive regular email communication on activities. It is unclear how or why the four ‘others/non-members’ who completed the survey obtained access to the link, they could have possibly come via the LNNM inclusion health group, which has a degree of overlap with the HIHP membership.

Overall, there is a very high level of overlap between membership of the HIHP and other specialist nursing organisations. Most commonly and understandably the RCN of which 80% of respondents are members; whilst 53% and 33% are respectively associated with the Faculty of Homeless Health and the LNNM Homelessness Group. A further 9% of survey respondents reported being members of both the
Institute for Health Visiting and the Frontline Network. Other individual respondents referred to more local networks or specialisms associated with their role in areas such as management, terminal care etc.

The demographics of respondents are generally representative of those working within inclusion health, i.e. well qualified/ in senior roles and of white ethnicity. The issue of explicitly inclusive resources and materials, as well as greater visibility and foregrounding of Black, Asian, Minority Ethnic (BAME) professionals in the HIHP, did in fact emerge in interviews with BAME participants in this evaluation as something that they would greatly welcome.

For detailed information regarding the survey respondents’ demographics, please see Appendix 5.

**Queen’s Nurses**

Perhaps somewhat surprisingly, only 34.7% of qualified nurses who responded to the survey (n=17) held the title of Queen’s Nurse. The theme of relatively limited visibility of the QNI arose in some interviews and focus groups, as indeed did the theme of ‘lack of confidence’ for individuals who did not hold a degree or higher degree, which one highly experienced nurse practitioner saw as a potential barrier to becoming a Queen’s Nurse. The potential for additional outreach to encourage applying for such a status, particularly amongst BAME or Diploma qualified nurses, is explored further and discussed within our recommendations.

**Working life**

In total, 56 respondents replied to a group of questions on working/volunteer status.

Overall, 54 respondents indicated that they were currently working and one respondent indicated that they are currently a student.

A total of six respondents indicated that whilst not in paid employment presently neither are they studying, potentially indicative of post-career volunteering for a number of respondents.

Table 6 illustrates the range of careers undertaken by respondents. Unsurprisingly, given the QNI’s role and reputation as a much loved and respected nurse-led organisation, the vast majority of respondents were nursing professionals. Of these, 24 (42.9%) identify as Adult nurses in community or hospital settings; 10 (17.9%) are specialist nurses in community settings, e.g. District Nurses, Community Children’s Nurses, 6 (10.7%) are Mental Health Nurses in either hospital or community settings; and a further 5 are Health Visitors or School nurses (8.9%). A further 6 individuals (11%) were nurse or clinical tutors or otherwise working in academic settings including in research.

Five housing support specialists also participated in the survey as did five nurse managers. In addition, one psychologist and one hospital-based children’s nurse
completed the survey. Nine other respondents indicated that they worked in ‘other roles’ and where information was provided by these individuals, whilst it was not possible to identify any clear trends in roles, it could be seen that they were predominantly associated with policy activities linked to NGOs or public health departments, working in hospice or NGO settings.

Table 6: Employment status/roles of respondents

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>RGN or RN Adult hospital or community</td>
<td>42.86%</td>
</tr>
<tr>
<td>RMN or RN Mental Health hospital or community</td>
<td>10.71%</td>
</tr>
<tr>
<td>RSCN or RN Child Health hospital or community</td>
<td>1.75%</td>
</tr>
<tr>
<td>RLDN or RN Learning Disabilities hospital or community</td>
<td>0.00%</td>
</tr>
<tr>
<td>SPO Nurse - District Nursing General Practice Nursing, Community Children's Nursing, Community Mental Health Nursing, Community Learning Disability Nursing</td>
<td>17.68%</td>
</tr>
<tr>
<td>SCPHN Nurse - Health Visitor, School Nurse or Occupational Health Nurse</td>
<td>8.93%</td>
</tr>
<tr>
<td>Student SPO or SCPHN</td>
<td>0.00%</td>
</tr>
<tr>
<td>Nurse Manager</td>
<td>8.93%</td>
</tr>
<tr>
<td>Dr / GP</td>
<td>0.00%</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0.00%</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>0.00%</td>
</tr>
<tr>
<td>Speech and Language Therapist</td>
<td>0.00%</td>
</tr>
<tr>
<td>Dietitian</td>
<td>0.00%</td>
</tr>
<tr>
<td>Podiatrist or Chiropodist</td>
<td>0.00%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1.75%</td>
</tr>
<tr>
<td>Psychologist or Counsellor</td>
<td>0.00%</td>
</tr>
<tr>
<td>Student Nurse</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other student health care practitioner</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other student</td>
<td>0.00%</td>
</tr>
<tr>
<td>Nurse Tutor or Practice Development Nurse</td>
<td>9.09%</td>
</tr>
<tr>
<td>Other Tutor</td>
<td>7.14%</td>
</tr>
<tr>
<td>Nurse Researcher</td>
<td>3.57%</td>
</tr>
<tr>
<td>Other Researcher</td>
<td>0.00%</td>
</tr>
<tr>
<td>Housing / Homelessness Support Worker</td>
<td>8.93%</td>
</tr>
<tr>
<td>Peer Worker</td>
<td>0.00%</td>
</tr>
<tr>
<td>Policy Lead - statutory services</td>
<td>0.00%</td>
</tr>
<tr>
<td>Policy Lead - voluntary sector</td>
<td>0.00%</td>
</tr>
<tr>
<td>Expert by Experience</td>
<td>0.00%</td>
</tr>
<tr>
<td>Retired</td>
<td>0.00%</td>
</tr>
<tr>
<td>On sabbatical / career break</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>16.07%</td>
</tr>
<tr>
<td>Total Respondents</td>
<td>56</td>
</tr>
</tbody>
</table>

Overall, 74.55% respondents indicated that their main field of employment is in inclusion health. In total, 96% (n=48) of qualified health professionals indicated that they worked in clinical settings, even where this was only a small part of their role (e.g. for nurse tutors or managers).
Table 7: Employer type

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>64.71%</td>
</tr>
<tr>
<td>Local Authority</td>
<td>5.88%</td>
</tr>
<tr>
<td>Social Enterprise or similar</td>
<td>5.88%</td>
</tr>
<tr>
<td>Charity / Voluntary sector organisation</td>
<td>31.37%</td>
</tr>
<tr>
<td>Academic institution</td>
<td>3.92%</td>
</tr>
<tr>
<td>Journal or Newspaper</td>
<td>0.00%</td>
</tr>
<tr>
<td>I am not currently working</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Respondents: 51</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Employer type**

In total, 51 respondents replied to this question and unsurprisingly the vast majority were employed by the NHS, with the next highest response rate coming from voluntary sector/NGO/social enterprise employees (aggregated n=19). This group included managers, the small number of non-clinical staff and also clinically qualified professionals whose contract was with charities which provided hostel accommodation; hospice care or tailored support for inclusion health, e.g. those with substance misuse issues, street homeless/roofless. A small number of respondents were employed in local authority roles such as community learning disability specialist; specialist health visitor for families experiencing homelessness or lead on Gypsy/Traveller health (clinical).

**Employment conditions (type of contract and team or lone working)**

Overall, 85% of respondents were permanently employed; 15% were on temporary contracts (in some cases, respondents combined two paid employment contracts, one part-time and permanent and one temporary or ‘bank’). Six respondents also indicated other employment status such as volunteering for an NGO on a part-time basis or being ‘agency/bank’ staff.

Whether participants/survey respondents work within teams or as lone workers was seen as critically important to assessing the value of the HIHP. This factor matters, not only in relation to numbers of client supported and potential for role development or inter-team knowledge sharing, but also in relation to potential for mutual support for clinical staff, diminishing risk of burnout, and enhancing opportunities for collaborative working.
All of these themes are to some extent touched upon within interviews and focus groups but given the emphasis on the value added aspect of mutual support for homeless health practitioners that emerged in responses in surveys, interviews and focus groups (as well as from oral interventions observed during attendance at special interest group meetings) it is pertinent to note that whilst 55% of respondents indicated they were members of a team (in some cases of only two or three people); 43% indicated that they were either sole workers or (where they held two discrete jobs) were a sole worker in one post. Accordingly (as also explored in interviews) having access to a network of colleagues who understood both the complex nature of the role and the pressures of working solo in often very challenging circumstances was seen as immensely important.

“Sometimes, people feel that they can’t be honest with organisations or with colleagues because they’re doing a job and they’re worried that that might affect them because if you say, ‘I’m finding this really difficult’, there isn’t always that open culture... Through events [meeting others who are part of HIHP] it’s trying to open up a conversation and say, ‘This is okay to talk about’. ” (Strategic Lead, NGO)

**Client groups supported**

On being offered a range of options for the groups with whom they most commonly worked, 46 respondents elected to respond to this question. It was possible for respondents to give more than one response (as for example in the case of interviewees, we found that many participants worked in an outreach team which engaged individuals who are homeless/roofless, refugees and/or vulnerable migrants under the general rubric of ‘inclusion health’). Chart 4 captures the categories of service users with whom respondents work. As can be seen rough sleepers (65.2%), people living in hostels (69.6%), families in temporary accommodation (41.3%) and clients with addictions (63%) are the most commonly noted categories of service users; whilst GRT communities (28.3% of responses) are least common, with people in prison and those on remand (30.4%) only slightly more likely to be represented as a service user group. Overlaps clearly exist for some other categories, e.g. those supporting vulnerable migrants (43.4%); individuals with TB (19.6%) is a category likely to include rough sleepers and some vulnerable migrants, whilst persons who have HIV+ status (recorded by 39.1% of respondents) may fall across a number of categories including individuals with addiction, refugee and asylum seekers and sex workers (41.3%), as well as people in prison.
In total, five respondents indicated that they do not work directly with inclusion health groups and a further four indicated they worked in 'other' settings, e.g. policy or psychology roles. Overall, ten respondents who replied to this section of the survey stated that they do not, and never have worked directly with inclusion health groups and this includes persons in roles such as nurse managers, researchers, policy specialists or mental health nurses who are accessing information to support a wider role and enhance their learning. A question on which inclusion groups respondents have worked with in the past (prior to current role), broadly mapped across to patterns of service provision/service user contact identified in Chart 4, although a slightly higher percentage of respondents had previously worked with GRT communities than currently do so, and a lower percentage had worked in the past with sex workers than do so now.

**Role in research and training on inclusion health**

Only four respondents (7.27%) indicated that they are currently involved in any form of research with inclusion health groups. A considerably higher number (including nurse tutors and those in academic positions as well as senior practitioners) – accounting for 29 respondents – (51.8% of responses to this question) – reported delivering education or training on inclusion health. The number of respondents tasked with delivering education or training is likely to account to some extent for the higher than expected number of individuals in this sample with higher degrees.
The four respondents who are currently students were invited to reflect on the extent of training on inclusion health they received in their current programme of training. One individual (25%) indicated that they had not received content relevant to inclusion health in their course, two (50%) indicated that there was some materials in their programme of study and only one person stated that there was “a lot” of inclusion health in their course.

Whilst the survey has not sought to capture details on the type of training currently being undertaken by students, as noted in the literature review, inclusion health is largely absent from professional curricula and this omission is therefore made up it would seem, through ‘on the job’ training (see in particular the QNI resource on Transition to Homeless Health Nursing which in interviews and focus group settings was particularly commended by practitioners as an important resource for new staff) and through accessing specialist resources such as those prepared and disseminated by the QNI in relation to families experiencing homelessness, foot care, epilepsy, mental health and substance misuse.

**Requirement for and access to ongoing training and professional development in inclusion health**

In the light of the lacuna in prior learning within qualifying courses discussed within the literature review, a resounding 94.6% (n=53) reported that they required access to ongoing professional development or specialist training to support them in their role. However, only 60.7% reported that training and development in inclusion health could be acquired through their employer, indicating a clear shortfall in accessible training and professional development in this area of practice.

That 85% of respondents reported that inclusion health was underfunded in their area, and only 56% of participants in the survey indicated that their service was permanently funded, further underpinned the repeated emphasis found in this evaluation on the importance of the HIHP in supporting practitioners in a challenging role.

In a question that asked respondents to identify key concerns facing them in relation to their service/professional role, 51% indicated uncertainty over future funding and sustainability of their service; 47% referred to under-staffing or problems recruiting, and 36% of respondents indicated they were concerned about lack of training, learning resources and access to continuing professional development (CPD). Overall, 53% of respondents to the survey indicated that they were working additional hours over and above those funded within their contract of employment or volunteering role, to enable them to undertake their job well. Whilst 86% of survey respondents felt that they were supported by their management in

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undertaking their post, the peer-to-peer support available through the HIHP was seen as invaluable:

For example, respondents praised the:

“Meetings and training!! Supervision! It feels very lonely out here and not many Practice nurses [are] like us.” (Clinical Practice Nurse, lone worker)

One Nurse Practitioner interviewee who reported that they are working considerably more hours than their post in a small city is funded for, and who is supporting increasing numbers of adults with complex needs who are homeless, referred to the psychological pressures of their role and concerns over delivering an appropriate level of service and being aware of up-to-date learning as “like carrying a big bag around”, noting that when she is able to be in contact with other Queen’s Nurses and Inclusion health specialists at conferences or via Network meetings:

“Then I can only tell you it’s just like going home. When I sit with my peers, my colleagues from the HIHP in the QNI, they get me. I get them. They are – they’ve been – fantastic” (Clinical Lead, Homeless Health)

Another respondent to the survey (employed by a local authority) having indicated their use of free resources provided by the HIHP, which underpin limited opportunities for CPD, tellingly pointed out that “we have to access our own choice of training and meet the cost ourselves”.

Given that 52% of respondents to the survey (n=28) were directly working for an inclusion health service, it would appear evident that a number of practitioners are currently reliant on accessing specialist information, training and knowledge exchange through the auspices of the HIHP, as well as similar professional groupings such as the Faculty for Homeless and Inclusion Health.

Importantly, 72% of respondents indicated that they made direct use of guidance and resources prepared and disseminated by the HIHP on working with inclusion health groups during the Covid pandemic, further emphasising the importance of practitioners being aware of, and able to access tailored resources appropriate to their client group through a specialist professional network.

**Value of the HIHP to Inclusion Health Practitioners**

In the light of the analysis that captures a picture of staff who often transition to inclusion health and then frequently find themselves working in small teams or as lone workers (with only 37% reporting that their line manager was a specialist in, or had knowledge of inclusion health), having access to good quality resources, training and a network of supportive practitioners is seen by many as exceptionally important.

Overall, 71% of respondents to the survey indicated that they had received direct support in their role from the HIHP in the year prior to completing the survey. Whilst
this support could range from accessing resources, to attending training events, conferences or Network meetings, a number of respondents (11%) also referred to being able to phone the HIHP Nurse Lead.

In total, 67% of respondents stated that their professional practice had been improved over the previous year and they had been able to offer “better care” to their clients as a direct result of their engagement with the HIHP.

As explored in interviews and focus groups and also survey responses, the role of the QNI in delivery of training, provision of networking opportunities and the source of free, high quality, accessible resources is thus seen as profoundly important in ensuring that clinical practitioners remain up to date in their knowledge. Participants also frequently spoke of the intertwined nature of support accessible through the HIHP, as in addition to being able to access specialist training, support and development designed with nurse practitioners in mind, there was a significant appreciation of the fact that the organisation behind the resources was supportive and understanding of their role.

Whilst we discuss this in more detail further in findings from interviews and focus groups where nurse practitioners reflect on the particularly high value placed on the HIHP, the following quotations are indicative of comments from participants:

“It’s important that it’s led by and for community nurses” (Clinical Practice, Specialist Nurse)

“At the time when I was fighting … to keep the post of homelessness and the work of homelessness, even just to keep it on the radar, having the QNI at my back while I was doing that project was really what enabled the service to keep going.” (Inclusion Health Lead/Service Manager for Gypsy, Roma and Traveller project)

“Until I got a second member of staff working with me, I hadn’t understood how isolated I was, and that’s why the relationship with other people in the HIHP was so important.” (Clinical Nurse Specialist, Homeless and Vulnerable Adults, Wales)

On being asked whether they felt the QNI should continue to support the HIHP, out of 52 responses, 51 (98%) indicated that they wished the programme to continue. When asked to rate how important they considered it was to their work that the HIHP continue; as shown by Chart 5; 58% of respondents indicated that the HIHP was ‘vital’; 37% that it was ‘very important’; and 6% that it was ‘quite important’ to their role. No respondents indicated that it was unimportant to them whether or not the HIHP continued to function.
The follow-up question that asked respondents to compare the overall activities/resources and HIHP to other professional networks which they make use of to support their professional development and role, found that 50% rated it as ‘excellent’; 46% as ‘good’ and 4% as ‘average’. No respondent selected poor or below average.

Whilst not the overall focus of this evaluation – although pertinent in relation to activities funded by this programme – of those respondents (53%) who had been aware of the nurse-led inclusion health innovation programme undertaken by the QNI in 2018 (evaluated by Bryar, 2020); there was widespread support for the repeat of such an activity. Overall 72% of respondents indicated that they would be interested in applying for such an opportunity, should this be offered by the QNI again.
Findings: focus groups and interviews with frontline clinicians and strategic leads

As discussed under the methods section, a key element of the evaluation involved obtaining qualitative data from a range of clinical staff who are members of the HIHP. We undertook one focus group (n=6) and a total of 10 individual interviews with clinicians to explore their use of QNI/HIHP resources, ways in which the HIHP has helped their practice, to consider recommendations for future development and to interrogate their views on the value of the HIHP overall.

A second focus group with key strategic leads from major external agencies (e.g. LNNM Homelessness Group; Doctors of the World; Homeless Link) who are connected to the QNI and HIHP was also held. In addition, three interviews took place (one with two senior RCN Strategic Leads and the other two with Strategic Managers at nationwide homelessness charity or support networks). This second focus group and individual interviews was more explicitly focused on issues around the strategic value of the Network, collaboration opportunities and networking across agencies, the role of the HIHP in supporting the delivery of training and policy engagement, and consideration of how HIHP activities could be supported should funding cease.

Separate topic guides were drawn up for the two categories of respondent and the same interview schedule was utilised for both focus groups and interviews (see Appendices 3 and 4). Accordingly, the data is aggregated simply into the two overarching categories of responses from strategic leads and clinical practitioners when presenting findings on the various key elements of the discussions.

Interviews and focus groups took place predominantly over a 6-week period – mid-October to early December with an additional two interviews with strategic leads which had to be delayed as a result of participants’ workload occurring as late as mid-December.

Accessing participants/sampling frame (clinical practitioners’ group)

To access respondents to participate in the clinicians’ interviews and focus group a sampling frame was drawn up, which identified variables of duration of membership and experience in inclusion health, age, role, geographical location, whether a lone worker or team member; gender and ethnicity. Some invitees had previously also been beneficiaries of the QNI/Homeless Health Innovation Funding Programme, but this was not an explicit inclusion criterion.

Having identified a range of potential participants in the qualitative data gathering exercise through review of the database of members and suggestions gathered during team meetings, approaches were made (via the auspices of the Nurse Project Lead Homeless Health Programme as per ethics approval) to a potential group of participants. Invitations to express interest in participating in the evaluation
by directly contacting the lead researchers, were sent to a larger pool of interviewees than initially intended (blind copied in email to the researchers, enabling potential participants to confirm if they were willing to take part in the evaluation while also providing participant information sheets, consent forms and other materials) (See Appendices 1–4).

We were able to meet a full target of ten individual interviews and a focus group of six participants, with focus groups and interviews taking place between October and December 2020.

Appendix 6 provides the demographics of the clinical practitioner focus group and interviewees.

Overall, when consideration is taken of interviewees and focus group participants in different regions and working with different groups, we consider that we have captured a relatively representative sample, based on survey and broader HIHP membership data thus enabling us to feel confident that we have explored participants’ variety of experiences, making the synergies in recommendations and comments on the impact of the HIHP more striking.

In the discussion that follows, to evidence the conclusions drawn and underpinned recommendations, we present the interview and focus group data under a variety of sub-headings, which are reflective of the topic guide used for qualitative data capture (see further Appendices 3 and 4). As such a large amount of data has been gathered during this evaluation exercise, it is only possible to provide indicative examples of comments from participants, but these have been treated to broad-brush comparative analysis – for example to explore where individuals employed in different types of services, role, gender, ethnicity or age, reveal significant variance in approach or recommendations, which are suggestive of wider issues than personal preference. Where opposing viewpoints are expressed in relation to any question or theme, these are illustrated by quotations, to enable transparency and confidence in the findings reported.

Findings from clinical practitioners (n=15) follow.

**First contact with the QNI/HIHP and duration of contact**

Length of membership amongst clinical practitioners interviewed ranges from 13 years to under 1 year. Whilst contact with the HIHP and QNI was of relatively recent duration for the majority of respondents, averaging 3-4 years, one individual (based in Wales) had been a member of the HIHP since 2007, prior to becoming aware of the QNI and subsequently became a Queen’s Nurse in 2010.

“The opportunity came along for somebody to organise a pilot scheme to see whether homeless people needed specialist healthcare. I think I joined the Homeless Health Network in about 2007, and really enjoyed being able to talk to other people who did what I did and who understood my patients. I found it really
useful to be able to go to conferences where there was a much better fit for what I wanted. I think there was an invitation for people who worked in homelessness to join the National Forum for the Homeless Health Network. I agreed to do that and so we’d go to London two or three times a year” (Clinical Nurse Specialist, Homeless and Vulnerable Adults, Wales)

Similarly, a London-based clinical specialist with extensive experience in inclusion health reflected on her long-term knowledge of the QNI pre-dating the HIHP, which led to accessing funding, training and becoming a Queen’s Nurse:

“I’ve known the QNI team for a very long time. I initially first encountered the QNI back when I was doing the original [homeless outreach] project, the intensive case management project, because it was the first of its kind, really, providing such case management for a group of marginalised people. So, they came out to interview myself and my colleague … I’ve known the QNI since around, I would say, 2009 or ‘10, so quite a long time. Then I knew that they were interested in homeless health and so I kept in contact. I joined their mailing list, but I really got to know the QNI back in 2018, when myself and my colleague applied for one of their funded projects.” (Nurse Practitioner with people with addictions, refugee and asylum seekers, London)

In contrast, another respondent became actively involved, and ultimately was awarded the status of a Queen’s Nurse after her personal story and work with people experiencing homelessness came to the attention of the QNI and the HIHP:

“I gave my own personal story to the QNI Homeless Health Network in 2018. I spent nine years homeless as a child on the streets in London. I became a nurse over time and obviously I run my own voluntary service out in the streets in South Wales now and I became a Queen’s Nurse last year.” (Community Staff Nurse and Clinical Lead for Homelessness NGO)

Overall, it was particularly striking that both individual interviewees and focus group attendees (clinical practitioners) had in many cases ‘stumbled across’ the Queen’s Nursing Institute and/or the HIHP as a result of casual networking, attending a conference, or a meeting of an external network such as the LNNM or Pathway.

“About a year and a half ago? I think I first became aware of it, obviously, through the Pathway’s meetings and then Sam [HIHP Nurse Lead] … I’ll be honest, I didn’t really know anything about it. It’d never been anything that I’d explored or been part of or really knew anything about.” (Lead Nurse, Homeless Pathway Team, Northern England)

“I was involved with it [HIHP] mainly by joining onto the emails circulation list and recommendations from other people … for about eight years now.” (Nurse Practitioner, London)
In total, around 60% of respondents mentioned word of mouth recommendations from a colleague working in Inclusion Health as a route into contact with the HIHP/QNI at which point they recognised the value and quality of the Network and available resources.

“So [I] started, informally, just networking and getting a lot of information. I’d been to QNI conferences, so I was very interested in, particularly, the standard of excellence and the aspirations that were beyond the normal service that we were able to deliver.” (Service Manager, GRT project, South of England)

Approximately 30% of those who reflected on how they had first heard of the HIHP mentioned that the HIHP Nurse Lead had acted as a dynamic conduit for contact, reaching out to former colleagues; approaching people she had heard speaking at workshops to invite them to contribute a case study to the HIHP resource bank; or emailing someone when she had heard about a project in inclusion health which was not known to the HIHP/QNI.

Another participant first became aware of the HIHP/QNI (a few months prior to interview), when undertaking research. They then subsequently encountered the HIHP Nurse Lead when presenting on a local community mental health project they were leading:

“I first heard about QNI when I was doing my advanced healthcare Masters and I was just doing a dissertation and I did it on the impact of having a homelessness mental health nurse. When I’d done the literature review, I found a lot of articles and lots of things from the QNI … [I was] talking in a conference recently and Sam was attending it and she asked me to do a case study which has just gone on the QNI site.” (Mental Health Nurse, East of England)

In contrast, three (senior) individuals indicated that they first heard of the QNI, HIHP and the availability of training and resources as a result of quite high-level contacts, for example through the Department of Health and Social Care, meeting the CEO in working groups or (as noted by a respondent in a strategic role) through involvement in regional level initiatives then finding out about the opportunities available for development through the QNI:

“I first came across the Queen’s Nursing Institute when I moved into the Department of Health. Crystal and her team were working with X on developing the District Nursing Framework here in Northern Ireland.” (Senior Clinical Lead, Nursing Officer Public Health, Northern Ireland)

It is therefore evident that there has been a shift in trajectory of membership since the HIHP was match funded with the Oak Foundation, enabling more inclusion health practitioners to become aware of and involved in the HIHP as activities have grown and nurse-led projects have been funded. In turn this has led to increased
numbers accessing the resources and benefiting from special interest groups. However, there is still clearly scope for development and growth. The role of the HIHP Nurse Lead has been identified throughout this evaluation as supporting dynamic growth in the expansion of the HIHP, but the piecemeal way in which inclusion health professionals have encountered the work of the HIHP and QNI could be more effectively developed through dedicated resourcing to enhance membership, advertise activities and increase outreach in a structured manner.

Membership of the HIHP and other clinical networks

As with the survey data, it is clear from interview and focus group data, that there is a substantial overlap in membership of the HIHP and a number of other clinical and specialist networks (particularly in London) with several interviewees mentioning the Faculty for Homeless Health, Pathway, Homeless Link, Groundswell and LNNM. Specialist practitioners also referred to the Tissue Viability Society and the Institute for Health Visiting. Two respondents also mentioned the RCN in relation to other clinical networks and organisations they are in contact with, although this was in a more generic sense, whilst one interviewee contrasted the HIHP favourably with the limited availability of inclusion health specific support available through the College:

“I’ve been speaking to the RCN recently about their forums but I don’t think they have a specific Inclusion Health forum.” (Nurse Practitioner, Homeless Health, London)

Other non-clinical, locally based inter-disciplinary collaborative groups, predominantly for those working in regions some distance from London who tended to have less access to specialist networks other than the HIHP, were also mentioned in some interviews.

“Pathway gave us a list of free courses to access. So, I’ve done stuff like Shelter. I take opportunities like that, ... when they do ... free hour webinars or half an hour here. So, that’s the kind of training that I’ve accessed in areas that I’ve not known about before coming into this job.” (Clinical Lead, North of England)

Whilst these other networks can also provide clinical support and guidance, with the LNNM – the most frequently mentioned network amongst London-based participants, there is a perception that the quality of supportive relationships offered by the HIHP/QNI team is unique (a theme reflected upon too, in discussions of special interest group meetings and added value discussions in relation to reducing isolation for rural or non-London based members)

“I’m also part of the QNI’s Facebook group, so just because I think it’s nice because it does feel like a family... Yes, I’m often in contact with them and asking for advice.” (Clinical Specialist, recipient of Nurse-led Innovation award)
“I’m [also] a member of the LNNM and I present at their conference every year. In terms of the QNI, I’ve learnt loads from it.” (Homeless Health Outreach Specialist, London)

Participants in the qualitative data gathering exercise spoke passionately of the benefits to them of membership of the HIHP, rating it exceptionally highly, most particularly in relation to access to resources, information, opportunities to share practice and support which they would find difficult to access otherwise.

Knowledge of the QNI more generally, was in some cases (found both in London and ‘out of London’ based HIHP members) noted as acting as a conduit to awareness of the HIHP, with around a half of interviewees commenting on how they first became involved through attending a QNI event. Given the symbiotic relationship between the HIHP and QNI, for many participants in interviews and focus groups the HIHP is synonymous with the QNI.

“I have to say, they’re absolutely phenomenal, the way it’s organised, the work that goes on, the work that we see and the work that goes on in the background …” (Academic/Specialist Practitioner, London)

“I was lucky enough to be asked to speak at the annual QNI conference last year. That was really good. That was another way of how the QNI supports you by ensuring that you remain visible, and the work that we do within our team is visible as well. They’re a great group of women and colleagues to know.” (Homeless Health/Asylum Seeking Families Specialist, London)

“We look at the grants that are available, so the funding as it comes through for projects. We look at the training that’s available, the newsletters that we get, and the work that they’re doing with Pathway.” (Lead for the Homeless and Health Inclusion Team, North of England).

“They do training. They send you things out to tell you what type of training that they are offering and then [to ask] what type of training you’d like, and job opportunities, international [news].” (Health Inclusion Nurse, London)

“This is the other thing I feel is important is the QNI is for community nurses. I suppose we’re not all community nurses but we’re still working with this group of people. In terms of the QNI, I’ve learnt loads from it.” (Community Clinical Nurse, London)

Although respondents were asked if there were other clinical networks they would wish to join, there was very limited response to this question, other than suggestions that it would be helpful to have more widespread support for inclusion health via the RCN, or a greater focus on mental health and inclusion groups.
“I think it will be brilliant if there was a network about mental health that anyone could join as well so keeping subgroups really open to everybody [not just mental health specialists]. As general registered nurses we have always found it a steep learning curve. It would brilliant if we could be involved in that as well ... also any extra information and knowledge about refugees and asylum seekers and Travellers and Gypsies as well would be really, really useful and people sex working as well.” [Homeless Health Outreach Nurse, London]

Indeed, this lacuna in specialist networks around mental health and homelessness since the interviews were undertaken has begun to be addressed (see ‘special interest groups’) with the HIHP and Pathway intending to create a special interest group in this area of focus, and as explored earlier there is a thriving network group engaged with issues around GRT and Boater health.

**Training/materials or other events accessed through the QNI/ HIHP**

Although a number of quotations in relation to access to and appreciation of the high quality of resources have been included earlier in this report (along with comments which indicate some participants were unaware of the range of materials available on the QNI/HIHP website), there was widespread enthusiasm for the accessibility of training and freely available downloadable resources as well as the flow of high quality information provided by the QNI and the HIHP.

Respondents reported that their primary focus was on emergent practice and funding opportunities:

“I keep up to date with what’s happening on Twitter with the Pathway and training. Our lead nurse is a Queen’s Nurse, so we often know about the funding, and the initiatives, and what we can apply for, and what grants are available. I’d say daily [contact with the HIHP/QNI] on Twitter, but at least weekly we’re receiving updates from QNI”. (Lead for the Homeless and Health Inclusion Team, North of England).

“I read the website, I get the newsletters, they’re really important, the newsletter. I applied for the scholarship. That’s how I was able to get the funding to do the [inclusion health education] module.”

“There are lots of blogs, as well, that you can read about other nurses, practitioners working within the field who you may not get to know about... So, it's really good in terms of getting connections with other nurses who aren't in the area, who are working within the field, and seeing what they’re doing, and then being able to share ideas and tips, and gain knowledge from them.” (Specialist Nurse Practitioner, London)

“The unique part of our group is that we work with services and we try to get the disengaged reengaged with the services that are already set up. So, it's really
getting information together and trying to get everyone to follow suit. “ (Community Nurse, Clinical Lead, Homelessness NGO, Wales)

“Guidelines for health-related street outreach to people experiencing homelessness. They have been endorsed now by the QNI – guidelines for services who want to start new street outreach parts of their service or services that are already doing street outreach and just want to have a look and review what they’re doing.” [These guidelines, produced by a HIHP nurse practitioner based in London drew on her primary research and was supported by the HIHP Nurse Lead. This resource was referred to by the NGO Clinical Lead in Wales who also participated in the clinicians’ focus group.]

Several participants commented on the particular value of receiving information on forthcoming policy changes, which they were alerted to through the HIHP newsletters:

“I mean I haven’t attended any of the conferences for the QNI but I do get the communication and the emails and the e-materials and the policies … in terms of the changing climate, there is new guidance coming in all the time. I find that to be quite useful.” (Homeless Health Outreach Specialist Clinician, London).

Attendance at QNI conferences where respondents were able to learn about HIHP activities, hear from colleagues working in inclusion health and engage in practice discussions emerged as a constant theme, noted by all but two frontline clinician participants (both relatively new HIHP members who hadn’t yet attended QNI conferences).

“I think there was one [event] last year or the year before specifically around working with vulnerable women, women who are homeless, hidden homeless. And that was quite nice to have a conference that was quite specific to that client group because their needs are different. It was … really nice to see new research in that area.” (Homeless Health Outreach Nurse, London based).

“I have been to a few of the conferences before which have been really beneficial for updates and also for networking with likeminded colleagues across the country. Seeing what everybody else is doing is really valuable…” (Community Outreach Matron, West of England)

Although inevitably Covid-19 impacted the ability to hold the QNI annual conference in a physical venue in 2020, the online event was also hailed as hugely successful for some participants in areas more distant from London or who struggled to access funding and time to participate in such events:

“It is actually brilliant to be able to attend more because it doesn’t take up so much time from your day and especially if you are having to travel. If the conference is in
London, for instance, and you are based elsewhere, I think that’s a brilliant thing about virtual conferences. I think it would be great to have more QNI ones.” (Nurse Practitioner, Homeless Health)

“They’ve done a lot of online webinars and talks, which have been amazing. They did awards. I couldn’t go to them, but you can watch them back, so that’s quite helpful.” (Tissue Viability Specialist, London)

Opportunities to apply for funding as a result of membership of the HIHP and QNI were regarded as exceptionally valuable, particularly for nurses who were (as evidenced in the survey material) often lacking in opportunities to receive substantive CPD and training, or who were working in insecurely funded services with little or no resource for development of services.

For example, a number of interviewees and focus group respondents had successfully applied for funding to undertake the UCL inclusion health training modules, or for Nurse-Led Innovation Projects (see Bryar, 2020 for details of the impact of these 10 seed-funded programmes of activity).

Interviewees who had been recipients of grants through the HIHP were particularly enthusiastic about the impact on their learning, ability to disseminate information to colleagues, and ability to improve the service delivered to clients which has occurred as a result of these opportunities.

“The QNI were very enthusiastic about the idea and felt that this was a neglected area [supporting Gypsy and Traveller children and families]. So, although it was a homelessness project, mine was the only one of the 10 projects that had anything to do with these communities... I think what I was unprepared for was the sharing of learning, because that was one of the really wonderful things about the project. When we came together as nurses, people, each of us with each of our own projects, we learned so much from each other about what they were doing. You know, they were able to see that everybody had stories about Travellers who are part of their caseload so it crossed lots of other boundaries … there were lots of points of commonality about what we were all doing, while there was [also] the very specific stuff about some upskilling even my peers and colleagues about the cultural aspects of why these communities struggle to engage with services.” (GRT Project Lead, Southern England)

**Support for special interest groups**

The frequency with which special interest groups have been referred to, and the provision of both clinical information sharing and ‘moral support’ via these meetings, is testimony to the high value that is placed on the HIHP/QNI’s support for these activities:
“I’m part of a very vibrant network of the two homelessness groups. The GRT group, came up as a subgroup because we realised that there were quite a few of us around the country doing similar things but we’d not been connected up together. So that’s a fairly recent development, I would say probably over the last 18 months or so, that we’ve come together as a specialist group… I’m [also] part of the standard homeless group. Between the two groups, we meet virtually probably once a month… There are also quite a lot of email exchanges between us."

(Specialist GRT Health Lead, South East England)

Value of the HIHP to Clinical Practitioners

The enthusiasm and value placed upon the HIHP and wider programme was self-evident from the interview and focus group data gathered from clinicians who participated in the evaluation study. However, it was also considered important to reflect on the specificity of the programme in supporting nurse practitioners, and to seek to identify whether there was a particular added value to nurses.

Amongst respondents in both one-to-one interviews and the clinical practitioners focus group, there was a widespread emphasis on the importance of having a nationwide network that was nurse-led and nurse-focused, and hence was differentiated from other types of broader homeless and inclusion health groups.

“The Faculty of Inclusion Health is more medical and the London Network is obviously more London centric. So I think the fact that the QNI is more nurse led and it’s across the whole of the UK is really important. I think definitely there isn’t the opportunities within our Trust to access training that’s specific to Inclusion Health. I’ve never been able to access that through our Trust. It’s always been through the QNI.” (Outreach Homeless Health Practitioner, London)

It was particularly noteworthy that the vast majority of clinical practitioners referred to the powerful impact on their sense of self-worth and pride when they were able to be together with other inclusion health nurses in events and activities convened through the auspices of the QNI/HIHP. Over and above the learning opportunities provided by conferences and networking opportunities, comments within the interviews and focus group data from clinical practitioners repeatedly emphasised the added value afforded to them by the palpable sense of cohesive mission and celebration of the value of their roles, elements that emerged particularly when the HIHP/QNI facilitated nursing peers come together:

“It’s about being on a limb professionally, but having a group of people where you feel very included and understood. I think it’s the camaraderie and the passion. It’s a bit like a club, and that’s not something that you get with your colleagues in other specialities, and the knowledge, and the information, and the funding, and the training, and the kudos, I guess, really.” (Clinical Team Lead, North of England)
“They are a passionate, fantastic bunch of people. I’ve just met so many great people ... it was just brilliant. I came away just feeling eight feet tall, like I was doing a really good job. I think that’s really important. I think we’re quite isolated, as practitioners. Nobody really knows what we do, but you get together with a roomful of people who know exactly what you do, and do the same job as you. It’s really powerful.” (Clinical Lead Inclusion Health, North of England)

“I don’t want to be exclusive, but I think, yes, it does help because it means that it’s very specifically ... by nurses, for nurses – where you can go for advice.” (Inclusion Health Specialist, London)

**Colleagues’ appreciation of the role of Inclusion Health Nurses and working with stigmatised client groups**

The theme of comprehension of the inclusion health nurse’s specialism, and how their role was understood by hospital-based colleagues also featured within interviews, as did the perception that working with some groups was perceived of as stigmatising. As such, this slightly ‘outsider status’ in relation to clinical work, even sometimes when compared to other community nurses, underlined the benefits articulated of membership of a specialist network of ‘like-minded practitioners’.

“I think the culture in ... the hospital, it’s awful. It’s absolutely awful, and that’s a big part of what our role’s been about. It’s been about educating and supporting staff to understand a little bit more about where it is we’re coming from and the real disadvantage that our patients face and, you know, the frailty that’s in the population and the life expectancy.” (Specialist Inclusion Health Team Lead)

“I think there probably is a little bit of a stereotype, especially when you come back and say, ‘They’ve got cockroach infestations and rats ... One of the buildings we’ve gone to has safety issues around it because the majority of people aren’t families and there’s no management there, so we go there isolated.” (Health Visitor with homeless families, London)

Despite the feeling articulated by many participants that their role is often misunderstood by other clinically based colleagues, the majority of respondents indicated that there has been a growth in awareness of the backgrounds and needs of inclusion health clients over the past few months, particularly since the Covid-19 pandemic, when discussions on homelessness have become more mainstream, and increasing media awareness has flagged up how precarious employment can be, tipping people into poverty and homelessness.

“... homelessness is not a stigma. It can happen to anybody. You can be alright today, tomorrow you are not alright. So, these things have made people realise that there is no place for giving somebody a name now, you know? So, asylum seekers and refugees, they come into the country, it’s the law that is holding them [back].
They are still human beings.” (Homeless/Asylum and Refugee Outreach Nurse Prescriber, London)

“I think living in a valley community … with COVID-19, homelessness has been brought to the forefront and they only realised that they had such a hidden homelessness problem… I think they really had their eyes opened and now they are having to put services in place further down the valleys to cope with what’s going on. We are having things like GP services getting in touch to say, ‘Somebody is sleeping in our doorway’. (Community Inclusion Health/Clinical Lead for an NGO, Wales)

One interviewee noted that: “I think it’s [membership of the QNI/HIHP] also given us a measure of professional legitimacy as well, so that we’re a network of specialists rather than being seen as, kind of, a bit of an anomaly in the organisations that we’re employed in.” (GRT Health Lead, South of England)

Despite this increased awareness of inclusion health amongst both the general public and other health professionals, approximately 60% of participants in the interviews and focus groups referred to their non-inclusion health peers as lacking a general understanding of the holistic and complex nature of their role, even amongst many other community nurses:

“I do think there’s a lot of negativity, but there’s quite a lot of professional curiosity. … When people come out with us … at the end of the day they get it, because it is quite hard not to get it from a care perspective, regardless of how you feel about sex-working women or Gypsy and Travellers…. We take them to see the beds in the church that we’re commissioned to put people in, and they think it’s worse than being in a prison. You’d have to be really hard-hearted not to see how grim it is, really, and how disadvantaged people are.” (Clinical Lead, Homeless Health)

“I think most of my colleagues would just say, ‘It’s wonderful what you do’, until they come out for the day with me. Then they say, ‘I wouldn’t do your job for all the tea in China’, because I think there’s a huge misconception about what nurses who work with homeless people do, but I think we’re not very good at explaining what we do.” (Inclusion Health Lead, North of England)

The QNI/HIHP as a nurse-based resource or open to other professions?

Whilst it was clear that there was overwhelming support for the role of the QNI’s HIHP acting as a national resource and support network for the diverse range of inclusion health specialist nurses, a thread of discussion which arose in approximately 20% of interviews and a small minority of clinical focus group participants’ comments, concerned the relationship with, provision of targeted
resources, and network membership opportunities, for wider inclusion health colleagues in diverse professions.

Analysis of the entire data set however illustrates that it is clearly possible to see some differentiation in responses by role of interviewees, with members of the strategic lead group exploring this theme in more depth, specifically because that group consisted of a wider range of practitioners and policy leads than the clinical practitioners who were invited to consider options for future opportunities and directions of the HIHP/QNI.

Overall, however, amongst the broadly characterised ‘clinicians group’ there was a significantly greater emphasis for retaining the HIHP as a specialist nurse-focused programme. However, a sub-group of respondents in the ‘clinicians group’ (particularly who had more established policy-facing responsibilities, or highly externally networked roles) were more likely to reflect on the potential and importance of expanding the network and offer to include other professions, in a manner similar to those who were part of the ‘strategic lead’ group:

“Physiotherapists and social workers, that would be nice. Social workers have no idea. Sometimes you are dealing with them, they don’t know what you’re talking about. Physiotherapists are getting more and more involved because a lot of sickness … most of the refugees that are coming, because of the roughness of their travel, come in unwell … some of them very ill, very ill and need support.” (Refugee and Asylum Support Practitioner, Nurse Prescriber)

Clinicians’ opinions on the most useful and effective elements of the HIHP

As already explored (see discussions on resources, conferences and added-value of the HIHP), participants in the evaluation repeatedly identified the importance of a nation-wide, nurse-led specialist network that provided access to free downloadable resources, ongoing telephone or email advice from the HIHP Nurse Lead, as well as training opportunities, conferences and participation in special interest sub-groups that permitted the exchange of knowledge as well as reducing professional isolation.

Bryar (2020, op. cit.) has evaluated the impact of the 10 seed-funded nurse-led homeless health projects funded under the auspices of the HIHP, demonstrating that only one of the projects would have commenced without the support from the HIHP, and that seven have received ongoing funding based on the success of the projects, whilst three have further expanded their service and remit.

Within this overall programme evaluation (which included data gathered from some participants who were awarded innovation project funding), we asked respondents to identify what they personally felt had been the most useful or effective element
of the overall HIHP and whether they had been able to share learning obtained as a result of participation in the suite of activities, with colleagues.

In all cases, respondents who had been actively involved in seed-funded innovation projects (n=3) enthusiastically endorsed the fact that without the QNI/HIHP support, their innovation project work would not have taken place, given funding challenges in their local areas. As Bryar (2020 op. cit.) demonstrates, these funded projects have had considerable reach, and enhanced the lives of numerous service users as well as facilitating exchange of specialist knowledge at both the geographically local area and in some cases regionally or nationally.

The current overall programme evaluation further illustrates that the overall suite of activities funded by the HIHP (e.g. innovation projects, network development, developing free-to-access resources, access to inclusion health educational modules, provision of advice and information from Inclusion Health specialists within the QNI) coalesce to create a jigsaw of best practice and act as a catalyst for enhancing inclusion health good practice and education throughout the HIHP, particularly via the mechanisms of multiple levels of information exchange.

**Dissemination of learning/access to specialist practitioners**

Whilst Bryar’s evaluation (2020:11) found that five out of the 10 funded nurse-led innovation projects had demonstrable national level impacts on inclusion health, utilisation of soft-measure evaluation methods such as exploring knowledge exchange through special interest group networks, suggests that the reach of these projects has in fact been greater than previously identified, both in engagement with wider numbers of HIHP members who have downloaded or viewed resources, and through enabling professional conversations to occur, which can lead to the development of new resources or practices:

“I met a fantastic lady who worked with learning disability clients. . . and I came away and thought, ‘I’ve got a fair number of people with learning disabilities who are homeless’. That has led to a whole raft of projects which were around looking at how many people I had with learning disabilities who were homeless, and then looking at their particular issues.” (Homeless Health Team Leader, Wales) N.B. The learning disabilities resource which emerged from this discussion was particularly commended by the Nurse Co-ordinator of Hastings Homeless Service, St John Ambulance.

Similarly, the Tissue Viability Specialist/Academic practitioner (London) reported that after a conversation on the need for enhanced learning, “Then we were able to facilitate this conversation to say, “This is a great idea, we’ve been meaning to do it [produce a wound care document for HHN/QNI]. Sam sent out within the newsletter a request for other clinicians around the country to get in touch with me if they had
any examples of practice. From that, I went on and had Zoom meetings with key people in the country, like from St John’s Ambulance, a lady in Cardiff. It facilitated all of that.”

A Pathway Team leader in the North of England also spoke about the assistance she received from QNI/HH Programme Lead who put her in touch with other practitioners that enabled her to explore differences in practice and take back suggestions to her commissioners and team:

“A direct example would be a shadowing visit that I did. After the first or the second QNI conference, I went to Birmingham to work alongside another clinical nurse specialist. That was fascinating to see how another team worked.”

**Impacts on clinical practice arising from membership of the HIHP**

Measurable impacts of localised projects and roll-out activities have been seen, such as the Gypsy, Traveller Health programme in East Surrey, the Liver Network in Sussex and practice developments from the South London Health Inclusion Team Plus, all recipients of awards. Other members of the HIHP who participated in this evaluation referred to how learning about effective interventions (at conferences, via resources on the QNI website, or through membership of special interest groups) had influenced their own practice or supported the development of new spin-off activities.

“Definitely our management of trauma has changed as a result of some of the things that we've learned about. There was a whole training day, I think, up in London, about two years ago, on trauma. That’s what started us thinking about what we were going to do, what could we do? I’m involved in a national ‘Train the Trainer’ trauma training.” (Pathway Health Lead, north of England)

Specific examples provided by participants include fruitful professional collaborations through meeting colleagues via Network meetings, in homeless health focused sessions at QNI conferences, or being deliberately connected up by the HIHP Nurse Lead to pursue the development of new learning materials (such as the development of wound care resources).

In total, five respondents reflected on how the opportunities which arose through the QNI’s management of the HIHP encouraged them to pursue opportunities to create networks of interdisciplinary practice with NGOs, local authorities, housing and education officers as well as clinical practitioners.

“In terms of the support that I get for things, so at the beginning of COVID, for example, I found myself having to go to meetings in Wales, with senior people from Welsh Government, to advise on what we were going to do about homelessness.
Because we were behind London, I was able to ring up my colleagues from London who were in the Homeless Health Network, and say, ‘Okay, what do I need to know before I go into a meeting? What things are going to help?’ (Inclusion Team Lead, Wales)

**Formal educational opportunities**

Practitioners who had received funding to participate in the UCL Inclusion Health Module (three in 2019; three in 2020; four in 2021 with a waiting list of an additional three applicants; costed at £750 for NHS staff in 2020/21) also indicated that not only had the learning been of profound individual professional importance, but this had also impacted their approach to practice. Respondents also indicated that there is an implicit ‘virtuous circle’ approach to the learning and networking opportunities provided by the QNI in relation to the HIHP, through which participants engage in learning opportunities and then develop and share materials for use by other HIHP inclusion health practitioners.

“The QNI have asked me to do a document similar to the one done by podiatry on *skin health, wound care and vascular. I said I’d be happy to do it in my own time just to say thank you. [The QNI/HIHP] is a huge valuable resource“. (Tissue Viability Specialist, London)

For example, one participant had both received funding for an innovation project to develop and supply self-harm kits to people experiencing homelessness and had also been able to take part in the inclusion health training supported by a QNI Education Grant:

“It’s this circle, if I hadn’t had insight to Sam, the QNI, the grant and [the inclusion health] module, then I wouldn’t have been able to do that [develop further practice and networks] … the information is fantastic, but there is another level that I was taught on the inclusion health module and it really, really opened my eyes.” (Tissue Viability Specialist Nurse/Academic Practitioner)

Discussion on the content and value of the short course inclusion health module illustrated that it formed part of the curricula of a Level 7 (Master’s Degree) programme. Whilst both participants in this evaluation who had been funded to complete this training already held post-graduate degrees, there was a requirement by the QNI that to be eligible for consideration of funding of the module, that participants were already nursing graduates.

This threshold qualification could therefore be seen as a barrier to learning for older, highly experienced nurse practitioners who were not graduates (as explored earlier in the findings from the survey) or where individuals felt that their strengths did not necessarily lie in academic writing, although their skills level, knowledge and
comprehension of training materials was highly developed, but where there were perhaps some gaps in academic skills:

“Something which I would love the QNI to do would be something about how to write an article; something about how to do an audit, some of the basic things that, maybe, are lost without your degree qualification… With my Diploma, I remember doing a module on research, but that was an awful long time ago.. just having that mentoring, maybe, to help me get through it, to know what I’m looking at and how. ” (Specialist Practitioner)

One participant in the focus group also suggested that there is a need for pre-qualification training to include learning opportunities for nurses to receive information or potentially a placement with inclusion health practitioners, which could also potentially be accessible to other practitioners who are considering moving into that field of specialist nursing, or for whom it could offer a top-up learning opportunity:

“Not a whole module because that would be too much, but something around Inclusion Health for future nurses that are training up.” (Outreach inclusion health clinical practitioner, London).

The development of such short courses or training elements for undergraduates or experienced nurses without a degree would thus potentially be accessible to a wider range of practitioners than those who may be interested in the UCL Module. This need for a less academic approach to detailed inclusion health training (which includes consideration of the social determinants of health and relevant datasets, as well as clinical care) has synergies with the reflections of the Tissue Viability Specialist. This practitioner (who holds a Doctorate) reflected on the fact that the UCL Inclusion Health module whilst containing highly important information relevant to all practitioners in that branch of health care, was pitched in a way which meant it was not accessible for all (even regardless of financial barriers to undertaking the short course) and thus it would be helpful if there was some way of making elements of the training more accessible to a wider range of nurses and other specialists:

“[It] is quite academic, it is that level up. If there was any way to amalgamate some of the information… I think it would be really valuable, it helps the understanding… We also need to know health inequalities, why this is happening, where it’s come from. I think that helps people’s understanding and ultimately how they treat people.”

Whilst the participants who took part in this evaluation discussed a wide range of activities and resources supported by the HIHP that they found particularly useful to
their professional practice (making it difficult to highlight particular elements), the importance of networking with other specialist nurses, sharing of learning through events and special interest groups, and access to free highly relevant resources were overall the most important aspects of the HIHP to the overwhelming majority of those to whom we spoke. Underpinning all of these comments was a clear sense of the important human resource of being able to reach out to accessible, knowledgeable nurses within the QNI (with mention made again and again of the HIHP Nurse Lead), and to know that their role was respected, understood and supported by their nursing peers within the Institute.

**Suggestions for improvements to the HIHP**

Clinical practitioners (n=16 interview/focus group participants) in the main were exceptionally satisfied with the level of support, resources and facilities available to them through the Homeless Health Programme, with the essential core message from the overwhelming majority of participants that all that was required was ‘more’ of what they were receiving from the HIHP.

As also noted previously, several respondents made reference to the fact that there is only one key worker (HIHP Nurse Lead) supporting the HIHP activities and that therefore the HIHP and resultant impact on service users could be enhanced through additional resourcing:

“I think the role needs to be permanent, full time.” (Clinical Specialist, Tissue Viability)

“It’s about investing to get more out of a service. I’m sure that, if we got Sam there more hours, we would have more opportunities to do other things and to develop new relationships or look at different projects... If you can make her full-time, that would be marvellous.” (Clinical Nurse Specialist, Wales)

Although there were very few specific requests or suggestions for how the service could be improved, other than provision of a wider offer underpinned by greater staffing levels and financing and development of training opportunities for more participants (see also the discussion above on use of training modules), an important theme that emerged in interviews and focus groups was the suggestion that it would be extremely helpful to develop resources and foreground homeless health matters impacting BAME service users (and also staff). Although respondents from a range of ethnicities referred to the need for specific resources on supporting BAME service users and staff, this theme arose most prominently from respondents who did not identify as White British/White Other.

“Obviously this year in particular, that has been highlighted much more because of the whole COVID in relation to BAME colleagues, and then with the George Floyd
stuff as well. I think now is the time to really look at and address those things. “(Homeless Health Clinical Practitioner, London)

“With the whole pandemic and when it first started, thinking, “Okay, I’m a Black woman and I’m going to be more at risk of this. Do I really want to keep myself on the front line?” Actually, maybe, having some kind of resources, or advice, or blogs from people who have had similar things might be quite good to have so people like me can go, “Look there’s that nurse. She’s Black. She felt the same way as me and I can relate to that.” (Inclusion Health Nurse, London)

The theme of resources tailored to specific cultures and communities also emerged in approximately one in three interviews:

“End of life, definitely. It’s very much needed. This client group [street homeless, often male East European migrants], they often don’t want to go to a hospice. That’s not their place of choice. They often struggle to remain in hospital, so, first of all, it’s about helping third-sector organisations to recognise frailty and recognise what end of life might look like for this client group, the trajectory that they don’t necessarily follow: the palliative trajectory of people.” (Specialist Homeless Health Nurse, North of England)

“I think there could be some resources around specific cultures, really, because I think, although we’re Black people as a whole within that, there are lots of different parts. I think each culture deals with it in a different way, so maybe having specific resources around black Caribbean and mental health, and black African, and then any other categories as well, and how… myth busting, I think, as well, would be really good because it’s addressing those things that people think … then giving the information that’s required.” (Homeless Health Clinical Specialist, London)

“We had 171 Syrian refugees come to Leeds about two and a half years ago as part of the United Nations resettlement plan. There are lots of language and cultural barriers. Yes, I think it’s really important [to be able to access culturally specialist resources to support refugees and families experiencing homelessness].” (Homeless Health Practitioner, North of England)

Several participants also used the question on how the HIHP could be improved, or additional resources that are required from the QNI, to reiterate the immense value of the Network meetings in reducing isolation during the pandemic (and more generally), stressing that they would like to see this aspect of the HIHP expanded upon further:
“Until I got a second member of staff working with me, I hadn’t understood how isolated I was, and that’s why the relationship with other people in the Homeless Health Network was so important.” (Clinical Nurse Specialist, Wales)

“More, regular, virtual events.” (Pathway Lead, North of England)

To enhance the value of the HIHP and further upskill special interest groups (especially for those working in isolation), it was proposed by a number of participants that there is a need for online lectures or experts/specialist speakers being given the opportunity to address Network sessions, particularly given the convenience of online access for frontline staff in widespread geographical locations:

“[Would like to see] something on working with refugees.” (Nurse Prescriber/Homeless Health Nurse, London)

“The one thing that we are all missing at the moment is face to face, maybe, if not conferences, but online short teaching sessions where you might have an outside speaker coming to talk about a particular type of assessment or a particular client group, something like that.” (Homeless Health practitioner, London)

A further suggestion (also linked to online resource development) consisted of a proposal for ‘bite-sized’ videos on use of resources, which would be easily accessible for the busy practitioner:

“Soundbites or information, not just written content but short videos or things like that that can explain something is really helpful if people have limited time.” (Homeless Health Specialist, North of England)

One practitioner also asked for short, accessible information pieces whether via blogs, videos or written materials, which engage with developing skills required to plan and lead a project or to provide tips for raising awareness of issues with commissioners and others.

“Those softer skills … because all of us Queen’s Nurses, all of those that engage with it, we all would, ideally, like to write an article, do an audit, do a piece of research. How do you set up one of these little projects? Some of us have the ideas, but you don’t always think you have the skills to be able to do it.” (Homeless Families Health Visitor, London)

Thus, in essence, the above participant was requesting access to some level of information and specialist skills knowledge, which those practitioners funded to
undertake a specialist nurse-led innovation project would be able to access via the series of 2-day workshops made available to them as part of their project (Bryar, 2020, op. cit.).

The impact on respondents, service user and other practitioners, if the HIHP was not funded

Although as has been evidenced by the 2020 Bryar evaluation of funded nurse-led innovation projects, 70% of projects seed-funded by the QNI obtained follow-up resourcing at local level as a result of their success in supporting clients (2020:3); we set out to more widely explore with HIHP interviewees what would be the impact on their professional practice, service delivery and themselves as individuals, should the QNI be unable to obtain ongoing funding to support HIHP activities.

As illustrated by responses to the survey, under-resourcing, difficulties in accessing training, and short-term funding for services is a perennial problem and a major source of concern to HIHP members, with 51% of survey respondents referring to these issues in relation to challenges faced in their role.

Accordingly, the oft-reiterated added value of the HIHP, which was consistently commended for enabling rapid access to specialist information, referrals to colleagues and free resources, as well as providing personal support to inclusion health practitioners, emerged strongly as a theme in response to the question of anticipated impacts should the QNI not be able to obtain funding to continue to support the HIHP.

However, the potential impact of reduced funding for the HIHP or loss of such facility, was not identified as quite so devastating for London-based practitioners who could participate in other networks such as the London Network of Nurses and Midwives Homelessness Group:

“I mean there are the other networks but I think the differences are that the QNI is more nurse led and it’s across the whole of the UK is really important.” (Outreach Homeless Health Nurse, London)

A clear sense of the importance of the HIHP to underpinning the inclusion health sector was evident in the responses of participants:

“I wish I had access to and known about this network about two and a half years ago when I started, I think it would have been really helpful.” (Homeless and Mental Health Nurse, East of England)
“None of this work would be happening. I really, genuinely, don’t think that we would be able [to run the service]. I wouldn’t be doing the work that I’m doing today without the QNI, no question about that. “ (Specialist GRT Health Lead, Southern England, whose project was seed-funded by the QNI Innovation Programme then recommissioned)

“[HIHP] being national and knowing what other centres are doing elsewhere is really important because you can sometimes just get caught up with what’s going on with your team and that’s it.” (Inclusion Health Specialist Outreach Nurse, London based)

“I wouldn’t feel so up to date and that’s not just … being lazy and not looking up stuff myself. It has that knock-on effect of not feeling up to date at work and for our clients and knowing what changes are going to take place at a national level that are going to affect them.” (Inclusion Health Team practitioner, South London)

A sense of anxiety was also articulated by some participants should the HIHP cease to function:

“My biggest concern is about long-term funding. The idea that it would not be there is my biggest concern really … because it provides such a good service to us – it’s a great support… I would be really concerned about what’s going to happen. I think the year to year, or every two or three years, having to reapply for funding to be able to carry on such good work has always been my major concern about what happens. I would like to see them have a permanent funding base or resource so that they don’t have to constantly re-evaluate and come up with more ideas.” (Pathway Lead Practitioner, North of England).

“I’m not sure where I’d go looking for it [information and advice], really. I guess we’d be looking at Public Health England to make links with other areas … we’re always aware that other cities have got [inclusion health] teams, and I guess we would be looking to them to form some kind of pathway or link.” (Inclusion Health Lead, North of England)

“It would be harder if there was a different kind of service development work that you wanted to work on. It would be much harder to get expertise from around the country if they weren’t there… It would definitely leave a hole.” (Nurse Practitioner, London)

“I think it’s really important that we can access that wider network – it’s not just about information, is it? It’s also a group of likeminded people who are supportive and who get it.” (Clinical Nurse, Homeless Health, Wales)
“It would be a shame to see them go. I hope they will continue to be there. Because you can only go online and you see what you want to find, you evaluate yourself and you get your answers from their sites on what you want to know or what you want to learn. Even if you think you are alone, there’ll be somebody that has had that situation before.” (Nurse Prescriber, Inclusion Health outreach, London)

Overall, no respondent indicated that there would be a neutral or non-existent impact on their practice should the HIHP cease to function as at present, as a result of funding difficulties. The strongest impacts and concerns were noted by those individuals who are unable to access pre-existing London-based networks or services, or who because of geographical or social isolation are particularly reliant on the QNI/ HIHP for access to up-to-date training, support and resources.

The final question asked of interviewees and focus group participants in the clinical group concerned recommendations for future developments of the HIHP. Whilst a number of these areas have been covered elsewhere in this evaluation, e.g. comments on increasing resources pertaining to BAME client groups, this question on strategic and practice based future direction is highly pertinent when compared to responses from the strategic lead group.

Responses to suggestions for future developments were relatively limited, given the high level of satisfaction with the HIHP to date. However, these responses fell essentially into two clusters, which had synergies with responses from the strategic lead group.

**Additional developments within and across special interest groups**

A number of respondents (n=4) made specific requests/suggestions on the ways in which the existing special interest groups could be developed, although these were predominantly engaging with the current direction of travel being undertaken – e.g. develop some additional special interest groups (dual diagnosis and mental health being mentioned twice), or provide opportunities for non-clinical specialists such as policy agencies to attend/speak at such meetings. One respondent also requested hearing from individuals who had lived experience of service use at focused meetings:

“Maybe to have more involvement of experts by experience, who had lived experience or who are currently homeless to try and feed into discussions about our practice to make sure that what we are doing is acceptable to people and is what they want from us as well.” (Outreach Homeless Health practitioner, London)

Further suggestions were made in relation to providing a mechanism where practitioners with quite diverse communities of service users could be linked into specialists with ‘specific groups’.
“Linking up the different practitioners who are working in different areas. I would be really interested to hear from [Specialist Outreach Nurse with GT communities – East of England] and other people who have worked with Gypsies and Travellers specifically to try and get some of their expertise on helping us work with people from the Roma community.” (Homeless Health Outreach Nurse, London)

“[Connect to] part of the [Homeless Health] Network that people work specifically with sex workers or specifically with refugees and asylum seekers. Even though homelessness is the main part of our work, that’s obviously quite a diverse group of patients that we’ve got.” (Inclusion Health Nurse, London based).

Expansion of service/marketisation of some aspects of the HIHP

Along with reiteration of suggestions for the provision of short courses on homeless/inclusion health (see discussion on training) or ‘bite-size’ training sessions for non-specialist nurses who come into contact with inclusion health groups and who require some information on best practice (“a full module would be too much”), two respondents emphasised the need to raise awareness more generally about the QNI and HIHP, a comment that had synergies with findings from the qualitative data and survey materials, which suggested many members had only found out about the QNI and HIHP as a result of word or mouth referral from colleagues:

“You see other people advertising against homelessness … to make people aware that this is happening. Other nurses … don’t think they know about these associations and some of them will need to know… So, if they [QNI] are planning and they’re advertising, and everything, it can get to [other practitioners].” (Nurse Prescriber, Homeless Outreach, London based)

“I would like to see the QNI branch out and reach out to other nursing bodies who maybe are struggling, like generalist nurses, who may not have that strong charity organisation like the QNI… if [they’re] not community specialists.” (Tissue Viability Specialist/Lecturer, London)

Aligned to the discussions within the strategic group around collaborative working and potentially also the opportunity to commercialise some aspects of the HIHP, one respondent stressed the need for voluntary outreach groups (often working in a relatively unsupported manner in more rural areas or away from large metropolitan locations, and frequently poorly resourced) to be able to access high-quality training to enhance their knowledge of good practice.

“A lot of voluntary groups don’t always have skills to back up what they’re trying to do on the streets. So it would be nice to see some kind of service put in to place to
help some of these people gain the skills that they need to help the homeless but also to direct the homeless to where they actually need to go back into services. In some respects they do more damage, they need guidance … and training as well” (Clinical Lead, NGO Wales, focus group participant)

Similarly, a second Welsh participant who took part in an interview suggested that the HIHP/QNI might be in a position to support inter-service programmes and Network development by assisting inclusion health specialists to work with NGOs to support populations at exacerbated risk of exclusion as a result of particularly complex needs:

“One of the good partnerships that we've got now in Wales is with Crisis. Crisis Cymru and Crisis Skylight, they're organisations that have been really supportive. They have been talking about ways in which they can work with nurses on a regular basis... I'm already really concerned about people with a learning disability, with a borderline learning disability who end up falling through the system, people with ADHD who end up in the system. People who have gender identity issues end up becoming homeless.” (Clinical Nurse Specialist, Homeless and Vulnerable Adults, Wales)

The emphasis on specific communities who require particular tailored support and where the Homeless Health Programme could potentially assist in replication of services was also highlighted by a Specialist Lead in Gypsy and Traveller Health (South of England) who suggested that access to funding to seed-fund or support projects with particular communities, would be helpful:

“I think, if they had the same amount of money [as was provided to a wider group of innovation projects through the HIHP suite of activities] to do just Traveller projects I think they’d get an enormous amount of interest around the country.”

**Interprofessional links and curricula development**

The reflections on provision of training and advice to NGOs and non-specialist inclusion health nurses, also has synergies to the discussion (not universally welcomed by participants) on whether the HIHP/QNI should also be seeking to reach other practitioners, such as physiotherapists or surgeons, or remain predominantly nurse-led and focused.

One interviewee (Specialist Homeless Families Health Visitor) passionately advocated for the HIHP/QNI to create and develop links to universities who offer nursing training, using such networks to embed good practice and alertness to the challenges faced by inclusion health at pre-registration:

“Building bigger links with all those places that train the future nurses, and the universities, because we need people to understand all the variety of nursing and all
the subtleties of people's lives. I will never forget a paediatric nurse, pre-reg, coming out with me, and going into someone's temporary home and not realising that, when they send them out of hospital with all their medicine and all their advice, that actually they might not be able to put any of that in place... That would be a massive opportunity, wouldn't it, to sell the amazing nursing career that we have, for a start, but also to show and to educate people so that they really could take it on board when they're thinking of nursing their families? Think family. Think homes. Think community."

Overall, findings from the focus group and interviews with clinical practitioners who participated in this evaluation indicate that there is an exceptionally high level of satisfaction with the HIHP/QNI and a significant level of positive impact on specialist practice that supports delivery of services for vulnerable clients. Whilst the most noticeable and irreplaceable (should funding cease) impact of the HIHP appears to be on respondents who are based outside of London (particularly in less urban areas), and hence who have fewer opportunities to access other networks, training or resources than colleagues in cities or where more resources pertain, overwhelmingly respondents report high levels of regular contact with the HIHP and a considerable level of engagement with resources.

A number of practice-based resources were considered to be unobtainable elsewhere than through the HIHP/QNI; and respondents strongly emphasised the added value of their membership of the HIHP, occasioned by access to expertise, sharing of knowledge and good practice and emotional support. A sub-group of participants who had made use of opportunities to undertake the funded inclusion health training module highly commended the programme and noted the impact on their practice.

Although as noted above, in relation to how participants discovered the HIHP, the Programme and Network seem to not be particularly well publicised or known to non-specialist health practitioners, it is clear that within the sector, the HIHP offer and host organisation (QNI) are highly respected and valued for their work on inclusion health. Notably in all the data gathered for this evaluation there has been an emphasis on 'word of mouth' recommendations which supports trickle-down of knowledge and engagement with the network.

Accessibility of free-to-access resources and special interest groups within the HIHP are especially commended by participants, as was the expert role of the HIHP Nurse Lead. Should the funded programme cease or the offer be truncated as a result of disruption of funding, respondents were clear that they would feel less able to remain up to date with their practice, and in a number of cases would not be able to effectively access training or resources as a result of shortage of funding within their local areas.
Overwhelmingly, practitioners emphasised the immense value to their work, professional practice, and clients, of the service offered under the auspices of the HIHP. The impact of support and engagement with practitioners who understand a field of work which has been identified as somewhat ‘marginalised’ or ‘stigmatised’ by a number of respondents cannot be over-emphasised.

Whilst some scope has been identified for expanding the offer to include delivery of activities and training to other professionals, there is a significant level of support for predominantly retaining a ‘nurse-led’ and ‘nurse-focused’ network, with calls to expand the offer and support the development of additional resources, geographical network coverage, provision of seed-funding for projects and to engage more with pre-registration and non-specialist nurse practitioners to embed good practice and knowledge of inclusion health throughout the nursing profession. Specific policy/practice focused recommendations – in addition to those outlined above – are summarised in the concluding section of this evaluation.

**Strategic leads/policy focused practitioners findings**

This section of the evaluation explores the responses from four inclusion health policy стратегические руководители who undertook interviews as part of this study; and also incorporates policy-focused recommendations from a senior nurse leader in Northern Ireland.

Although the topic guide (Appendix 4) used in interviews and the focus group with strategic leads (drawn from clinical practice and specialist NGOs as well as those working in Health Policy) is broadly similar to that utilised with clinical practitioners, within the qualitative data gathering exercise there was a clear focus on how the QNI/HIHP can engage with other services and develop a direction of travel that reflects challenges in the geography of funding, as well as opportunities for growth and sector collaboration and strategically determined partnerships with professional bodies and key agencies. Further, an exploration was undertaken of suggestions that engaged with the potential for commercial support and/or funding of specific elements of the HIHP.

**Accessing participants/sampling frame (strategic lead group)**

Participants in the strategic lead focus group and individual interviews were purposively sampled to ensure that we were able to access individuals of sufficient seniority and experience to support this element of the evaluation. Although we did seek to ensure variables such as age, gender, ethnicity and geographical location were taken into account when drawing up a list of potential participants, almost inevitably perhaps, given the demographic profile of senior policy and practice professionals in the UK, we found that our core group was largely made up of middle-aged senior practitioners (age range of 37–63; mean age of 52), largely of White British heritage (12/15). Participants were largely London based (even when...
their service supported policy and practice throughout the UK) and with a female: male ratio of 6:2 in the focus group and 1:3 in relation to individual interviews.

Appendix 7 provides further detailed demographic information and recruitment of these participants.

In addition to the focus group, four separate interviews were held with strategic specialists who were unable to attend the focus group. In the case of the Northern Irish specialist who has been working with the QNI since 2020, it was felt that it would be helpful to capture their experience of developing a new homeless health strategy and focus in a geographical context in which a distinctive focus on inclusion health has been relatively new. One joint interview captured findings from two senior strategic leads at a national nursing body.

**Summary of findings from the strategic policy specialist focus group and interviews**

**Duration of contact with the QNI/HIHP**

In addition to a number of senior strategic leads/policy professionals from a range of key agencies, the strategic focus group contained two current staff members at the QNI (HIHP Nurse Lead and Director of Nursing Programmes (Innovation)) and the co-founder of the HIHP (currently MHCLG Health and Homelessness Advisor). Accordingly, there is a deeply entwined relationship between some participants and the QNI/HIHP, which offers a wealth of information and advice, as well as evidencing a deep level of commitment to the overall programme and suite of activities offered.

As may be expected, those with a very close connection to the QNI’s HIHP (employees and co-founder of the Programme) and strategic leads in clinical roles, e.g. Clinical Director of Pathway, and senior RCN practitioners, were more likely to have had longer-term relationships with the HIHP and the QNI, enabling them to reflect on both the current offer and to consider potential directions of travel for the programme refracted through their experiences.

Knowledge of the HIHP – with varying degrees of contact and experience – ranged from approximately 13 years (since founded) for strategic leads with substantive community/inclusion health clinical experience (e.g. RCN Professional Lead for Public Health Nursing; Clinical Lead Pathway; HIHP Nurse Lead); to an average of 3 years for policy leads at non-clinically specialist NGOs working with populations experiencing homelessness (whose services may offer a limited range of therapeutic services or dedicated provision including smoking cessation or substance use support, as well as facilitating access to health services).
The more recent development of connections to non-clinical agencies working to support populations experiencing homelessness evidences the growth of engagement with broader homelessness networks since the expansion of the HIHP and broadening of the offer, e.g., through the creation of special interest groups.

As also noted by respondents in the clinical/practitioner data gathering exercise, overwhelmingly strategic leads became aware of the HIHP as a result of word of mouth professional contacts, meeting the QNI CEO in high level consultations or encountering the QNI at a conference, confirming the impression that the HIHP could increase reach and network engagement by organising a strategic campaign to raise awareness of the services offered:

“About three or four years ago. The first time I ever saw anything from the network was actually at a London Network of Nurses and Midwives conference because there was a table full of leaflets and guidance.” (LNNM, Network Development Manager)

“I first came across the Queen’s Nursing Institute when I moved into the Department of Health. Crystal and her team were working on developing the District Nursing Framework here in Northern Ireland ... about five years ago.” (Nursing Officer, Public Health, Department of Health, Northern Ireland)

Interestingly, the Director of Nursing Programmes (Innovation) at the QNI who has been in post for 2.5 years indicated that she was unfamiliar with the work of the HIHP until taking on the current role:

“I wasn't really involved in much inclusion health in my role in education or district nursing ... so, it has been a really interesting learning experience for me.”

**Most valuable aspect of the QNI/HIHP**

As a result of the seniority of participants and strategic focus of this set of interviews/focus groups, and also that they were primarily in a strategic health role or operating within the homelessness sector more broadly, it was less likely that participants had personally used HIHP resources, in contrast to the clinicians who had commented about them. Similarly, few noted that they had contacted the HIHP Nurse Lead to request access to other practitioners with shared interests, or to be explicitly networked to those in other localities to share practice, although as highlighted above, a number of strategic leads attend special interest groups to engage with clinicians and policy specialists around areas such as Gypsy, Traveller health and families experiencing homelessness.

Thus, overall, engagement with the HIHP from those who took part in this element of the evaluation was more likely to be with QNI leads around the process of developing strategies or services, or in relation to collaborations at a high level to
feed into policy and practice guidance, e.g. through the RCN; MHCLG or Public Health England.

When asked to consider the most important aspect of the QNI/HiHP the following themes were identified by strategic leads.

**Access to website resources/newsletter**

There was a strong emphasis amongst both clinicians and those in NGO non-clinical roles of the importance of being able to access high-quality, quality-assured, free-to-access resources, which could be disseminated to colleagues delivering services and thus reduce the need to “re-invent the wheel”.

Similarly, the newsletter was highly praised as collating information in an accessible manner to enable trickle-down to colleagues responsible for teams of practitioners on the frontline.

“As a non-clinician, it's useful as a repository of information, and seeing what's happening across the country, and seeing what's happening in quite a grassroots, hands-on way.” (Director of Advocacy, Groundswell)

“I have always found the clinical guidance aspect of what the network puts out particularly useful. Especially when it has been in areas where there isn't really existing guidance, so in doing clinical work around things like running a physical health clinic in a substance misuse service, and having quite a broad remit around things like wound care, skin integrity, general health checks and stuff. It's been the QNI HiHP guidance that I've often gone to first to build protocols and assessments around... It was also how I discovered the Network. I used the guidance that was coming out, before I really engaged in other aspects of the Network.” (Network Development Manager, LNNM)

“I use the newsletter, which is brilliant... Some of the resources that QNI have produced have been useful... about three or four years ago, I was reviewing what we assessed on our information system around health, and [the health assessment] was useful. More recently, I've looked at the oral health one and nutrition. Those are probably the ones that stand out in my mind.” (Health Strategy Manager, St Mungo’s)

“Well, it is the resources online. The tools for us that we have looked at are in relation to the AHP, podiatry and stuff like that. And the QNI had done a presentation in relation to pregnancy and maternity, and women who were homeless during that experience, so I think here in Northern Ireland we probably need to be using resources more. It is maybe the fact that people aren't aware that the resources are there. And maybe I should be promoting them more.” (Nursing Officer, Northern Ireland)
“The recent brilliant Street Medicine guidance which is about to be published [late 2020], which is absolutely fabulous.” (Clinical Lead, Pathway)

“We signpost and we link the information and the resources on our networks and our websites, so when people are searching from a nursing perspective, they are not seeing different things from the QNI and from the RCN. I think strategically that’s really important that we are seen to be working as a profession.”

(Professional Lead for Public Health Nursing, RCN)

Access to specialist one-to-one advice and support (including internationalisation)

This element was less commonly cited by strategic leads than in the clinical interviews/focus groups, but was highly commended by the Northern Irish Nursing Officer:

“The Queen’s Nursing Institute have been fantastic working with us in relation to the District Nursing Framework and the Neighbourhood District Nursing pilot that we are operating here in Northern Ireland … they’ve delivered all of the training for us on that. It is through that then, that we became aware that they had work in relation to Homeless Health.”

As a result of that initial contact, the CEO of the QNI and HIHP Nurse Lead are now beginning to provide tailored support to colleagues in the Northern Ireland Department of Health in relation to developing their strategic work around inclusion health:

“There are some people who are working on the projects who are extremely passionate about it, and they are delivering a fantastic service. [But] homelessness, … it falls between housing, education, health and the Department of Justice, so lots of organisations working together in relation to homelessness… There is no clear lead in relation to Homeless Health.”

This transfer of knowledge and assisting colleagues internationally in developing and replicating the HIHP is also ongoing in relation to the Republic of Ireland (see case studies) and thus going forward will represent a considerable impact for the funding of the HIHP as service reach is developed and clients are positively supported.

Conferences and special interest group events

Although the quality of QNI conferences were mentioned by some strategic group participants (predominantly those who are also active as senior clinical practitioners), NGO strategic leads largely suggested that this aspect of the HIHP was seen as too clinical and specialist for their staff members. Thus non-clinical NGOs appeared to require perhaps a more generalist ‘on the ground’ approach to dissemination of information and materials to enable the conference to become more accessible for
non-clinicians, although non-clinicians also commended the fact that the QNI are seen as champions of the specific discipline of inclusion health:

“I’ve been to a few events, which have been really useful. I think … to give a profile for inclusion health, is really useful. Within the Queen’s Nursing Institute, it sits in a place where it feels like it’s important, that it’s a discipline [but] our peers [in NGOs] don’t engage with it all that much. We send things round about events and stuff, but obviously they’re very much, rightly, pitched at nurses. So, people don’t really seem that interested, because I think they feel they’re at a slightly – not higher level [but] clinical level, rather than what they’re doing. So, it might be good if there was more interaction with people with lived experience [at conferences].” (Director of Advocacy, Groundswell)

It was striking that whilst policy leads working in NGOs referred to the value of having a representative body such as the QNI engaged in promoting inclusion health in dialogue with Government agencies such as Ministries, Professional bodies and Public Health England or the NHS, overall, they had very limited contact with special interest groups, such as those working with families experiencing homelessness or GRT communities.

“I’m not very aware of them, if I’m honest. We are obviously a homeless and housing organisation, so there aren’t that many of us that focus on health issues, so it’s not going to be a mainstream topic for people.” (Health Strategy Manager, St Mungo’s)

In contrast, clinically trained strategic leads (e.g. those working in specialist health inclusion roles) repeatedly emphasised the importance of the special interest groups as a conduit of both clinical knowledge and solidarity. They placed a particular emphasis on the added value of having a forum for nurses, which recognised their expertise and knowledge in a way that differentiated them from other clinical groups such as Pathway, or the Faculty of Homeless Health.

“For me, the benefit is … the importance of the mutual support and network, and overcoming the isolation – particularly of nurses and allied medical professions. I see it as giving a powerful collective voice to nurses in the inclusion health debate, because the power structures of the NHS tend, generally, to mitigate against that voice being heard. I think its particular ‘nursyness’ [focus on nursing] is really important.” (Clinical Lead, Pathway).

“All of the networks, just being able to connect with people that are doing what you do, and understand it, and also can help you reference yourself, benchmark what you’re doing, think about it clearly, I think, is vital.” (Homeless Health Nurse Programme Lead, QNI).

“Being able to meet quite a number of people working in inclusion health, so working with other asylum seekers, refugees, migrants, travellers, gypsies, families
experiencing homelessness, as well as working with people who were single homeless. There were times when you’re working alone and feel quite alone. You may not be getting ... either no supervision or the right supervision, and also just needing, at times, someone to talk to or to know where to get information from. That was why the Network has been so invaluable: just knowing there are other people out there who you can contact and get advice and support. Also, times when you might need mentoring, there have been people there who you can go to.” (Health and Homelessness Advisor, MHCLG; co-founder of the HIHP)

Further, amongst clinicians in strategic roles there was a dual focus on the value of the HIHP and special interest groups, which highlighted the inter-relationship between capturing frontline experience and then translating that knowledge into a mechanism to influence wider policy:

“One of the most valuable aspects – particularly, recently – one of the goals of the QNI is about collecting data and evidence in order to be able to influence policy. During the pandemic, and thanks a lot to Sam, who has been able to set up groups for Gypsy, Roma, Traveller, Boater communities and for health visitors who are working with families who are homeless, or refugee and asylum seekers – we’ve been able to get them together and gather the data, and the evidence ... we’ve been able to feed that up to people that needed to hear what has been going on for people. I think being able to influence policy, being able to contribute to policy, for me, as an outsider looking into it as a network, that has been an incredibly valuable part of the QNI Network.” (Director of Nursing Programmes (Innovation), QNI)

“If it is a theme that we see come up, then yes, we feed it through the hierarchy, and it will come round to policy, and we will work together with policy to try and influence that. But I guess we also work with external stakeholders, so it is not just something that is involved that we do within our own organisation.” (Professional Lead for Community and End-of-Life Care, RCN).

“It’s about knowing the politics, and that’s often what the QNI also helps with, and the RCN, to put it into some political context of how we can add our voices. It’s taking – being able to be ready to take – those opportunities on board.” (Health and Homelessness Advisor, MHCLG; co-founder of the HIHP)

**Developing and foregrounding nurses’ experience**

The theme of perceived hierarchies and that nurses’ voices may be suppressed or over-ridden by medics or senior managers (which also emerged in the clinical focus group) formed a key theme for clinical practitioners in the strategic focus group, with several participants emphasising that the QNI was in a powerful position to present evidence that an individual would not have the authority or would perhaps be too anxious to raise with senior colleagues, or through media channels.
“Although [specialist nurses and health visitors working with families experiencing homelessness] all recognise issues with substandard accommodation, people being in temporary accommodation too long, people being in out-of-borough placements, all of those kinds of things, they feel really nervous about saying anything. Because I do think that they feel that it’s not their place and that they might bring their organisation into disrepute and they’re not allowed to do that, but with the support of the QNI – Jane [MHCLG advisor] has been involved in those meetings, as well – that they can do something about it.” (HIHP Nurse Lead, QNI)

**Stigmatisation and precarity**

A discussion also ensued on the stigmatised and potentially stigmatising nature of working in inclusion health. Although this is a sub-element of the evaluation questions, it was noted by both health practitioners and non-clinical strategic leads that there is still some sense that the communities with whom they work are perceived of as being of less value than many other members of British society, leading to lack of clarity over funding and precarious employment for those in the field. This issue of lack of investment in inclusion health and the impacts on staff of lack of security also arose within the survey where 15% of respondents were in short-term or insecure employment. Considerably more participants combined permanent jobs with temporary or short-term funded inclusion health roles.

Thus, having a very old and deeply respected body such as the QNI championing both communities included under the rubric of ‘inclusion health’ and those who worked with them, was significant and symbolic, underpinning the added value for clinicians of having inclusion health recognised as a discipline in its own right.

“This thing about stigma … I think this goes for a lot of the nursing programmes as well; it definitely goes for our programmes – that a lot of the funding you get is very short term. Or the majority of our funding only lasts for a year, so it has to be renegotiated, year on year. That leaves you in a state of precarity … not knowing quite what’s going to happen, not being able to properly plan ahead, not being able to invest properly in resources, which actually mirrors what’s happening with the people that we’re working with … it is very difficult to work with people who don't know where they’re going to be tomorrow, when often, as a staff team, you don’t know where you’re going to be tomorrow. You don’t know whether the weird basement that you’re working out of is still going to be yours, or whether you're going to have funding, whether you're imminently going to have to make your entire team redundant, or whether it's safe to take on new volunteers, because you might not have funding for them, which then exacerbates some of the issues that you’re working with.” (Director of Advocacy, Groundswell)

“I just wanted to confirm that the issue of stigma is really important in all of this… Over the decades there has always been a perception that people who work in this area are providing a poor-quality service for patients that are not deserving. That's
why we’ve worked collectively to set standards, and demonstrate the quality of what we’re doing, and measure, and audit, and show that we’re providing high-quality healthcare for a very needy group of people who require high standards of collaborative care.” (Clinical Director, Pathway)

Value of the HIHP to other stakeholders and potential to expand the membership

Participants were asked to identify to which groups they considered the HIHP to be of most value, and which other professions did they feel the HIHP could reach out to in relation to sharing of resources or delivering training.

Several participants in interviews and the focus group identified potential groups of stakeholders who might be potentially incorporated into a wider network within the HIHP, most predominantly reflecting on the strategic importance of the HIHP and the QNI acting as a conduit for dissemination of information and policy development. Thus there was a focus on moving beyond specific clusters of practitioners who are not closely engaged with the HIHP to effectively working to mainstream inclusion health throughout the sector:

“For me there’s something around how inclusion health is being raised now as a national agenda... We’ve got Directors in every provider organisation responsible for health inclusion. How can we take advantage of that? What I’d like to see is that actually we’ve got Directors in commissioning bodies as well, because I think that would help to take it [inclusion health] to the next level … there’s something around the value to the other groups or the value to the wider system.” (NHS England Homeless Health, National Nurse Lead).

“It’s being able to put it within a political context, really, and being able to talk the language of the moment, as well. So, it is around – and what COVID-19 has done has really highlighted those inequalities – it is not only talking about health inclusion but talking about tackling health inequalities, which is a priority for the NHS, for DH, Public Health England. Being able to emphasise our point, our meaning, and especially when I go round the areas that I advise, it is talking to them that this is part of their local health inequalities agenda. It’s reminding them that it’s groups like people who are experiencing homelessness, the Travellers and Gypsies, asylum seekers, refugees, need to be part of their local plan.” (Health and Homelessness Advisor, MHCLG; co-founder of the Homeless Health Network).

“There’s this huge disconnect between the structure that we’re working with and the work that we’re trying to do. I think that organisations like the QNI HIHP are absolutely critical in trying to bridge that gap between the basic care that we want to be giving and the structural, political considerations that get in the way of it being delivered.” (Network Development Manager, LNNM)
Although there was a broad agreement of the need to ensure that inclusion health becomes accepted, recognised and core to a wide range of health and other service providers, it was also acknowledged that there is a need to ensure that the nursing specialism is retained to avoid ‘disenfranchisement’ of highly experienced and dedicated inclusion health nurses. Some participants indicated that upskilling other health professionals whilst maintaining inclusion health as a specific discipline “like palliative care, or cardiology … [is] a really complex balance.” (HIHP Nurse Lead, QNI)

This is a point echoed by the London-based GP specialising in homelessness who is also an academic Fellow at UCL, who noted that:

“The QNI and Pathway [noted by a NGO participant elsewhere within this focus group as associated far more with being a network for medical practitioners than the QNI/HIHP] are both trying to do quite a difficult job of diversification, of inclusion within a specialty and trying to keep all of those people together, in a way. It’s a very, very difficult thing to do.”

Interestingly, although there was a clear collective agreement that all participants in the focus group were members of a strong overall sector and that it is important to engage with other colleagues in order to strengthen the inclusion health work, some participants flagged up the importance of retaining separate organisations largely focused on different disciplines rather than a larger centralised collective, whilst emphasising the value of bringing different perspectives to lobbying and policy development discussions:

“Thinking about the different organisations, the London Network of Nurses and Midwives, and the QNI Nursing Network and the Faculty, I think that we all have valid perspectives. I think, in terms of influencing the system, we can do that very well when we come together and present a collective voice, but that isn’t to say that we all need to be in the one organisation. I think there’s a real value to those different perspectives.” (Clinical Director, Pathway)

**Specific suggestions for developing the HIHP**

Although some particular suggestions were made for future developments of the HIHP (should funding be obtained to maintain the stream of activity), there were relatively limited recommendations from strategic leads for ways in which membership of the HIHP could be expanded to other non-nurse stakeholders, other than invitations to include a small number of named NGOs whose work had synergies with particular special interest groups.

“People like the Frontline Network and the Asylum Network. There are some really, really brilliant, credible organisations [out] there. I do just think – and obviously the RCN Public Health Forum – that we’re going to be better together.” (HIHP Nurse Lead, QNI).
The St Mungo’s Policy Lead suggested in a one-to-one interview that it would be helpful for the HIHP to reach out to the broader homelessness sector to encourage them to engage with them:

“I guess it’s people with health within their role, [such as] our policy team, who do quite a bit around responsive health services at a national level, like specialist mental health services. There is quite a big push within the rough sleeping, monies and substance use. We’ve done stuff recently on dual diagnosis and substance use services.”

Although, in common with participants in the focus group, the St Mungo’s Policy Lead also acknowledged that there is a risk that such outreach could be a ‘double edged sword’ as bringing in people who are not nurses to the Network could thus risk diluting the uniqueness of the HIHP and hence the value to health professionals.

In addition to these suggestions, the Health Policy Lead from Homeless Link actively volunteered to assist in facilitating an interdisciplinary meeting to enhance reach and value of the work undertaken by the QNI/HIHP.

“We at Homeless Link regularly and frequently liaise with the Local Government Association. Would there be merit in organising an event that engages QNI nurses and relevant Local Authority staff? If there’s interest, I am happy to propose and facilitate that.”

The lack of diversity in mainstream inclusion health and homelessness agencies, and what appeared to be a relatively limited cross-over engagement with specialist BAME, migrant and refugee organisations was also commented on by some participants as both an area for future development and a consciousness-raising exercise that the QNI was well placed to lead on, echoing suggestions made by (in particular) BAME clinicians interviewed for this evaluation:

“I absolutely agree with what you’ve just said around the pervasive whiteness of a lot of the umbrella organisations that exist. That’s a problem throughout the NHS… I think it’s very important to be talking about the relationship between the kind of grassroots work that a lot of us are aware of, and the higher level. Not just political and commissioning side but also in terms of the collective consciousness of nurses and the clinicians as a whole.” (Network Development Manager, LNNM)

“I agree with the diversity issue. I must admit, there is relatively little diversity in inclusion health practitioners that I am aware of. I’m not sure what to do about this… Possibly we need to do more marketing, but also do work to understand whether the lack of diversity is real, and if so why.” (Nurse Inclusion Health Project Lead, QNI).

Importantly, these reflections also drew out the perception that the precarity of such roles may especially impact BAME health colleagues who could potentially feel
unable to risk taking a short-term, part-time or insecurely funded role, feeding into a vicious cycle where there was less diversity within a workforce who may be working with communities including vulnerable migrants, refugees and asylum seekers:

“It’s harder to recruit a diverse workforce if people don’t feel that jobs are secure.” (Policy Lead, Homeless Link)

In common with comments in the clinical practitioner interviews, one participant noted that there is a largely female BAME inclusion health workforce, but these staff are often not especially visible, politically prominent or mobilised, and frequently clustered within particular (geographical and practice-based) areas of work:

“There are quite a lot of women and BAME inclusion health care staff but rarely visible in the political and public arenas. COVID-19 increased the voice and visibility of inclusion health healthcare staff locally but [there is] still a lack of this visibility nationally – still an element of powerlessness… I think I’m biased by working in London and in mental health. BAME staff are much more visible in supported accommodation and mental health working settings.” (GP Inclusion Health Practitioner/Clinical Fellow, UCH).

Accordingly (see under recommendations) there is clearly scope for engaging further with the issue of diversity, visibility and voice of BAME colleagues when developing the HIHP going forward.

**Visibility of the HIHP and suggestions for enhancing membership/public knowledge**

As referred to in the previous section (and also found with the clinical practitioner group), we have identified that there is relatively limited visibility of the HIHP for those who are outside of specialist practitioner networks, or who are not explicitly introduced to the QNI’s work through strategic group membership. Participants were asked to propose how the profile of the HIHP could be enhanced but this threw up relatively few concrete suggestions, with these predominantly coming from health practitioners with national level responsibilities:

“There are regional homeless/inclusion health needs in each regional NHSE team and also there are regional safeguard leads who could promote networks.” (National Nurse Lead, NHS England Homeless Health).

Similarly, the MHCLG Health and Homelessness Advisor and co-founder of the HIHP reported that:

“MHCLG actually fund several millions’ worth of health posts around the country, mainly around mental health and substance misuse. When I go out to have those conversations with those areas and the other areas that are funded through the
MHCLG, I do have those conversations about who’s supporting them, where their management is coming from, but then say, ‘Do join the QNI’. It is about linking up what’s happening with those local authorities … saying, ‘There is an incredible resource and guidance out there’. But I also think it’s also their joint working, which QNI, the HIHP, have been really good at doing … the toolkit that was developed around homeless families, the events that happen, and how people from other organisations are asked to contribute as speakers, and how that then develops interest from other areas. Looking at health from the broadest definition, so those social determinants … but also putting it within a safeguarding framework and also a cultural framework. So, asking regions: how are they making what’s provided relevant to the client group that’s there? Safeguarding has been a real hook, and the cultural issues have been real hooks for areas to actually think about the vulnerability of the client group … [also] membership is free, and that has been key for quite a few people.”

One theme that emerged clearly from this discussion was the ‘chicken and egg’ situation, that because of short-term and limited funding, the role of the HIHP Nurse Lead was inevitably constrained (although as with the clinical group, it was almost universally acknowledged that she undertook a remarkable degree of work in her extremely time constrained post which was funded for one day a week). Within these constraints, it was therefore seen as extremely challenging to grow visibility and membership of the programme:

“Marketing is a massive thing… For example: I put out a couple of tweets about practitioners doing flu vaccines last week. They got a lot of pickup, but comms is a job. It’s a full-time job. It’s also a job that needs talent behind it. … Comms focused entirely on inclusion health, and the inclusion health networks, would be absolutely brilliant.” (HIHP Nurse Lead, QNI).

“If we had the funding, we would do this. At the moment, we only have Sam one day a week. I think she probably does a heck of a lot more than one day a week, but if we had Sam for three days a week, which is what we would like to have, going forward, then who knows what we could achieve above what she has already achieved in the time that she has been with us.” (Director of Nursing Programmes (Innovation), QNI)

“You can't do this [marketing/publicity] in the periphery of another full-time job you've got and expect the optimal results … that takes us back to funding, of course. [But] all of these things are interlinked. The more nurses you recruit who are enabled to speak publicly, be included in your briefings to government … then you’ll have more impact in terms of policy influencing. Perhaps that also is the key to recruiting more nurses who are willing to be vocal, i.e. communicating to potential recruits that they can make a strategic difference to the people that they are all about, i.e. their patients, by joining QNI, by being vocal, by putting their name to
contributions to briefings, by agreeing to speak to trade press, mainstream press.” (Health Policy Lead, Homeless Link)

The issue of enhancing visibility of the HIHP/QNI through presentations at conferences that showcased certain elements of their work was proposed by one participant as a way of raising awareness:

“[I know that the QNI presented] at the Faculty for Homeless and Inclusion Health Conference. I don’t know how much the QNI puts forward presentations to other events, but I would have thought … there is a report about some of the projects that have been supported with funding. That will make an excellent [presentation] – pick out three of those at a conference, for example, under the general banner of innovation around homeless health, that kind of stuff … [and] reaching out into the general NHS sector, to promote homeless health.” (Policy Lead, St Mungo’s).

To add to this suggestion, it was proposed by the RCN strategic leads (in their joint interview) that both QNI staff and advocates of their work embed information about the organisation and also showcase resources produced by them within curricula and training opportunities provided for health professionals.

It was noted that the concept of linking the QNI/HIHP into pre and post registration training was also found in interviews with clinical staff and emerged within suggestions for future directions of the HIHP. Essentially though, participants emphasised that without having a dedicated resource, which included marketing and a social media drive, it was necessary to opportunistically publicise the inclusion health work of the QNI whenever possible:

“Just keep doing it [publicity, social media opportunities, networking], and any opportunity I think is the way to do it.” (Professional Lead, Public Health Nursing, RCN)

“When you provide any education that actually you can promote all of those organisations [such as the QNI] that can help students and give them that signposting. I guess for me, if there was anything that I could do … that is what it would be, to include those [organisations and resources] in all of the training that you provide.” (Professional Lead for Community and End-of-Life Care, RCN)

**Future direction on the QNI HIHP**

Participants in both the strategic focus group and individual interviews were asked for their opinions on how the HIHP should develop its offer going forward.

As with the clinical practitioners’ responses to this question, there was a continued emphasis on the need for maintaining the production of resources, as well as ongoing support for the HIHP and special interest groups as well as growing the inclusion health sub-group where possible by networking specialists in a range of fields including “mental health” and “TB”.
The role of the QNI in foregrounding policy and making use of their excellent networks rooted in a strong reputation for evidence-based knowledge was also revisited by several respondents as an area to be continued and developed:

“Sometimes in the past ... we've been able to actually have questions raised in Parliament that were relevant to this client group. It is those political links that can be really important, but also the All-Party Parliamentary Groups, so making sure that we’re visible within those settings. Also, I know we've tried to, in terms of campaigning – especially around homeless families – tried to link in, writing to the ministers.” (MHCLG expert advisor Inclusion Health)

A major area for expansion, highlighted by a number of participants was the opportunity for the QNI to develop and offer training for a range of professionals, both those involved in frontline clinical roles (pre and post registration) and also more generalist NGO staff who come into contact with clients with health needs:

“I think it’s really an early intervention question in terms of trying to embed inclusion health in education, in training. That’s something that the QNI Pathway, the London Network are placed to do, so I guess that’s an area I feel we should be looking at.” (Network Development Manager, LNNM)

Although very much an ‘of the moment’ subject, the topic of provision around education on delivery of services and how to engage with inclusion health groups around Covid-19 arose in two interviews, with participants suggesting that provision and delivery of rapid response type specialist training would also be something which the HIHP was well placed to deliver, as well as offering more generic training around working with particularly vulnerable inclusion health groups given an anticipated increased call on inclusion health services in coming years:

“With COVID, the problem is there has been so much stuff really. The problem has been too much guidance rather than too little. And the task for us at St Mungo’s has been translating the raft of guidance that is out there into what is practical for our setting... At the early stage, [it] would have been useful, but it was all in flux, wasn’t it? It was a bit chaotic at the beginning... [information] wasn’t there for quite a few weeks, while we were grappling with the problem.” (Health Policy Lead, St Mungo’s).

“I wonder whether the pandemic is going to raise anything around homelessness and COVID, and then, you know, the susceptibility... I just wonder if that is going to change; is it going to shift, or is it just going to make people more of an underclass, because that is how people are perceived as if they are homeless, aren’t they?” (Professional Lead for Community and End-of-Life Care, RCN)

“One of the questions I was asked a couple of times in some of the media was about the COVID vaccine, and will people have to have a registered GP. I think, you know, these inequalities, what the pandemic has certainly done has thrown into
really stark reality the terrible inequalities that we have in our society.” (Professional Lead for Public Health Nursing, RCN)

Although very few ‘specific asks’ emerged from strategic specialists, the St Mungo’s Health Policy Lead highlighted their sense that there was a gap in training and ‘bridging’ activities in some particular areas, which the QNI would be well placed to deliver:

“There is quite a lot of resource around mental health and substance use. I find generally there is less around physical health... what would we like more guidance or training on? I think something like hepatitis or TB work... and hepatitis C, for example. The NHS has got this elimination of hepatitis C programme. Seeing it as a priority for the NHS, how could QNI create a bridge between that kind of NHS initiative and homeless services, for example. One of the reasons obviously why homeless people don’t have such good health, is that they are not so integrated into all of the NHS screening and vaccination programmes. I’ve never found it very easy to find a nice, neat summary of what people are supposed to get, what the system actually looks like. So... having some support to translate the standard healthcare system into homeless health services would... be useful.”

Whilst not dealt with explicitly in this evaluation, other than within the interview with Senior Clinical Lead, Nursing Officer Public Health, Northern Ireland, and also in relation to the good practice case study from the Republic of Ireland, there is clear scope to expand on detailed consultancies engaging with transferable models of expert knowledge and development of services in other regions and localities in the UK.

“We work with the QNI on an awful lot of work, and we are probably at the early stages of working with the QNI in relation to the Homeless Health Project... Crystal [CEO of the QNI], came over and did some presentations in relation to their role of QNI and Homeless Health... there is certainly still a lot of development to be done. There is a lot of development in the Belfast city centre area and they reach out into other areas where there are problems, and then through some of the transformation funds. We started small in relation to others, got an advanced nurse practitioner in relation to addressing the homeless problem in Derry... One of the big challenges in relation to... working within multidisciplinary teams is the financial situation that we are all facing... posts come up within our Homeless Health Project and they are temporary funding. For that group of vulnerable people, people do need to have consistency who want to work there and they’ve got [to have] job security.”

As noted when considering the survey data, there are relatively large gaps in geographical coverage where membership of the HIHP is low and potential exists to both expand the membership in those areas (perhaps through the development of
regional clusters of inclusion health practice), as well as providing delivery of training and supporting service expansion by working with commissioners. (N.B. This proposal aligns to comments by the National Nurse Lead, NHS England Homeless Health with regard to the expansion of the Network and Membership).

“As Sam says, putting the inclusion health agenda broadly into people’s consciousness will mean that people will feel more empowered to budget for it. They’ll feel more empowered to support the production of guidance, and build their own inclusion health networks and join ours.” (Director of Nursing Programmes (Innovation), QNI).

“There are two kinds of streams: there’s the advocacy stuff and the public face of inclusion health, and then there’s the educational stuff that some of us have been talking about quite a lot recently in terms of embedding inclusion health in the training for pre-reg and post-reg nurses and medics.” (Inclusion Health Advisor, MHCLG)

Throughout this discussion on the future direction of the HIHP, the themes of lack of security in relation to funding and limited capacity within the QNI were prominent, with QNI staff members emphasising that it would be possible to expand and develop more effectively if funding existed to enable the HIHP Nurse Lead to be employed for additional days.

“If we had some more funding, we would be able to do more interventions … education is something Sam and I have talked about having, trying to embed that across pre- and post-registration courses for doctors and for nurses, and probably for allied health professionals as well. If we had the funding, we would do this. (Director of Nursing Programmes (Innovation), QNI)

“It is still just [having enough] time to do everything … managing, directing and motivating the join up [of networks] takes time … we need to link in more with the Royal Colleges – but again this takes resource.” (HIHP Nurse Lead, QNI)

**Collaborative working with other organisations/strategic partners**

The subject of collaborative working across the sector has been explored in relation to the particular strengths of the QNI and the HIHP, as well as in discussions on opportunities for expansion of the Network and future development of the HIHP. Participants were however invited to contribute particular recommendations for ways in which their own organisations could work more closely with the QNI around the HIHP.

Overwhelmingly, responses consisted of suggestions for encouraging awareness of the QNI services to potentially share opportunities, to invite each other to participate in workshops or conferences, and to collaborate around particular policy initiatives or
to raise awareness of the need for responsive action around homelessness through lobbying.

The QNI/HIHP have already foreseen this potential for drawing in other professions to share knowledge, and the special interest groups that have been developed – particularly since the pandemic – are increasingly involving participants from NGOs, academics and stakeholders in national or regional strategic roles as well as frontline health practitioners. It was noted however by the National Nurse Lead, NHS England Homeless Health, that going forward there:

“are opportunities with the national drivers around health inclusion… I would encourage you to think about how the future of the Network can align to some of those key national drivers and how you can be there as enablers.”

These opportunities to expand on collaborations that utilise specialist knowledge of NHS systems were echoed by the Health Policy Lead at St Mungo’s, who noted that there is a need for collaborative working to enable:

“… homeless services [to best] support clients to make the most of health services … how do we work in partnership with NHS bodies, to encourage services that are responsive? Now, you need to be able to understand the way that services are set up and, for our policy work, we need to understand how the decision-making works, and the planning structure, which seems to be ever-changing … another potential [collaborative role] is translating what is going on in the NHS to homeless services.”

Moreover, in some geographical localities where there is a relatively under-developed inclusion health programme, it was suggested that:

“If the QNI helped us do some of the training and the development, the support, that probably would be beneficial.” (Senior Clinical Lead, Nursing Officer, Public Health, Northern Ireland)

**Perceived impact on the sector should the HIHP cease to operate**

As with the clinical practitioners, strategic leads were asked to reflect on the sector and practice impact should loss of funding lead to the QNI ceasing to support the HIHP. They were also asked whether they considered that there is capacity and expertise to meet any shortfall of provision elsewhere in the specialist field of inclusion health. Participants were adamant that they wanted the high-quality service provided by the QNI/HIHP to continue:

“Obviously, I would not want to see the HIHP end. There has been a lot of investment into it. It makes such a difference in people's lives – particularly nurses.” (Inclusion Health Specialist Advisor, MHCLG)

When asked to consider to whom practitioners could be referred should the HIHP come to an end, there were limited recommendations, essentially mention being
made of the participants who had taken part in the focus group: “Pathway”; “London Network for Nurses and Midwives”

“Well, clearly the Faculty for Homeless and Inclusion Health is a very popular and growing band of people, and an excellent conference. So, that would be there and an excellent newsletter as well... Homeless Link, for us, does some health stuff, particularly more likely to be around things like psychologically informed environments, and those kinds of things, and they do venture a little bit into homelessness and health... they’re not really networks, but the King’s Fund [also] does some good stuff around health.” (Health Policy Lead, St Mungo’s)

In their joint interview, the RCN leads stated unequivocally that there is no real substitute for the QNI in relation to nurse-led inclusion health provision:

“I don’t think there is [any service who could provide support] in the same way. I guess, probably, if I was to direct people and not direct them via the QNI, I would go to somewhere like St Mungo’s. But I’m not saying they are comparable... [as non-clinicians]. But that is probably who I would use in the absence of the QNI... It’s a conduit, isn’t it? All those smaller, locality-based organisations, the good practice from them, actually it feeds through, and that is how people share is through the network. That wouldn’t happen [without the HIHP and networks].” (Professional Lead for Community and End-of-Life Care, RCN)

“One of the things that the QNI do... is that they provide this look over the whole country, whereas obviously other sectors, there are other organisations that provide really useful information and resource, but they tend to focus in particular parts of the country. That is the challenge sometimes, and particularly for [us], when we are trying to represent a full country organisation.” (Professional Lead for Public Health Nursing, RCN)

Strategic leads nevertheless recognised that the key challenge to maintaining the HIHP service is the challenge of obtaining sustainable funding, amid the push-back from Central Government/NHS in relation to funding, in the light of the argument that charitable support was required, whilst funders identified the need for specialist inclusion health support to be something that was the responsibility of statutory services, creating a situation where the QNI was often existing in limbo.

However, it was stressed by the Director of Nursing Programmes (Innovation) at the QNI that even in a worst case scenario, the HIHP would manage to operate at a basic level, although not with the level of support and activity convened by the HIHP Nurse Lead and without capacity to grow the Programme in the way explored earlier.

“We have, in the past, had periods of time where we weren't funded. We have managed to keep the Network going with just minimum amount of communication... so the Network will not go, for sure. We will keep the Network going, but we
want to keep the whole programme going. We want to have it funded properly, so we are constantly putting in bids and trying to find money, but we are always pushed back and told that this should be funded by NHS or health organisations."

This tension over where and how to obtain funding for specialist provision was acknowledged by the Clinical Director of the other major inclusion health organisation as a concern that bedevilled the (limited) health inclusion sector:

“Yes, so just to echo that there’s not an easy answer to this. We, in Pathway and the Faculty, have been struggling with the same tension since we came into existence 10 years ago. Everybody thinks the NHS should be paying for this, but it won’t. I can’t see it’s ever going to [be resolved]." (Clinical Director, Pathway)

**Future ambitions for funding the HIHP**

Given the focus on funding challenges in relation to maintaining and growing the HIHP, participants were invited to comment on their preferred model of funding for the Network and wider HIHP.

Representatives from NGOs all commented on the problematic nature of obtaining sustainable funding within their sector (see comments made above on this theme e.g., under the discussion on stigma impacting the homelessness sector).

Building on comments provided about the lacuna in sustained financial support for the HIHP, with charitable bodies often perceiving homeless health activities as a service that should be supported by statutory funders, and centralised Government (MHCLG) funding essentially operating in pockets of relatively short-term grants for localised inclusion health activities, a sustained and engaged conversation arose over the complexities and ethics of funding the programme going forward.

“It probably should be across the system based on what we have said before. It would be nice to think that some of the national players would fund it, because obviously it adds to the resources that they provide. As a charity, I’m not sure about membership [fees], because nurses … it’s difficult, isn’t it? Where you don’t have people earning huge salaries being expected to pay membership fees.” (Professional Lead for Public Health Nursing, RCN)

“In an ideal world, if you could wave a magic wand you would hope that they would be funded the same way that any other statutory service is funded … it is a challenge. It is a challenge for everyone, because … we know charities are all suffering, and if that divide gets bigger they will suffer even more, because people won’t have the access ability to contact [the QNI HIHP]. We know, generally speaking, the people that contribute the money are the people that don’t have that much excess.” (Professional Lead for Community and End-of-Life Care, RCN)

“I want to be mainstream funded. Surely this is the only sustainable way forward?” (HIHP Nurse Lead, QNI)
There were mixed views articulated on the value of being an independent voice able to lobby for change around inclusion health, which it was felt would be more difficult should the inclusion health work become a Central Government-funded workstream.

“There is an advantage of not being part of the system, coming back to that tangential, slightly external, independent voice… I think it is worth saying that there isn’t a clear answer to that question, but, if we can find a way of collectively keeping the independent voice, I think that’s the most important thing.” (Clinical Lead, Pathway).

“[There’s] the tension between not being able to get funding, because actually it should be mainstream, but then actually I’m hearing also that … the vision as a charity is, really, do you want to be totally mainstream funded and then mainstream restricted?” (National Nurse Lead, NHS England Homeless Health)

Ultimately, broad agreement was reached that ‘blended funding’ would be the preferred option going forward, whereby the HIHP was core-funded by a central Government grant, but additional income was generated through training, expansion of development of consultancy, teaching and opportunities for working with universities to embed inclusion health into pre- and post-registration training for nurses and other practitioners.

“My feeling is mixed funding would be ideal. I’ve always found it easier to get project specific funding than longer funding. Having core funding so that additional funding can be sought … is an ideal model in terms of trade-off between autonomy and interconnection.” (Network Development Manager, LNNM)

QNI colleagues were broadly opposed to the idea of charging membership fees, which could act as a barrier to practitioners already often experiencing funding challenges and often on low wages; thus, ‘mixed funding’ would offer a middle way and further encourage collaborations across the sector, with the QNI taking a leading role in developing health resources and convening specialist national level networks.

Ultimately, however, the main challenge facing the QNI consists of obtaining some sort of sustainable funding, whether at the current level of income or preferably at an increased rate to meet the increasing level of demand for their services at a national level.

**Anticipated demand for inclusion health knowledge/services until 2025**

Given the extent of the evidence pertaining to increasing demand (and recognition of the value of offer from the QNI) across the sector, participants were asked to comment on whether they envisaged more, less or about the same degree of
demand for inclusion health expertise and Network sustainability in the 5 years to come. (N.B. This sub-theme links back to responses on whether there is adequate capacity and knowledge within the sector to support the work currently undertaken by the QNI should funding not be obtained to sustain their current programme of work).

There was unanimous agreement from participants that there would be no decline in demand for inclusion health services in the next 5 years and almost certainly greater calls for the type of specialist provision offered by the QNI/HIHP.

“I cannot see that there will be any less need. I can’t see it reducing. If it stays the same, I think we are very lucky.” (Professional Lead for Public Health Nursing, RCN)

“Poverty and Inclusion Health are increasing and will dramatically increase so this work will be needed even more.” (GP, Inclusion Health Specialist, GP Research Fellow, UCL)

“There’s definitely going to be more need because of what COVID-19 has actually highlighted in terms of inequalities.” (Specialist Advisor, Inclusion Health, MHCLG).

“I think there’s going to be more need—significantly more need. The economy is in the middle of taking a significant dive... As other people have highlighted, inequalities have been brought to light... Loads of people are going to be made homeless, for example, lots of people who’ve lost their jobs, who aren’t going to be able to pay their rent after COVID. Obviously, we’ve also got Brexit coming up, which is a bit of an unknown quantity, to put it optimistically... It’s one of those areas where, frustratingly, a bit of extra work and a bit of extra money can have massive impact and make huge savings down the line, but the focus on short cycles and siloed budgets is going to mean that inclusion health is going to be scrabbling to keep up, unless we get better support.” (Network Development Manager, LNNM).

**Three Case Studies**

The final data element of this evaluation consists of the selection of three exemplar case studies of work undertaken by QNI colleagues under the auspices of the Homeless Health Programme. The projects were selected from a range of alternative options, and agreed by the evaluation team, following on from an exploration of regional spread and variety of interventions delivered by, or with the support of, the QNI Homeless and Inclusion Health Programme.

Leads on the case studies were contacted by email and follow-up phone call if required and invited to submit evidence of the activities that they have developed and delivered with the assistance of the QNI Homeless and Inclusion Health Programme, and to reflect in their submission on the ways in which the programme has facilitated the development of an innovative service or transfer of knowledge.
Whilst one of the three illustrative case studies follows up on the projects discussed by Bryar (2020), the two remaining examples are presented here for the first time, to illustrate the added value and scope of the funding on influencing and impacting Homeless Health across the UK.

**CASE STUDY ONE: illustrating internationalisation of the QNI Homeless Health model**

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<th><strong>Title of the Case Study</strong></th>
<th>Nurses and Midwives for Inclusion Health: Partnership in Practice, Ireland</th>
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<td><strong>Year submitted</strong></td>
<td>2020</td>
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<tr>
<td><strong>Period when the impact occurred</strong></td>
<td>2017 onwards</td>
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**Background of the study site**

In Ireland, community health nursing is structured around a generalist model. The most common role is called a public health nurse (PHN). This role is similar to a General Practice Nurse in the UK. PHNs have general nursing, midwifery and public health nursing qualifications.

The ratio of public health nurses to the population is estimated at 1:3500, however this is a conservative estimate. Public Health Nurses offer a range of health care services, including: child health surveillance, family support, wound care, chronic illness management, palliative care and elderly care. Other nursing roles in the community setting include registered general community health nurses and community mental health nurses, but these roles don’t usually sub specialise.

A recent survey of Irish PHNs and community nurses identified a range of challenges, including inadequate staffing levels, overwhelming workloads, poor workload planning, a lack of defined scope of practice and few opportunities for support and professional development. Unlike the UK, which has been developing nursing roles in health and social inclusion since the 1990s, there has been no corresponding development in Ireland, leaving a gap in provision for marginalised and socially excluded groups.

**Summary of the impact**

Using the QNI as a model for a specialist inclusion health clinical network

Direct support from the QNI HIHP to shape a new clinical network internationally

Mirroring the QNI HIHP to share good practice and improve clinical care

Networking with public bodies to undertake research
Details of the impact

Using the QNI HIHP as a model for a specialist inclusion health clinical network

Nurses who work in the context of inclusion health are at the forefront of providing comprehensive care to vulnerable and often stigmatised populations facing multiple and complex social and health problems. Intensive, skilled nursing care is invariably required for this population due to higher rates of mental and physical illness, complex co-morbidities and a lack of continuity of care.

Responding to the need among Irish community-based nurses to develop specialist practice in the area of Inclusion Health, nurse academics at the School of Nursing, Psychotherapy and Community Health established a special interest group in this area. The establishment and development of this group was informed by the QNI Homeless Health Programme.

Nurses and Midwives for Inclusion Health (NMIH): Partnership in Practice, is a new professional interest group of nurse and midwife practitioners working in contexts where access to/uptake of health services is limited because of marginalisation, discrimination or lack of awareness of health services. Examples of these practice areas include: homeless health, migrant/refugee health, Traveller health, mental health, disability health, forensic and prisoner health, addiction health, sexual health. The aims of NMIH are to:

- develop and share excellence in nursing and midwifery inclusion health
- support practitioners in professional and practice development, education and research

The NMIH network is developing a range of practice, education and research initiatives, which can be viewed on: [https://sites.google.com/dcu.ie/nmih/home](https://sites.google.com/dcu.ie/nmih/home)

Utilising support and resources from the QNI HIHP to shape a new international clinical network

The QNI gave advice and guidance to help develop this new network. Irish nurses attended QNI conferences, reviewed QNI guidelines, case studies, research and reports to help shape the network.

Mirroring the QNI HIHP to share good practice and improving clinical care

The Nurses and Midwives for Inclusion Health: Partnership in Practice launched in November 2019 with Sam Dorney-Smith, HIHP Nurse Lead as a keynote speaker. Sam provided further insights and engaged in discussions about how the network could establish itself. This 1-day conference and launch brought together a large group of nurses and midwives from a variety of health services. Delegates shared their practice and research in oral and poster presentation format, and discussed the contexts, practices and development of Inclusion Health Nursing and Midwifery in Ireland.
Mirroring the QNI HIHP to share good practice and improving clinical care

This new network has engaged with practice development and research projects, inspired by the work of the QNI. They are currently gathering case studies from Irish Inclusion Health Nursing practice and sharing these with practitioners through their website in 2021.

Networking with public bodies to undertake research

One of the network’s most recent projects is a government-funded study: An analysis of nurse-led COVID-19 interventions among homeless populations – a mixed methods study. This research involves nurse practitioners examining the characteristics of a selection of nurse-led COVID-19 service interventions among populations experiencing homelessness in Ireland. Through analysing the strengths and limitations of these initiatives, the most effective practice in preventing, identifying and treating COVID-19 among these populations will be identified and communicated to guide practice and policy development. Early findings are expected in 2021.

References


Pitman 2020: Public Health & Community Nursing - PHN Conference 2020 - Steve Pitman - INMO PHN Section Survey Results on Vimeo (vimeopro.com)

Contact details for further evidence of policy/practice impact

Briege Casey, Associate Professor, Academic Lead Community Health, School of Nursing, Psychotherapy and Community Health, Dublin City University
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CASE STUDY TWO: illustrating career development and transition to specialist inclusion health nursing

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<th>Title of the Case Study</th>
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**Background of the study site**

It is uncommon for specialist homeless health nurses to directly work out of substance misuse services.

Sue Grave is a homeless healthcare nurse. She has been a nurse for 6 years, previously working in Intensive Care, then as a community nurse and education facilitator. Sue was attending conferences run by QNI and events as a student.
nurse and after qualification, but began her transition to homeless and inclusion health nursing in 2018 when she started her District Nurse Specialist Practitioner Qualification (SPQ). Sue linked with the QNI HIHP after attending a conference and was linked by the HIHP to other homeless health charities and services. These networks helped her facilitate inclusion health placements for her alternative practice week.

Through these networks, Sue developed skills to become an inclusion health nurse and take on an innovative role within a local substance misuse service working both within this service and outreaching into the community.

This case study outlines how she developed her skills through the support, training, networks, and funding opportunities of the QNI into a new innovative role within substance misuse.

Her new integrated service links with community services, including local authorities, GPs, hostels, outreach teams and hospitals to meet the needs of local people who are experiencing homelessness. Sue’s role has been extended for another year in respect of the success of the service.

**Summary of the impact**

Professional understanding of good practice

Sharing of good practice and improving clinical care during the Covid-19 Pandemic

Taking opportunities to attend specialist training events

Sharing learning with others

Communicating the importance and value of the QNI HIHP

**Professional understanding of good practice**

Sue became aware of the QNI as a student when she attended the Florence Nightingale Commemoration Service in 2014. At that event she met Queen’s Nurses and found out about the charity, and the diversity and importance of their work.

She attended QNI events and kept in touch through the website and email communications both as a student and during her post registration studies.

Sue was inspired to work Inclusion Health after attending a London Network of Nurses and Midwives (LNNM) conference in London in 2018. Many of LNNM
nurses are linked to the QNI homeless health programme and are Queen’s Nurses.

At this conference, Sue learnt about end of life care for people who are homeless and connected with the QNI HIHP team who linked her with various homeless healthcare charities and services. This helped Sue arrange placements with specialist homeless health practices and services as part of her “alternative practice week” and wider SPQ training.

Sue spent her alternative practice week in London, with many organisations supporting people experiencing homelessness. This ranged from shadowing a doctor from a Pathway Homelessness Team on ward rounds, Queen’s Nurses working in a day centre, outreach and women’s refuge, and time with drug and alcohol services.

The QNI also linked Sue with specialist GP practices who work with people experiencing homelessness and communities that find it hard to access services. She was able to see how such specialist practices offer drop-in GP services, needle exchange and wound clinics. She also arranged placements with specialist primary care services around the UK, which helped her to see the range of service provision.

Sue used the HIHP transition module into homeless health nursing to learn more about homeless and inclusion health in practice and to confirm her interest in the field of inclusion health nursing.

Sharing of good practice and improving clinical care

Through shadowing nurses and services, speaking to the QNI and accessing support from the homeless health programme staff and lead, Sue has shaped her current role. She was approached by the local drug and alcohol service to apply for her current role as a homelessness nurse, which runs out of a clinic setting. This happened because Sue was known to the services because of her interest in inclusion health and the SPQ.

After starting her role, Sue adapted and adopted the health needs assessment from the QNI to assess the needs of her patients. She carries out mental health referrals and organises food vouchers and other sundries. Having seen how QNI inclusion health nurses have worked across boundaries, particularly with very vulnerable people, she has modeled that approach to include outreach to vulnerable adults, women and those in complex needs settings. Sue now runs a ‘drop in’ session with a local homelessness charity, supports key workers with clients and works directly with a hostel to increase access to GP services, making referrals and liaising with the GP and other services as part of a multidisciplinary approach to caring for patients with multiple complex needs. This has proved
effective in increasing GP registration and care for those with multiple health and addictions issues.

Recently, Sue facilitated a Health Education England initiative around optometry visiting the hostels and women’s refuge. They will offer health checks and eye tests, supply glasses, and even repair or replace spectacles. There has been a lot of interest in this initiative.

Sue notes that she has learnt how to engage patients and how to develop services through these networks and shadowing opportunities facilitated by the HIHP/QNI.

Covid-19 pandemic
During the COVID-19 pandemic, Sue has supported hostels through delivering training and education, helped them manage Covid positive cases and ensure residents self-isolate and keep others within the hostel safe. She has also encouraged residents to attend for testing and educated them about hand washing and wearing masks and has offered and administered flu vaccines in the winter months.

Taking opportunities to attend specialist training events
During her SPQ, Sue’s tutor and inclusion health Queen’s Nurses suggested she apply to undertake the HIH MSc module. This module is part of an academic course and one of only two such programmes available in the UK. Three places are available each year funded by the Company of Nurses in collaboration with the QNI.

Sue was successful in her application and undertook the module in 2019. She developed a deeper understanding of epidemiology as part of the social determinants of health, as well as working with a range of people across sectors to complete the assignment. Sue used the opportunity of participating in this module to explore a needs assessment and service evaluation for a “one-stop shop” service development. She has also linked with community faith-based services as part of the engagement and assessment for this service and has had the benefit of learning with and from people with lived experience of exclusion and homelessness who attended the course of study.

Sharing learning with others
Sue has been able to share knowledge and experiences about inclusion health with other community nurses, which has helped to raise the inclusion health agenda more broadly within the nurse community.

Sue continues to follow the QNI/HIHP by email and via their website and newsletter. She attends their online conferences and hopes to attend the QNI’s annual 2-day conference in 2021.
Communicating the importance and value of the QNI homeless health programme

Sue was supported to write a blog about her experiences of the SPQ for the QNI website and was also the subject of an article about her accessing funding to attend the homeless and inclusion health module/MSc programme. She went on to present her experiences of the MSc course to the Company of Nurses and has also shared her experiences with colleagues, encouraging other nurses to apply for the course as, well as being inspired to become a Queen’s Nurse.

An award-winning nurse

Sue won the QNI Philip Goodeve-Docker Memorial Prize for innovation and enterprise, for her approach to Inclusion Health Nursing during her SPQ.

She was also awarded Learner of the Year in her healthcare Trust for her achievement and approach to the SPQ as a learning and development opportunity.

References:
MSc Module in Homeless and Inclusion Health UCL: https://www.ucl.ac.uk/epidemiology-health-care/study/short-courses/homeless-and-inclusion-health
Company of Nurses https://www.companyofnurses.co.uk/
London Network of Nurses and Midwives: https://homelesshealthnetwork.net/

Contact details for further evidence of policy/practice impact:
Sue Grave, Homelessness Nurse, mobile number: 07786 035397

CASE STUDY THREE: Enhancing the development of a nurse-led Inclusion Health Clinic

Title of the Case Study
Beacon House Ministries Nurse Led Clinic

Year submitted
2020

Period when the impact occurred | June 2019 – ongoing

Summary of the study site
Beacon House provides primary healthcare services to people who are homeless, in insecure accommodation, or at risk of homelessness, in Colchester, Essex. The centre provides a full range of primary healthcare services to people experiencing
homeless in a day centre setting. Two nurses run the clinic, Hannah and Michelle, both of whom are Queen’s Nurses. Their work includes drop-in clinics, vaccination, sexual health screening, Blood Borne Virus screening and needle exchange, occupational therapy and podiatry. The day centre also offers a wide variety of practical help, personal development opportunities as well as food/showers/laundry etc. All services are offered free of charge.

www.beaconhouseministries.org.uk/

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The QNI HIHP has built relationships with a range of key individuals around the UK, to raise the profile of Inclusion Health nursing and the clinical speciality. The QNI linked inclusion health services and projects with healthcare leaders including the Chief Nursing Officer for England, Ruth May, who was appointed to post in 2019. In May 2020, Beacon House hosted a visit by Ruth May.

After the visit by Ruth May, the QNI HIHP Nurse Lead facilitated links with NHS England and NHS improvement. This helped Hannah and Michelle engage with NHS screening services and they are now working to improving access to bowel and breast screening for people accessing Beacon House services.

This builds on previous work with the QNI HIHP that linked Beacon House with a cervical screening hub. This helped the nurses to provide cervical screening to
service users, increasing uptake from 20% to 48% of women attending Beacon House in only 6 months.

**Highlighting the importance, value and quality of care delivered by specialist inclusion health services and healthcare staff**

During her visit, Ruth May had the opportunity to explore the role of Inclusion Health Nursing and specialist services, as well as the unique challenges and opportunities of providing health care to people experiencing homelessness. Michelle and Hannah were able to communicate the key challenges, the needs highlighted by the QNI, and the support given by the QNI to address these, including:

- The importance of pre-registration education and placements in inclusion health to improve quality of care to people experiencing homelessness and other inclusion health groups. Beacon House has been providing pre-registration placements for mental health and general nurses for 5 years. They use the resources including the ‘Transition to Homeless Health Nursing’ publication produced by the QNI as an example of an effective resource used with students on placement.

- The need for long-term funding of specialist inclusion health services, which should be commissioned and supported to deliver care, offering a ‘one-stop opportunistic’ approach where possible. Beacon House is a multiple health provider, including drug, alcohol, and sexual health nursing, as well as social care. Alongside the nursing aspect, it also offers housing and occupational therapy services.

- The value of nurse outreach to identify and treat acute and chronic diseases, which reduces admissions to hospital and increases trust, engagement and continuity of care with community health services

- The risk of isolation and burnout for inclusion health staff and the need for tailored support provided by the QNI

- The development of structured specialist training and high-quality, peer-reviewed resources in inclusion health available on the QNI website

- The value of the QNI network in providing learning, improvements in clinical care and service provision

- The gap in appropriate public health messaging for inclusion health groups during Covid-19 that was filled by work from the inclusion health sector in creating tailored informationals
• Events include specialist training conferences and sub-group meetings. After learning about an increase in Group A Strep wound infections, the Beacon Health Nurses increased routine swabbing and quickly diagnosed two cases.

**Sharing of good practice, improving clinical care and clinical innovations**

The nurses at Beacon House provide a range of bespoke services including:

• A ‘drop in’ cervical screening hub

• Provision of a smoking cessation service, with respiratory assessments for identifying new patients with Chronic Obstructive Pulmonary Disease.

• The use of a ‘day bed’, which specifically only operates during clinic hours, with nurse supervision to facilitate interventions for those at risk of trauma, health deterioration or attending Accident & Emergency, particularly with substance misuse issues

• Opportunities to increase the provision of education, training and placements for nurses in inclusion health settings

• Screening patients with wounds for Group A Strep infection. This intervention was shared by colleagues at a QNI conference after an increase in poor healing rates in wounds was noted. The Beacon House Nurses increased routine swabbing and quickly diagnosed two cases

In 2019, Beacon House was awarded the Queen’s Award for Voluntary service.

**Taking up opportunities to attend specialist training events**

Hannah and Michelle attend the QNI conferences annually and Queen’s Nurse regional meetings, which they feel provides them with valuable networking opportunities and a sense of belonging to a community of specialised nurses.

**Utilising resources to support education and training of others**

Hannah and Michelle use a range of resources produced by the QNI to support nurses on placement with their service. These include:

• The ‘Transition to Homeless Health Nursing’ publication
• Epilepsy
• Foot Health
• Oral Health
• Food and Nutrition
Increasing specialist support and reducing professional isolation

Inclusion health nurses have traditionally worked in isolated pockets throughout the UK. For many years, the Beacon House nurses had little or no interaction with other inclusion health nurses or any training or support specific in the field. With the development of the Queens Nurse HIHP and Network and under the leadership of Sam Domey Smith (HIHP Nurse Lead) they describe how the field has been transformed with a nationwide network of inclusion health nurses who are committed to improving services for people experiencing homelessness and addressing health inequity.

The QNI has enabled them to have a voice to make change, from a grass roots level, working with strategic partners.

Adapting practice to respond to the needs of inclusion health groups during the COVID-19 pandemic

During Covid-19, many routine services at Beacon House continued while the nurses expanded their role to support the work of the ‘Everyone In’ programme. This included creating a triage point for referrals into appropriate emergency accommodation to reduce the risk of transmission of coronavirus to those most at risk.

Supporting communication about the work of inclusion health nurses and services

The QNI supported the Beacon House nurses to write a blog, which has been shared nationally through the QNI website. This raised the profile of the Beacon House project and led to further visits from Melissa Dowdeswell, Chief Nurse for East Suffolk and North Essex and support from the local MP, Will Quince.

Making use of the QNI HIHP Nurse Lead

The QNI team, in particular the HIHP Nurse Lead, has further provided invaluable responses to a host of queries raised during the pandemic, e.g., accessing testing for homeless during COVID and support regarding Strep A testing in wounds for
people experiencing homelessness. Where she has been unable to support, the HIHP Nurse Lead has referred or provided links for accessible information.

References
Queens Nurse Institute Homeless Resources 2020
https://www.qni.org.uk/resources/2020

Jo’s Trust: The growing issues of accessing screening and how to overcome them;


Contact details for further information about the impact:
Michelle Wilkinson and Hannah Mulvey
beaconhouse.clinic@nhs.net
01206 761960

The case studies illustrate and exemplify the variety and range of support provided by the QNI through the auspices of the wide-ranging HIHP, and the impact on individual nurse practitioners, the development of the health inclusion sector as a whole, and client groups, as well as underlining the importance of having a specialised experienced, well networked nurse practitioner in the HIHP Nurse Lead role.

In the final section of this evaluation report, we now turn to responding to the core evaluation questions by summarising the core impacts of the funded programme prior to detailing recommendations for future development.

We were asked to evaluate the breadth, take-up and professional value of the learning network established by the QNI for nurses, allied health professionals and others working across sectors to improve health care for people experiencing homelessness and other excluded groups.

**Summary of findings**
The learning networks and special interest groups for practitioners working in particular fields of inclusion health have been exceptionally successful, demonstrating a substantial growth in membership both of the overall HIHP and also the recently formed special interest groups such as the health visitors working with families experiencing homelessness, and the GTR and Boater communities.

Although staff capacity and resource remain exceptionally constrained, regular meetings have taken place throughout the period of the pandemic in particular, with group meetings and ongoing email and phone support provided by the Inclusion Health Lead being widely acknowledged by both frontline practitioners and strategic leads as especially impactful in relation to rapid dissemination of knowledge and best practice in supporting particular groups. A further key professional value of the learning network has been the reduction in isolation and stress amongst practitioners, particularly those who are lone workers, or in locations that are relatively isolated from other larger clusters of inclusion health practitioners or outside urban areas (e.g. Wales, East of England, South West and Northern England).

As noted earlier in the report, the spread of the inclusion health network is somewhat ‘patchy’, with greater numbers of inclusion health specialist network members found in certain regions of the country. Additional funding to support the work of the Network and Programme more generally would support development of the learning network and assist in the growth of regional sub-groupings of specialists and permit an enhanced engagement with commissioners and interdisciplinary teams in relatively underserved areas of the country.

An exploration of the added-value, accessibility and use of QNI resources by network member and associated professionals who have participated in the HIHP was identified amongst survey respondents, clinical practitioners who participated in the focus group and interviews, as well as strategic leads who took part in the qualitative data gathering exercise, that the free-to-access, high-quality and up-to-date resources provided by the QNI are regarded as exceptionally valuable for professionals working in inclusion health.

This is most noticeable in relation to participants’ repeated comments on the fact that specialist information would not have been otherwise available to them; that new resources are regularly and responsively developed to meet the needs of practitioners (often involving identification of a lacuna in materials by network members); and that professional bodies such as the RCN, Pathway and other leading NGOs routinely utilise such materials and direct network members to the QNI resources.

Accessibility of resources is underpinned by the free-to-access nature of both network activities and downloadable materials, with numerous respondents to the
survey, interviews and focus groups providing examples of the use of QNI/HIHP developed resources, which support care of inclusion health groups.

The human resource of the HIHP Nurse Lead (Samantha Domey-Smith) was repeatedly identified by clinical practitioners and strategic leads as a remarkably effective and knowledgeable individual who is a lynchpin of the inclusion health activities, operationalising special interest groups which bring together practitioners, strategic leads and UK and international NGOs, academics and policy specialists; producing newsletters on inclusion health and providing face-to-face and online/telephone support to frontline practitioners.

She also works closely with colleagues in the QNI and across a range of other organisations to strengthen and develop the HIHP and to underpin other strategic developments, including supporting internationalisation of the QNI inclusion health model (see case study 1 and interview data from the Senior Clinical Lead. Nursing Officer Public Health, Northern Ireland).

One especially strongly identified added-value of HIHP membership consists of the growth of a coherent professional identity as inclusion health specialists, which members repeatedly emphasised reduces isolation, enhances a sense of being valued as knowledgeable professionals and reduces stigma. The issue of stigmatised, under-funded and precarious employment conditions emerged as a theme for a number of participants across both clinical and strategic groups.

That the QNI is ‘nurse-led’ was identified as being especially important to nurse practitioners, who emphasised that they can be disempowered or invisible in political and policy discourse, particularly given hierarchical working practices and contractual limitations on their ability to engage in public discourse, which highlights the conditions impacting inclusion health groups.

The exceptional professional reputation of the QNI and access to key policy and practice networks to which the organisation has access were also identified as extremely important in adding value to the QNI HIHP, as the organisation works to capture evidence that can aid in developing and influencing practice and policy around inclusion health.

Participants in interviews and focus groups were invited to identify the potential impact on specialist homeless health professionals who are members of the Network should the programme be discontinued, or offer be truncated, as a result of lack of continuity of funding.

Although for strategic leads and clinical practitioners based in large urban conurbations where they could access other associated resources such as the London Network of Nurses and Midwives, the impact of loss of the HIHP appeared to be potentially less dramatic than for practitioners working in non-Metropolitan localities (with particular concerns raised by those in rural or more isolated areas
such as some areas of Northern Ireland, South West England, East of England and Wales where the inclusion health offer and access to resources is under-developed); it was universally agreed that should the service be reduced or discontinued this would have a dramatic, negative effect on inclusion health practitioners and the sector as a whole.

The Royal College of Nursing clinical leads emphasised the high value they placed on the QNI as a result of the organisation’s reach, knowledge and that it offered a whole country service. Both practitioners and strategic leads emphasised the importance of the QNI being able to draw together coherent, quality assured, specialist resources, networks and policy engagement in a way which is limited for other service providers. Participants repeatedly emphasised that the QNI/HIHP was ‘a lifesaver’ and a number of respondents suggested that significant reduction or loss of the network and wider homeless health programme offer would be ‘devastating’ to nurse practitioners given greatly reduced access to training, resources and specialist support. Moreover, loss of the programme would reduce capacity and knowledge amongst NGOs and clinical strategic leads who engage regularly with the QNI, special interest groups within the network (such as for practitioners working with GTR and Boater communities and Health Visitors working with families experiencing homelessness) and specialist inclusion health practitioners who are members of the Network.

The evaluation sought to identify recommendations and scope for growth and sustainability of the Network and programme by examining potential for enhanced collaboration and strategic partnerships with other specialist organisations and professional bodies. This element of the evaluation found that there is already a generally high level of working with other key agencies, although often other organisations and professional bodies rely on the QNI/HIHP and network of practitioners to underpin their own activities and enhance knowledge in specialist working areas.

A key barrier to further development of collaborations (although as previously noted, opportunities for engaging with clinical commissioners, local authorities and education and training providers could potentially be enhanced further) is the lack of staff capacity, given the limited funding available to the QNI to support the inclusion health nurse-led project lead role, and the degree of stretch which already exists on QNI staff members.

This element of the evaluation is closely intertwined with the final theme of the potential for commercial support and/or funding of specific elements of the QNI Homeless Health offer. Although some key recommendations are provided that could help to develop and increase income generation possibilities, a tension can be seen to exist between the desire to remain a free-to-access professional network that provides resources for practitioners at no cost (identified as particularly important for practitioners who may be in part-time or precariously funded, relatively
low waged roles), and the lack of core funding to support the inclusion health network and enhanced offer (access to training, seed-funding for nurse-led projects, and resource development) from the QNI.

Considerable debate took place amongst practitioners, strategic policy leads and QNI staff around the challenge in striking a balance between maintaining an independent (at times critical) professional voice on inclusion health, and the impact (although this was identified as highly unlikely) should they receive core, central Government funding for their work. That a core stream of inclusion health work is overwhelmingly seen by external funders as the responsibility of central Government and statutory agencies has created a particular lacuna in access to funding to support the QNI HIHP activities, although it would seem from comments from knowledgeable policy leads in NHS England/Improvement that there may be some limited potential for funding to come on-stream in the future. This would however need to be linked to tailoring service provision and offer to meet the needs of newly developing policy and practice opportunities which are at present unclear, and in any event are unlikely to offer sustainable, long-term income to support the central inclusion health work of the QNI.

Other opportunities for income generation were identified in collaboration with strategic leads and clinical practitioners, particularly the development and delivery of core inclusion health training and learning materials, and the potential for consultancy and strategic development work on behalf of clinical commissioners.

All of these activities would, however, require access to greater resource to support the inclusion health nurse lead to develop such opportunities. It is suggested however that this could (over time) offer a sustainable return on investment for funders who are willing to support core costs as the new stream of QNI/Inclusion Health work develops, including through enhancing collaborations with professional bodies and Colleges to shape materials and training, which is aligned to an anticipated growth in need for inclusion health resources in the next 5 years.

Concluding Recommendations for the QNI/HIHP

This final section of the evaluation report identifies and summarises a number of key themes that have emerged from the evaluation of the suite of activities supported by the HIHP. These have been underpinned by the provision of key quotations from participants to emphasise the voice of stakeholders in shaping these recommendations.

There is a need to obtain core funding to support the unique QNI HIHP. Ideally this will permit a full time role (or job share) to support the activities of the inclusion health lead such as to support the growth of income and impact generating activities already outlined.
It is particularly recommended that consideration is given to the provision of an assistant to support the HIHP Nurse Lead role, to both ‘spread the load’ and ensure succession planning, given the risk of reliance on a single individual, particularly where they are exceptionally well known and networked and thus a risk exists should they be on long-term sick leave, or discontinue the role for any reason.

Consideration may be given to provision of funded internships to work with the Nurse Lead, enabling clinical practitioners who are considering developing their practice to develop a more strategic and country wide understanding of the inclusion health terrain.

“Yes. To me, it needs to be a full-time role with a proper pathway and structure within it, which means it’s evolving and there’s always that back-up plan. A lot of the time we handle very badly this back-up plan for these specialist roles. We have an amazing person in a role, like Sam, then they may leave or whatever and there’s nobody to fill that. ... I think the role needs to be permanent, full time and it needs to be shared out with an apprenticeship to learn those skills. It is a skill to keep all that running.” (Specialist Tissue Viability Nurse/Academic Lecturer)

Given the clear finding that the majority of network members had ‘stumbled across’ the QNI/HIHP or been notified of the inclusion health offer through word of mouth recommendations from others working in the field, there is a very clear need to enhance awareness of the QNI and the broader HIHP.

Once more the potential to expand and develop public awareness of the HIHP and resources will require dedicated time and human resource but this could potentially be costed relatively cheaply – perhaps through engaging with universities to offer internships or placements for policy or media students and via working in collaboration with NGOs, professional bodies and Royal Colleges to raise awareness of the work of the QNI and Inclusion Health Network within pre and post-registration training and dissemination activities through professional journals etc.

Increase visibility of the inclusion health work of QNI and greater visibility of Black and Minority Ethnic (BAME) service users and staff as well as enhanced emphasis on intersectionality in resources, training and network development.

For example, participants in this evaluation proposed that there is scope for inclusion of more international materials and learning opportunities for inclusion health specialists, e.g. relating to pre-migration status; wound care of non-White skin, working with migrants/refugees etc.

It is also strongly recommended (bearing in mind limited capacity) to work to attract and promote visibility of more BAME inclusion health colleagues and enhanced showcasing of projects led by BAME nurse practitioners.

Targeted exploration (e.g. surveys, focus groups etc) of the extent, discipline and geographical location of BAME inclusion health staff (which takes into account the
diversity of experience amongst people subsumed under the BAME category, as well as personal migration histories) should be seen as a priority in developing the network and QNI/inclusion health membership further. This is particularly important given the lack of visibility and voice of many BAME health professionals within this particular discipline, as noted within the qualitative data gathered from some BAME participants in this evaluation.

“I don’t know whether that’s a case of that there aren’t enough people from those backgrounds putting themselves forwards, or whether they’re not seeing the opportunities or getting the opportunities. So, that’s something to look at, but ... it would be nice to see a bit more people who look like me being focused.”

“[There is] a cultural difference and thinking, perception, you know? If I can relate to somebody that is giving me some advice, then I’ll be able to [relate and think of what he or she is saying]. I’ve nursed in Nigeria, I’ve nursed here, and I would ... say that ... things are not the same ... everywhere.”

“In terms of some resources specifically around things that might affect people from BAME backgrounds, that would be really good, actually. That’s not to say that everybody else isn’t affected, but I think, specifically for that group of people, it would be good because it has been quite a tough year in terms of those things...”

“... maybe something very specific to BAME colleagues and things like that. I think just really recognising the year that we’ve had, and what with the COVID stuff, I know that they’ve got a little section on COVID, but really looking at those who it has really affected might be a good one.”

**Outreach to wider groups of nurses beyond those working in community settings.** This enhanced diversification should also explicitly target the older cohort of practitioners who may not be graduates or who do not see themselves as necessarily able to participate fully in the Inclusion Health Network if they are not Queen’s Nurses, given that some lack of clarity was found to exist over the parameters of membership of the Homeless and Inclusion Health Network, or ability to apply for support for undertaking training modules.

“I wish it was made more ... advertised that [HIHP] it’s not just for Queen’s Nurses... The Queen’s Nurse title is a very prestigious title, it’s very recognised. I’ve always said to nurses and the students, ‘It’s okay, you don’t need to be a Queen’s Nurse. You can still go on the website’. ‘Can I?’, ‘Yes, it’s fine’. There needs to maybe be a little bit more work around this for everybody.” (Tissue Viability Nurse, Lecturer)

**There is a clear potential to expand and focus on regions with low levels of engagement in the HIHP** (potentially building on existing Queen’s Nurses in such
areas to develop localised pockets of expertise, activities and support, which can engage with other elements of the QNI’s work such as reducing isolation and poverty amongst retired community nurses). In turn, developing new regional sub-groupings which may also encourage special interest group meetings to take place with input from NGOs and commissioning groups, permits of in-reach to local commissioners and local authority networks, which over time may support income generation through the opportunities for the QNI/HIHP to deliver training, consultancies or strategic developments at local and regional levels.

In addition to the growth of special interest groups and responsively developed new regional sub-networks, e.g. in certain localities, or focused on working with asylum seekers and vulnerable migrants, who may meet on a face-to-face basis as post-Covid restrictions are lifted, it is strongly recommended that continued use of online meetings/conferences occur given restrictions on access to travel expenses, finances for attending training and work-stretch which were highlighted by clinical practitioners in particular.

It is recommended that further work is undertaken to enhance engagement across the nations of the UK, i.e., Wales/Northern Ireland, as well as exploring the scope for enhanced internationalisation as represented by Case Study One, and the increased attendance of Republic of Ireland practitioners and policy specialists at meetings of the special interest group focused on supporting GTR communities. Potentially some special interest groups (in particular those working with GTR communities and refugees, asylum seekers and migrants) could use such networks to engage with colleagues in mainland Europe, who although working within different types of health systems, will be encountering similar practice issues.

Based on comments from clinical practitioners in particular, there is potential to review and reorganise aspects of the QNI website to ensure that inclusion health resources are more visible and accessible. The qualitative data gathering exercise, as well as the evaluation team’s review of materials on the site, identified that the site can be quite ‘busy’ or require several attempts at searching to differentiate types of inclusion health resource, making it more challenging to search for specific materials, and thus reducing the likelihood that busy practitioners will make full use of the available resources.

Although at the point in time of the evaluation, suggestions for further enhancing direct collaboration with other specialist policy agencies and professional bodies were relatively limited and constrained by lack of capacity within the QNI inclusion health team (see findings from strategic leads interviews/focus group), it is recommended that the suggestions for scoping out opportunities to engage with extended networks of practice such as local government associations or commissioners, are operationalised through the development of a clear strategy of collaborative working with other key agencies, including those who participated in the strategic lead focus group and interviews.
In addition to the suggestion regarding enhancing awareness of the QNI HIHP to non-community nurses, there is also scope for reaching out to practitioners working in social care agencies, as well as volunteering with NGOs, etc. As one practitioner commented

“It’s not just about community nursing. I know they [community nurses] do an amazing job, and [the QNI] see them predominantly, but they’re also in the hospital setting. They’re also in other settings, care homes, hospices, it’s not just the community nurses.” (Tissue Viability Nurse, London).

Interestingly this quotation underlines the lack of clarity in the ‘messaging’ around the Network which has been noted elsewhere in this evaluation, as we are advised that the QNI understands nurses working in care homes and hospices to be included under the rubric of ‘community nurses’, as they are working in non-hospital settings. Indeed, it was stated by the QNI Director of Nursing Programmes (Innovation) that “Hospital nurses who work in inclusion health are able to join the network. This would be very relevant to them.”

In turn this discussion indicates a potential to publicise and reach out to non-nurses, or non-clinical practitioners (albeit this idea is not entirely uncontroversial with some interviewees) “When I first heard that acute nurses could become QNs that really naffed me off. I was like, ‘Really? That’s us. That’s us community people’. It took a little while to think, actually, no, we need to be inclusive. But I just wanted something to stay community and primary care focused because nothing does. Everything is about integrating everybody.” (Senior Strategic Lead)

The level of interest and discussion on lack of inclusion health training modules in pre and post registration settings clearly indicates that there is scope to grow the HIHP offer around training and development. It is recommended that consideration is paid to the design of both non-credit bearing (or non-graduate level) short introductory courses on inclusion health, and a longer-term focus on engaging with Royal Colleges, professional bodies such as the RCN and academic providers to deliver (or franchise) credit-bearing CPD programmes of study, which could be delivered to a range of health professionals and co-marketed through other organisations such as Pathway:

“I know there’s a link between the module that’s provided at UCL and this link [HIHP]. I think it would be useful to have a stronger link with the school, with UCL, in terms of the information that you teach and maybe a greater promotion of the course. The information is fantastic, but there is another level that I was taught on the inclusion health module and it really, really opened my eyes… I’d like to see a

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19 The regulations for becoming a Queens Nurse (QN) indicate that whilst someone who may be based in acute practice for a percentage of their time, thus must be community based (broadly defined as in the discussion above on hospice or care home settings) for a minimum of 50% of their working week. Thus someone who is purely hospital based/working in an acute setting is not eligible to be a QN.
greater link between the course that’s provided within your Institute and the QNI because they’re both relevant. I think nurses, if they can, they need to do it. Other professionals that were on the course, dentists, physiotherapists, we need more doctors on it, we need a few surgeons, definitely. I think now that we have this amazing resource and people who are really experienced working on it, we need to use the context we have in London, use the universities, get it on the curriculum, get it accredited.” (Tissue Viability Specialist, London)

This scope to develop and market training programmes also links to the potential to **generate income through the marketisation of specialist knowledge and strategic expertise, consultancy and bespoke training**, but will require capacity beyond that which currently exists. Such growth of capacity could be partially met by additional funding for the Inclusion Health Lead role, but as such commercial activities grow, the network of consultants would need to expand, e.g. inclusion health specialists who are members of the special interest groups or Queen’s Nurses delivering activities on a split-cost basis, with the QNI or working in partnership with academic and policy specialists to provide expertise at a competitive commercial rate.

Other opportunities that could be considered to increase access to funding to support the growth and development of the HIHP/inclusion health offer include **collaborative funding applications for research** with other key agencies or universities (e.g. through the National Institute of Health Research; Medical Research Council or European Health Agencies). There is also potential to explore opportunities emerging from **new streams of funding**, which may come on stream in future months, through central Government developments and emphasis on inclusion health, as implied within the strategic leads focus group.

Although clearly subject to obtaining funding to support such a project, there was considerable appetite from respondents for a **renewal of the seed-funding for nurse-led inclusion health innovation projects**, should finances permit.

Finally, and the evaluation team are aware this is not regarded as a particularly popular option for the QNI, which is conceptually wedded to the concept of free-at the point of access membership of the Institution and open access to resources, it would be possible to consider **paid membership of the QNI, or a minimal fee to download resources for individuals using an institutional email address**. This could be extended to provide the opportunity for health authorities or professional agencies to purchase an **institutional subscription** which would permit their employees or members to continue to access the QNI’s resources in full, with a more limited ‘free’ offer for those without such membership.

**Conclusion**

This report which presents the findings of the end of project evaluation of elements of the Oak Foundation/Queen’s Nursing Institute (QNI) co-funded Homeless and
Inclusion Health Programme (HIHP), concludes that, based on a robust analysis of evidence and primary research activities/interviews with participants that there is abundant evidence of high value to relatively low cost of delivery of the HIHP offer.

As discussed extensively above, the value of the HIHP to inclusion health practitioners (particularly those in more isolated areas of the UK, or who are sole workers) is highly significant positively impacting their professional practice and reducing isolation.

There is substantial added-value to Network members and participants in the HIHP provided by access to free to use resources, and professional special interest groups. Importantly, as explored above, a range of other professional agencies, including the RCN utilise the high quality materials collated and produced by the QNI/HIHP, and there is a virtuous cycle of delivery of up to date, practice based materials, driven by engagement with practitioners who are members of the HIH Network.

It is clear that professionals who are members of the HIHP would suffer significant loss of access to high quality training, information exchange and support if the Programme should close and it is thus strongly recommended by all participants in this evaluation that every opportunity should be taken to ensure that the offer continues, not just in its current format, but expanded to meet anticipated future need.

Whilst we have explored potential opportunities for funding and commercialised growth of the HIHP offer these would only offer a partial solution to the need for core funding and would take time (and resource) to develop. Whilst there is clearly some appetite for a mixed form of funding whereby core costs for the service are provided by statutory services and then additional charitable or self-generated funding supports a wider range of activities, at present the funding climate remains highly challenging and lacking in clarity. Accordingly, there is an urgent need to secure funding to continue the work of this highly respected, and exceptionally good value for money service, delivered by the QNI.

**Update: Activities of the HIHP/Network since the Oak Foundation funding ceased**

Whilst this evaluation has focused on a range of core activities co-funded by the QNI and Oak Foundation, since funded ended in 2020 the QNI/HIHP Nurse Lead have continued to work on a range of new activities as well as supporting the existing Network and SIGs:

- Street Outreach group launch
- The Health Visitor’s working with families experiencing homelessness group wrote a letter to the Ministers of Health, Housing and the Home
Office regarding the plight of families experiencing homelessness and that specialist Health Visiting posts are essential to provide the expert support that these families need. [https://www.qni.org.uk/wp-content/uploads/2020/05/Homeless-Families-Letter-28.5.20.pdf](https://www.qni.org.uk/wp-content/uploads/2020/05/Homeless-Families-Letter-28.5.20.pdf)

They also led on the authorship of ‘Health Visiting with Homeless Families during the COVID-19 Pandemic’, an article profiling the role of specialist Health Visitors during the pandemic, authored in partnership with the Magpie Project [https://www.magonlinelibrary.com/doi full/10.12968/johv.2020.8.5.190](https://www.magonlinelibrary.com/doi full/10.12968/johv.2020.8.5.190)

- Working alongside Medact and the Shared Health Foundation in improving the plight of homeless families for the longer term
- The recruitment of a new member of staff, seconded in to support the HIH programme
- Funding received from the QNI to support ongoing work whilst they explore the potential for additional funding partnerships
- Project funding from NHSE/I and PHE to enable the QNI to raise awareness of the HIHP in all the networks; to update the Transition to Homeless and Inclusion Health Nursing resource; to inspire and raise awareness of the importance of inclusion health with student nurses; to fund three leadership places on the QNI Aspiring Leaders programme; to collate and create a collection of homeless and inclusion health case studies and examples of good practice, which demonstrate the impact of nurse leadership in Homeless and Inclusion Health.
Bibliography


Appendix 1

Evaluation Study
An Evaluation of the Queen’s Nursing Institute Homeless Health Programme

Information Sheet for Participants
Focus Groups and Interviews

What is the project about?

As part of the end of funding cycle activities associated with the QNI’s Homeless Health Programme, the organisation is required to undertake an independent evaluation of the activities, impact and potential future direction of the QNI’s Homeless Health Programme activities.

A collaborative team of researchers (consisting of a GP Homeless Health specialist/academic researcher Dr Zana Khan, QNI Homeless Health Nurse Project Lead Samantha Domey-Smith; and Margaret Greenfields, Professor of Social Policy and Community Engagement at Buckinghamshire New University) are engaged in a multi-level evaluation and review of activities supported by the Homeless Health Programme.

The evaluation consists of a literature review, documentary analysis of materials pertaining to activities and outputs from the Programme; analysis of responses to the annual survey of membership/activities disseminated by the QNI directly; and an independent research element to the evaluation consisting of interviews and focus groups with strategic health leads and frontline practitioners led by Margaret Greenfields.

A small number of case studies will be developed which will consist of a summary review of extant materials and (as required) individual interviews with case study leads.

You are being invited to participate in a focus group, case study or interview within the primary research stream of evaluation activity, to explore your experiences of the QNI Homeless Health Programme; use of QNI resources or participation in seed-funded projects; perceptions of the value gained by yourself, peers and service
users through participation in the Programme/Network; strategic recommendations, and/or any other information you wish to share with us.

**What will we be doing?**

As part of this project we are gathering information from a small number of selected strategic leads in the area of homeless/inclusion health policy and practice and also a small number of frontline staff working with inclusion health groups.

We will be carrying out a series of up to twelve one-to-one interviews and two separate focus groups with an average of 8 participants in each group. Both individual interviews and focus groups will use closely related sets of questions, tailored to the participants’ roles. An additional three case studies will be prepared to illustrate the impact of the QNI on practice, through delivering seed-funding to inclusion health projects.

The focus group discussions and interviews will all take place online and will be audio/video recorded and then transcribed. Transcriptions will only be seen by the research team members and all data used or shared will be anonymised. We won’t identify you or your particular answer in relation to any reports, presentations or publications which come out of this project, unless you ask to be specifically identified (for example if you are a representative of an agency which has been supported by seed funding by the QNI Nurse Led Homeless Health programme and wish to be identified, or a policy lead for an agency who is willing for your agency or area of practice to be named in the evaluation report).

Explicit permission must be given on the consent form you will receive with this information sheet to be named or have your organisation identified in any outputs from this evaluation.

**What happens if I agree to take part and then change my mind and don’t want to have my information used?**

If you change your mind and don’t want to carry on with being part of the study, you just need to notify us. You can withdraw your consent up to 14 days after we have received back the transcript of the interview/focus group (10 days after interview/focus groups take place) – but in any event no later than the 30th November 2020 for focus group and individual interviewees (8th December for case study lead interviews if your interview takes place in early December) when analysis of final interviews will commence, to enable completion of the evaluation by late December 2020.
If you wish to withdraw from the primary research element of the evaluation we can then either share the transcript with you so you can review what you have said, and/or remove your particular responses from the data we analysed.

If during an interview or focus group you want to give us information – for example to provide an example or more detailed data - which you don’t want to have recorded please tell us and we can turn off the recorder for that part of the conversation.

You can also talk to us about any worries and concerns about the project at any time.

All data provided will be held securely in compliance with Data Protection Act regulations. Findings from the study will be disseminated internally at Bucks New University to help us with our developing work on supporting GRTSB students, and externally to Higher Education network members via reports, workshops, presentations and journal publications.

**How do I get involved?**

If you want to know more prior to committing to taking part in an interview or focus group, in the first place get in touch with either Professor Margaret Greenfields or Samantha Domey-Smith Nurse Project Lead supporting the QNI Homeless Health Programme and we will get back to you and tell you more about how you can become involved in the evaluation.

Professor Margaret Greenfields – Principal Investigator; Buckinghamshire New University. Margaret.Greenfields@bucks.ac.uk

Samantha Domey-Smith, Nurse Project Lead supporting the QNI Homeless Health Programme, Samantha.Domey-Smith@qni.org.uk

Full ethical approval has been gained from the Buckinghamshire New University ethics panel at the University before you have been approached to take part in this research element of the programme evaluation. Ethical Approval Reference: UEP2020Oct01

If you have any concerns or complaints about any aspect of the study, please contact the researchers in the first instance using the contact details above. However, if after speaking with the researchers you wish to complain formally you can do this through contacting

The Research and Enterprise Development (RED) Unit
Buckinghamshire New University,
High Wycombe, Buckinghamshire HP11 2J Z
red@bucks.ac.uk.

Normally your complaint will be acknowledged within five working days and answered as soon as possible thereafter.
Appendix 2

Informed Consent Form –
An Evaluation of the Queen’s Nursing Institute Homeless Health Programme

Ethics Approval Reference: UEP2020Oct01

Please tick the appropriate boxes

1. Taking part in the study

I have read and understood the study information dated 18/10/2020. I have been able to ask questions about the study and my questions have been answered to my satisfaction.

☐

I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and I can withdraw from the study at any time, without having to give a reason. I can withdraw my data up until [30/11/2020] which is the final date before data is analysed.

☐

I understand that taking part in the study involves participating in an audio/video recorded online interview or focus group.

☐

2. Use of the information in the study

I understand that information I provide will be used, in anonymised form, in the final evaluation report that findings from this evaluation may subsequently be uploaded onto a project and university website; or disseminated in conference/workshop presentations or academic publications.

☐

I understand that personal information collected about me that can identify me, such as my name or role, will not be shared beyond the study team (without explicit permission granted to identify my agency/name) and funders/partners engaged in future policy formation that are linked to the evaluation and programme outcomes.

☐

I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with current UK Data Protection legislation.

☐
I agree that my (suitably anonymised) information or data provided can be quoted in research outputs

or with explicit permission given [sign below and tick relevant boxes below] my agency or name may be identified.

I give permission for my agency/employment context to be identified – e.g. Pathway; XX
Health Authority

I give permission for my name/role to be identified in reports or outputs

SIGNATURE__________________________________________________________

3. Future use and reuse of the information by others

I give permission for the transcriptions of audio/video recordings in which I have participated and data that I provide to be used for future research and learning.

If you consent to sharing of data for use by other researchers, the data will be stored in anonymised format (transcripts, audio recording, survey database, etc).

The use of data and access will be restricted to the authorised academic researchers and research/policy partners/QNI Programme funders.

4. Signatures

Name of participant [IN CAPITALS]   Signature  Date

Name of researcher
MARGARET GREENFIELDS/ ZANA KHAN [Delete as Applicable]

Signature________________________ Date________________________

5. Study contact details for further information

In the first instance: Professor Margaret Greenfields – Principal Investigator;
Buckinghamshire New University, Margaret.Greenfields@bucks.ac.uk

Or, Samantha Dorney-Smith, Nurse Project Lead supporting the QNI Homeless Health Programme, Samantha.Dorney-Smith@qni.org.uk

If you have any concerns or complaints about any aspect of the study, please contact the researchers in the first instance using the contact details above. However, if after speaking with the researchers you wish to complain formally you can do this through contacting
Appendix 3

An Evaluation of the Queen’s Nursing Institute Homeless Health Programme

Topic Guide [Clinical Practice group]
Individual Interview Schedule (Clinical Practitioners)

Unique Code: ___________________________ Date: ____________
Location of interview: ONLINE 
Time: ____________

No./Gender of participants : ___________________________

GENERAL

1. Standard Introduction (all participants)

2. Age/Gender/Role – type of agency

3. How did you first hear about/become involved in the QNI Homeless Health Network?

4. Which (other) clinical networks are you part of (or would like to be part of) and why?

5. What training/materials or other events have your specifically accessed through the QNI Homeless Health Network?
6. How do you think the QNI Homeless Health Programme specifically support nurses and others? Is there any added value about being part of the QNI network as opposed to other similar networks? Probe re issues of isolation/stigmatised role as health professional working with ‘inclusion health’ groups + experiences with/attitudes of non-specialist colleagues.

7. What do you think are the most useful/effective elements in the QNI Homeless Health Programme? Have you ever shared learning from the QNI Homeless Health Programme with peers/other professional colleagues? [probe for which professionals and extent of reach/impact of such shared learning]

8. What do you feel could be improved/changed in the QNI Homeless Health Programme?

9. Has your practice changed/been supported in any way which can be demonstrated to enhance patient care as a result of your membership of the QNI Homeless Health Network?

10. What (if any) impact would occur for you/your service user and other practitioners, if the QNI Homeless Health Programme were to close?

11. How do you think the QNI Homeless Health Programme can develop its work in the future? Expand/Probe to cover: What would be helpful for you/people in your role – and wider professional networks/colleagues with whom you work?

CHECK IF ANY OTHER ISSUES THEY WISH TO RAISE

Thank Participant and End

Ensure they know of ability to withdraw from study if desire; aware of contacts if any question raised/complaint or in need of further support etc.
Appendix 4

An Evaluation of the Queen’s Nursing Institute Homeless Health Programme

Topic Guide [Strategic Lead group]
Individual Interview Schedule [Strategic Leads/Senior Leaders]

Unique Code: 
Date: 
Location of interview: ONLINE 
Time: 
No./Gender of participants: 

GENERAL

1. Standard Introduction (all participants)

2. Age/Gender/Role – type of agency

3. Based on your professional experience what is the most valuable aspect of the QNI Homeless Health Network/ Programme? And the least (e.g. replicates other networks/services/training etc).

4. Who is this network of value to? Which groups – including those you believe don’t access the network/relevant training and materials - could effectively benefit from the Programme? In what ways? Probe for opportunities for shared programmes/training/input to medical training etc…

5. (Build on questions above) How visible is the work of the QNI Homeless Health Programme? What do you feel could be done to enhance visibility/membership?
6. How do you think the QNI Homeless Health Programme should develop its offer going forward? (probe for missing elements, potential for particularly marketable training and additional services/information development).

7. How can the inclusion health/homeless health work be strengthened of the network – individually by QNI and collectively – what might you/your organisation be able to bring to this task?

8. If the QNI Homeless Health Programme were to close – is there capacity and expertise to pick up this slack elsewhere in the specialist field of inclusion health? Would such programmes – e.g. if delivered by a professional body/royal college should it be accessible to nurses/full range of health professionals if so?

9. How do you envisage the field of inclusion health in the coming 5 years? Is there going to be more, less or about the same need for such services? Could this need be filled effectively if the QNI Homeless Health Programme was no longer functioning – e.g. probe for issues of resource sharing/training/access to CPD etc for staff going into the area of work and value of such networks

10. How do you think the QNI Homeless Health Programme should be funded going forward?

CHECK IF ANY OTHER ISSUES THEY WISH TO RAISE
Thank Participant and end – ensure know of ability to withdraw from study if desire; aware of contacts if any question raised/complaint or in need of further support etc.
Appendix 5.
Demographics of survey respondents

Gender

Of the 55 full responses received; 93% of respondents (n=51) identified as female; 7% male (n=4). No respondents selected any other gender options available, e.g. transgender female, transgender male, non-binary or prefer not to say.

Ethnicity

An exceptionally high number of respondents to the survey (83.64%) 46/55 identified as White British; three as White Other (5.45%); two respondents (3.64%) as ‘other mixed ethnicity’ (unspecified); and one respondent each selected “Black African or African British”; “Asian or Asian British (Indian)”; ”Mixed White and Black Caribbean” and “Any Other” Ethnic background.

Given that the most up-to-date NHS Workforce statistics published in March 2020 indicates that White people made up 77.9% of all NHS staff (out of those whose ethnicity was known); Asian people (aggregated categories) made up 10.7% of NHS staff; Black people (aggregated data) made up 6.5% of NHS staff and those of ‘Other ethnic group’ accounted for 2.6% of NHS staff; even taking into account the few older age or potentially retired respondents to the survey (e.g. over 65); it is clear that this sample is not aligned to general NHS workforce statistics. Whilst this may simply be an artefact of the sampling methods/response rate, it should also be considered that those working in inclusion health may not be representative of wider demographics of the NHS workforce (potentially also therefore not representative of their client groups), offering scope for the QNI to work to engage a more diverse workforce and support individuals from non-majority ethnic groups to consider entering into inclusion health roles.

Age

As illustrated by Chart 2, the sample of respondents consisted of individuals between the ages of 25 and 74; with 40 out of the 55 who had completed demographic data (73.72%) being aged between 45–74 years of age; most commonly aged 45–54 (40% of responses). Of those aged below the age of 40 (18.18%), 10 respondents were 34–44 years old with the remaining five (9.09%)

---

stating their age as 25–34. Three respondents were between 65–74 years old (5.45%)

Chart 2: Age of survey respondents

Highest qualification of respondents (including where currently studying)

In total, 56 respondents replied to this question (i.e. one additional respondent who has not supplied demographic information/or skipped earlier questions submitted a response to this element of the survey), including two respondents who whilst replying to other questions, declined to answer a question on level of qualifications held.

Chart 3: Highest qualification of respondent
In total, one respondent held a PhD (a clinical psychologist); 18 had a Masters level qualification (predominantly employed in the NHS or local authorities in fairly senior roles) and a further 29 (51.8%) respondents held a first degree. Little variation existed in age range by level of qualification. Thus, overall 85.72% of respondents were graduates.

Whilst the age range of respondents inevitably captures a cohort of graduates (with the move towards an all graduate profession being announced in 2009 and coming into force in 2013), given the age range of respondents and (see below) information on duration in role, it is clear that we are seeing here a more highly qualified cohort than may be anticipated across the entire sector.

Inclusion health is not an immediate post-qualification career in the main. People need to build knowledge and experience first. Perhaps unsurprisingly the higher levels of academic qualification were associated with higher professional or more managerial or team leadership type roles, e.g. Head of Business Development; Clinical Psychologist. That only four respondents (all White British, aged 45–54) indicated that they were registered general nurses (RGNs) who held a Diploma level qualification (the pre-2013 minimum qualification for nurses) is further suggestive of the fact that either inclusion health practitioners are (by age range) potentially better qualified than many others in the nursing profession, or that the findings of high levels of qualifications – including for nursing professionals in their 60s and upwards, are an artefact of the low response rate.

One respondent indicated that they had GCSEs as their highest level of qualification and analysis of their response indicates that they are employed as a hospital discharge support worker located within a non-clinical (hostel) setting.

**Years employed in Inclusion Health/level of prior experience**

Respondents indicated that they had been clinically qualified for a very wide range of time, with the most newly qualified participant having become a nurse 4 years previously (with 10 months of experience in inclusion health), and the most senior/older professional reporting in excess of 40 years as a qualified nurse, of which 36 years had been spent in inclusion health.

When controlling for those who indicated that their role was not directly in inclusion health (e.g. more general management, nurse tutors or hospice care etc); 21 respondents had been working in inclusion health for 5 years or less; 10 respondents had between 6–11 years of experience and a further 10 reported between 15–20 years of working in this field (none reported 12–14 years of such work). A further six individuals each had between 22 and 36 years of experience, which for more senior staff in particular could include roles as both frontline practitioners and/or volunteering activities with people with substance misuse issues, and management roles.

**Salary bands**

As can be seen in Table 8, 65% (n=34) of respondents were employed on clinical Bands 6 or 7. For non-clinicians or those in NGO non-clinical employment payment rates have been selected by respondents.

To some extent, the salary bands may relate to level of seniority of respondents and relatively high levels of experience noted by those who completed the survey (see duration of employment in Inclusion Health/prior experience)
Table 8: Salary bands of respondents

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 3 (£19,737 - £21,142 outside London, £24,210 - £25,615 inner London)</td>
<td>1.89% 1</td>
</tr>
<tr>
<td>Band 4 (£21,892 - £24,157 outside London, £26,365 - £28,988 inner London)</td>
<td>1.89% 1</td>
</tr>
<tr>
<td>Band 5 (£24,907 - £30,515 outside London, £29,888 - £36,738 inner London)</td>
<td>11.32% 6</td>
</tr>
<tr>
<td>Band 6 (£31,365 - £37,890 outside London, £37,638 - £44,780 inner London)</td>
<td>22.64% 12</td>
</tr>
<tr>
<td>Band 7 (£38,890 - £44,503 outside London, £45,780 - £51,393 inner London)</td>
<td>41.51% 22</td>
</tr>
<tr>
<td>Band 8a (£45,753 - £51,668 outside London, £52,643 - £58,558 inner London)</td>
<td>9.43% 5</td>
</tr>
<tr>
<td>Above Band 8a (£53,168 + outside London, £60,058+ inner London)</td>
<td>9.43% 5</td>
</tr>
<tr>
<td>Not working</td>
<td>0.00% 0</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>1.89% 1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>53</td>
</tr>
</tbody>
</table>

Geographical location of respondents

Answers to the question pertaining to location of respondents (drop-down box to enable selection of geographical region) showed some interesting variance from the overall pattern of Homeless Health Network membership (Table 4).

Whilst there was only a slight uplift amongst survey respondents vis-à-vis the percentage of Network members based in London (18.2% : 17%); 27.3% of survey respondents were based in the (aggregated) South of the country (South East at 16.4% and South West 10.9% combined) compared to 32% of overall Homeless Health Network members.

The Midlands accounts for 10% of Network membership overall, but 29.1% of respondents to the survey were based in that region; and whilst 23% of Network members report living/working in the North of England, only four responses (7.3%) emanated from that locality.

In addition (Table 3), despite 18 (1.4%) Network members being based in Northern Ireland, no survey responses were received from that area of the United Kingdom, and only two from Wales (despite overall network members consisting of 56 individuals or 4.4% of membership in that country). One survey response was received from Scotland which has 28 registered Homeless Health Network members but these practitioners are potentially primarily actively engaged with the QNI Scotland. Further work would be required (e.g. tailored survey questions) to ascertain why in particular there are these inconsistencies in response rate to the survey across the countries and regions of Britain.
**Appendix 6**

Table 9 illustrates the demographics of clinical practitioner focus group participants.

**Table 9: Focus group demographics – Homeless Health Programme Clinical Practitioners**

<table>
<thead>
<tr>
<th>Age (Decade)</th>
<th>Gender</th>
<th>Ethnicity where stated</th>
<th>Role/Whether Queen’s Nurse</th>
<th>Duration in Post</th>
<th>Location of Service</th>
<th>Name of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-49</td>
<td>Female</td>
<td></td>
<td>Nurse Practitioner QN</td>
<td>8 years</td>
<td>Inner City London</td>
<td>Community Healthcare NHS Trust</td>
</tr>
<tr>
<td>40-49</td>
<td>Female</td>
<td></td>
<td>Community Staff Nurse</td>
<td>5 years</td>
<td>, South Wales</td>
<td>2 x part-time roles Community staff nurse + Clinical Lead at Homeless Help</td>
</tr>
<tr>
<td>(audio sound problems on file as she was on a train missed this detail) ?</td>
<td>Female</td>
<td></td>
<td>Community Nurse Specialist (Refugee Health) QN</td>
<td>6 years</td>
<td>Inner City London</td>
<td>Healthy Inclusion team</td>
</tr>
<tr>
<td>40-49</td>
<td>Male</td>
<td></td>
<td>Role?</td>
<td>5.5 years</td>
<td>Inner City London</td>
<td>Homeless Health Service, Community Healthcare NHS Trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Currently working on psychological informed intervention/ MDT team</td>
<td>2 months in current role</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>Female</td>
<td></td>
<td>Lead nurse for Gypsies and Travellers QN</td>
<td>?</td>
<td>Eastern Region England</td>
<td>Public Health (Local Authority)</td>
</tr>
<tr>
<td>40-49</td>
<td>Female</td>
<td></td>
<td>Community Outreach Matron</td>
<td>?</td>
<td>Weston-Super-Mare</td>
<td>Sirona Care and Health (CIC)</td>
</tr>
</tbody>
</table>
There is little variation in age (40–52 years) amongst clinicians, and just under half are London-based practitioners (n=3) working across three different Trusts. The practitioner group was predominantly female (5:2) – as were other clinician interviewees who participated in this study. Gender balance is however broadly aligned to the preponderance of women working in nursing settings. Employers are balanced local authority provided services; community interest companies and NHS Trusts. Whilst one participant is a mental health nurse, all others qualified as general nurses. All have specialisms in inclusion health with an average (where this data is provided) of 5.4 years in the field of inclusion health. Two participants were based in the East of England, one in Wales and one in the West Country but there is no representation in this focus group from clinicians based in the Midlands or the North of England. However, subsequent interviews with practitioners include individuals working in other regions. That several are Queens Nurses indicates a close and ongoing engagement with the QNI and HIHP as does a review of resources on the Homeless and Inclusion Health section on the QNI website, which showcases the work of a number of these practitioners.

Table 10 summarises the demographics of the clinical practitioners who took part in individual interviews.

**Table 10: Demographics of Clinical Practitioners (Interview data)**

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity – where stated</th>
<th>Role/Whether Queen’s Nurse</th>
<th>Duration in current Post</th>
<th>Location of Service</th>
<th>Name of Service if given</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-49</td>
<td>Female</td>
<td>Black Caribbean</td>
<td>Nurse practitioner with people with addictions, and refugee and asylum seekers</td>
<td>12 Years</td>
<td>London</td>
<td>Clinical Trust</td>
</tr>
<tr>
<td>50-59</td>
<td>Female</td>
<td>White British</td>
<td>Homeless and Health Inclusion team</td>
<td>5 years</td>
<td>Northern City (1)</td>
<td>City Community Health Care</td>
</tr>
<tr>
<td>40-49</td>
<td>Female</td>
<td>White British</td>
<td>Lead nurse for the Homeless Pathway Team</td>
<td>1 year (new service) many years prior inclusion health practice. Clinical</td>
<td>Northern City 2 separate city</td>
<td>Hull City Infirmary</td>
</tr>
<tr>
<td>Age</td>
<td>Gender</td>
<td>Ethnicity</td>
<td>Role</td>
<td>Years in Role</td>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>--------</td>
<td>-----------</td>
<td>------</td>
<td>---------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>Female</td>
<td>White British</td>
<td>Nurse for Homeless and Vulnerable Adults, clinical nurse specialist</td>
<td>10 years</td>
<td>Welsh City</td>
<td></td>
</tr>
<tr>
<td>60-65</td>
<td>Female</td>
<td>White British/Australian</td>
<td>Service manager for the GRT project</td>
<td>8 years in current role</td>
<td>South East England</td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>Female</td>
<td>White British</td>
<td>Specialist health visitor: homeless/vulnerable families (QN)</td>
<td>7 years in current role</td>
<td>Outer South London Borough</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>Female</td>
<td>White Irish</td>
<td>Homeless health; wound/tissue viability nurse (outreach/clinic); academic lecturer</td>
<td>12 years – some seconded to current practice role</td>
<td>Inner City London Borough (until 2020)</td>
<td></td>
</tr>
<tr>
<td>60-65</td>
<td>Female</td>
<td>Black African</td>
<td>Homeless Team (Community Clinical Nurse)</td>
<td>13 years</td>
<td>Cross-Borough (South London)</td>
<td></td>
</tr>
</tbody>
</table>

There is once again a relatively restricted age-range of participants amongst clinical practitioner interviewed (age 38–62 years) with the majority being in their 50s (n=4); whilst two each were in their 40s and 60s. Two participants were Black (one of Caribbean and one of African heritage), one interviewee was White Irish and the remainder were White British. All were female. Once more this pattern of engagement may perhaps be assumed to be reflective of the level of experience and collaboration with the HIHP/QNI and confidence in engaging in discussions on HIHP activities as a whole. As with the clinical practitioners focus group, there is some over-representation of London-based practitioners (n=4) although a regional spread can be seen (North of England: n=2; South East England: n=1; Wales: n=2). Respondents are employed by a variety of services funded from relatively diverse sources, including NGOs, community interest companies, primary care trusts (PCTs) and Local Authorities, which enables us to reflect on differences in access to training, resources and delivery of services in rural and urban contexts as well as the impact of being essentially a lone worker, or part of a larger team.
Appendix 7

Demographics of Strategic Leads participating in interviews and focus groups

Tables 11 and 12 illustrate the demographics and roles of specialist senior strategic leads who participated in the study. Typically, and unsurprisingly given the high level of seniority of participants in this aspect of the evaluation, participants held (or had held, multiple very senior roles) and had considerable years of experience in working in Inclusion Health in either a clinical or policy/strategic role. Not infrequently, participants combined both activities, e.g. as clinical lead for specialist services provided both by the NHS and civil society, or policy specialists working with Government departments or professional bodies.

Access to Participants

Having identified a range of potential participants to take part in the qualitative data gathering exercise, with named individuals identified through conversations with the Commissioners, identified by the evaluation team as a result of personal knowledge of the strategic role occupied, and suggestions gathered during team meetings; approaches were then made, initially via the auspices of the HIHP Nurse Lead (as per ethics approval) to a potential group of participants.

As with the clinical practitioners, invitations invited potential participants to express interest in taking part in the evaluation by directly contacting the lead researchers. The invitation was sent to a larger pool of potential strategic lead participants than was ultimately obtained (potential participants blind copied into an email to the researchers, enabling potential participants to confirm if they were willing to take part in the evaluation whilst ensuring that they received participant information sheets, consent forms and other materials (see Appendices 1–4) to aid their decision making process).

In a number of cases it took some time for participants to confirm attendance at the focus group and in those cases, or where someone indicated that they were too busy to participate in a focus group, we offered individual interviews where we felt that it was particularly important to capture their views.

Substitution with other potential participants occurred in two cases. Ultimately, we convened a focus group of nine participants and also carried out four individual interviews (comprising five individuals as one interview had two members). Two participants in the focus group were directly connected to/employed by the QNI in their current roles but their prior and additional activities and ability to engage in dialogue with strategic leads and carefully monitored engagement with the research process meant that we are confident that no undue influence occurred as a result of their participation in this aspect of the evaluation study. Focus groups and interviews took place between October and December 2020.
### Table 11: Focus group demographics – Homeless Health Programme Strategic Leads

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Role</th>
<th>Role duration</th>
<th>Organisation</th>
<th>Location</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>61–70</td>
<td>Male</td>
<td>GP background</td>
<td></td>
<td>Pathway Charity</td>
<td>Medical Director</td>
<td>White, British</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Secretary</td>
<td></td>
</tr>
<tr>
<td>51–60</td>
<td>Female</td>
<td>Nursing background</td>
<td></td>
<td>Pathway Charity</td>
<td>Nursing Fellow</td>
<td>White, British</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Homeless Health Nurse Lead</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Queen’s Nursing Institute</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>London Network of Nurses and Midwives</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Homelessness Group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>City of London</td>
<td></td>
</tr>
<tr>
<td>51–60</td>
<td>Female</td>
<td>Policy Manager and Director of Advocacy</td>
<td></td>
<td>Homeless Link</td>
<td>Director of Advocacy</td>
<td>Greek</td>
</tr>
<tr>
<td>51–60</td>
<td>Female</td>
<td>District Nurse background</td>
<td>2.5 years (extensive prior general community nursing experience)</td>
<td>Queens Nursing Institute</td>
<td>Groundswell</td>
<td>White, British</td>
</tr>
<tr>
<td>41–50</td>
<td>Female</td>
<td>Director of Advocacy</td>
<td></td>
<td>Groundswell</td>
<td>Groundswell</td>
<td>White, British</td>
</tr>
</tbody>
</table>
Table 12 provides information on the demographics and roles of those strategic specialists who participated in individual interviews.

**Table 12: Demographics of Strategic Leads (interview data)**
<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity – where stated</th>
<th>Role</th>
<th>Duration in current Post</th>
<th>Location of Service</th>
<th>Name of Service if given</th>
</tr>
</thead>
<tbody>
<tr>
<td>50-59</td>
<td>Female</td>
<td>White British</td>
<td>Professional Lead for Public Health Nursing</td>
<td>Post 2012 into post re change of system</td>
<td>National Role</td>
<td>Royal College of Nursing (RCN)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30 years of nursing – (community predominantly, health visitor, midwife qualified, GP practice, community set-up) current post date unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td>Female</td>
<td>White British</td>
<td>Professional Lead for Community and End-of-Life Care.</td>
<td>40 years nursing – community throughout qualification. DN: Palliative care, education role</td>
<td>National role</td>
<td>(RCN) [joint interview]</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Currently training as a sole midwife, so an end-of-life care doula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>Female</td>
<td>White British</td>
<td>Partnerships Manager for St Martin’s Frontline Network</td>
<td>3.5 years</td>
<td>London</td>
<td>St Martin’s Frontline Network</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10 years in homeless sector in Cambridge + international work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-65</td>
<td>Male</td>
<td>White British</td>
<td>Health background (unspecified)</td>
<td>Extensive (unspecified)</td>
<td>Throughout England, but focused in mainly urban areas: Bristol, Bath, Oxford, Reading, Brighton, Essex, and many services in London</td>
<td>St Mungo’s</td>
</tr>
</tbody>
</table>
Although we did not capture full data on years of experience in the inclusion health sector, based on information on prior roles and/or clinical practice history, we believe that participants had an average of 18 years of working in a senior inclusion health policy related strategic role and in some cases, considerably longer. Several practitioners referring to community-focused experience ranging over 30 years.

We did invite participants from a wider range of localities than took part in the evaluation in an attempt to capture strategic issues and suggestions for expanded working with the Homeless and Inclusion Health Network/QNI impacting those in non-urban areas and from outside London.

Although this would have been preferable based on findings from clinical practitioners and survey data, it was not particularly successful as a strategy with the majority of senior strategic leads being based in London and the South East. Perhaps unsurprisingly, given the seniority of participants in this aspect of the evaluation, a number of potential interviewees declined to take part in a focus group or were not able to find time to be interviewed, further limiting the diversity of the cohort. However, we do not feel that this in any way diminishes the quality, validity and reliability of data obtained, given the richness of experience, strategic and policy knowledge, and seniority of those who agreed to take part.