GIG CYMRU NHS WALES

Iechyd Cyhoeddus Cymru
Public Health Wales

Health Inclusion Programme Wales

Description of services providing Primary Health Care to vulnerable groups across Wales

March 2024

Developed by The Primary Care Division, Public Health Wales
in collaboration with the Health Inclusion Nurses Network for Wales

Health Inclusion Programme Wales

CASE STUDIES - Description of Services in Wales

The new Health Inclusion specification for clusters describes services for people who might not be accessing primary care services in Wales despite the increased need.

There are many excellent services across Wales that would come under the category of 'Health Inclusion.'

The services in different parts of Wales have different histories and designs.

Not all areas of Wales have services.

Common themes:

- Multidisciplinary and collaborative in both planning and delivery, including people with lived experience.
- Services combine drop-in, outreach and in-reach with a non-judgemental, trauma-informed approach.
- Funding is often short-term and insecure.
- Accessing certain services including oral health and dental services, mental health, psychological support, and treatment for complex trauma, is difficult.

CONTENTS

The following pages are a snapshot of services in Wales.
These are constantly evolving. Local areas may be aware of more services.
Please do feedback to us on these.

Cardiff and Vale Health Inclusion Service CAVHIS

Service Description

Nurse-led service for adults experiencing homelessness since 2000

CAVHIS - began as a health screening for asylum seekers, refugees, trafficking survivors, and those without access to public funds.

In 2021, a health inclusion network and needs assessment enabled the remit to be extended to:

- Multiply Excluded Homeless
- High-risk sex workers
- Newly arrived asylum seekers and refugees

Services for Roma, Gyspy & Traveller people and prison leavers will be developed soon..

Service Provided

- Permanent Registration as appropriate for primary health care
- Health screening, including communicable disease, sexual health, physical and mental health
- Holistic need assessments
- Immunisation catch-ups
- Physical and mental health care
- GP Clinics
- Outreach GP clinics
- Community Dental services
- Midwifery services
- Homelessness support

Workforce

- Service Lead B8a
- Physical Health Lead B7
- Nurse Lead B7
- Specialist Midwife B7
- Inclusion Health Nurses 4.00 WTE B6
- Health Visitor B6
- Operational Manager B6
- Assistant Operational Manager B4
- Healthcare Support Worker 0.8 WTE B3
- Receptionist/Admin Assistants 2.22 WTE B2
- Admin (Homeless) 0.5 WTE B2
- 21 GP sessions (14 FT, one locum, six non clinical sessions)

Service Volume and Caseload

- 700-1000/ year, expected to go up to 3,500

Lessons Learnt

- Identify key enablers and allies at strategic and operational levels.
- Create a shared vision and values among partners and stakeholders
- Establish a system-wide governance and leadership
- The availability of allied services is critical when developing care models considering roles, skill mix, and complexity.
- Start with a clear understanding of population health in the local context
- Use structured assessment templates to improve the consistency of screening and case finding.
- Use consistent coding to improve data quality and enable audit and evaluation

Specialist Mental Health & Substance Misuse Housing Outreach Service Cwm Taf University Health Board

Service Description

The service was set up in 2020, initially in Taff Ely cluster. It is a collaboration of housing leads from Merthyr, Rhonda Cynon Taf (RCT) and Cwm Taf Health Board, coordinated through the Regional Planning Board. It is a specialist mental health and substance use service.

Nurse-led health service comprises the three local authorities RCT, Merthyr, and Bridgend. Working in collaboration with the Health Board and 3rd Sector organisations.

Groups supported include:

- People experiencing homelessness
- Prison leavers and those in the criminal justice system
- Substance and alcohol use
- Other vulnerable individuals
- Sex worker-specific service 'clinic in a box.'

Service Provided

- Weekly Drop-in Sessions (RCT and Merthyr)
- Sessions led by Psychiatric consultants on Monday and Friday
- Health assessments
- Trauma-informed counselling
- Independent Domestic Violence Advocacy
- Harm reduction, overdose awareness
- Diversionary Activities which meet the needs and interests of individuals
- Service Involvement Group (SIG)
- Employment Service (In & out of work support and peer mentoring)
- Breakfast runs established in Bridgend
- Social worker pilot (RCT)

Workforce

- 1 Team Coordinator WTE
- 2x admin support
- 3x B7 WTE, Nurses
- 4 x B6 WTE, Nurses
- 4x B3 WTE (two Health Care Support Workers and two Barrod Support Workers)
- 1 Social worker WTE (Pilot for RTC only)

Service Volume and Caseload

- 502 referrals/ year

Lessons Learnt

- Needs assessment demonstrated some people were registered but not accessing care
- Regular face-to-face steering group which brings together all partners, supports service development and creates positive working relationships
- Promote the role of outreach to ensure and sustain the delivery of care to vulnerable individuals
- Outreach work focuses on building trust and support of individuals to overcome barriers to engaging with healthcare
- A joined Multi-agency approach with 3rd sector, Health and Local Authorities is crucial to maximise the service for the individual

Homeless Health Service
Swansea Bay University Health Board

Service Description

Homeless service initiated by Cyrenians 20 years ago.

The Homeless Health Service provides nurse led, practice-based, outreach and in-reach (hostels, B&Bs, other temporary accommodation) services in the Swansea area. With the Wallich they provide a "Bus" outreach service for Swansea, Abertawe Medical Partnership provides this nurse-led Local Enhance Service (LES) coordinated and delivered by a dedicated nursing workforce, supported by an enthusiastic and passionate general practice.

Groups supported include:

- People experiencing homelessness
- Also receives referrals for people on probation, complex needs etc.

Service Provided

- Physical health care
- Mental health care
- Trauma support
- Preventative health care including immunisation and screening
- Referral to other health and wellbeing services where needed

Outreach work is a core part of the service.

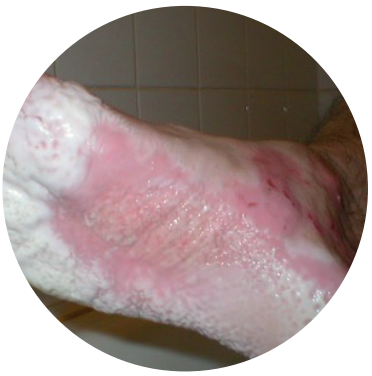
- The nursing team engage and support individuals experiencing homelessness to remove barriers in accessing health care and support

Workforce

- Nurse prescriber 0.8 B7
- Nurse and MH nurse 0.5 B6
- Occupational Therapist support National Lottery supported therapist working across services and areas

Service Volume and Caseload

- Numbers are not yet known (estimate 300 a year)



Lessons Learnt

- GP engagement and support drives the service
- Well established agency working enables services to come together and provide complete, person-centred health care
- Health Board executive support is a key enabler
- Outreach work supports individuals to overcome barriers in engaging with healthcare
- No specific GP time – fits around the clinic.

Neath Port Talbot Homeless Health Service
Swansea Bay University Health Board

Service Description

Based on the Swansea model, this nurse-led service started in Neath Port Talbot (NPT) in 2024.. The Rosedale Medical Group provides the Local Enhanced Service for NPT and has three practices across Neath, Briton Ferry, and Port Talbot that offer homeless health provision.

Practice-based, assertive outreach and in-reach healthcare.

Nurses also collaborate with the Wallich to offer a "Bus" outreach service.

Groups supported include:

- People experiencing homelessness

Service Provided

- Physical health care
- Mental health care
- Trauma support
- Preventative health care, including immunisation and screening
- Referral to other health and wellbeing services where needed

Outreach work is a core part of the service.

- The nurse engages and supports individuals experiencing homelessness to remove barriers in accessing health care and support

Workforce

- Nurse 0.4 B7 WTE
- Therapist support funded by National Lottery working across services and areas

Service Volume and Caseload

- Numbers are not yet known

Lessons Learnt

- Mental Health specialist support is essential. Currently NPT do not have this provision despite it being a significant need for individual experiencing homelessness
- Well established agency working has supported the smooth development of the NPT service
- When developing services consider needs up front and put things in place at the start
- Health Board executive support is a key enabler

Swansea Bay Health Access Service for Asylum Seekers
Swansea Bay University Health Board

Service Description

Nurse –led service supports individuals going through the asylum seeker process.

It is the first point of contact to connect individuals with relevant healthcare services for their needs and remove system barriers to accessing healthcare and support.

The service routinely uses language line interpreters to overcome the language barrier.

Groups supported include:

- Asylum seekers living in the Home Office provided accommodation.
- Unaccompanied asylum seeker children
- Subsidised asylum seekers living with family/ friends.

Service Provided

- Initial health assessment
- Mental health & Sexual Health assessments & referrals
- Support GP registration
- Third-sector service referrals to support social/emotional well-being
- Safeguarding assessment/referral
    - Modern day slavery
    - Domestic servitude & Domestic violence
    - Female Genital Mutilation (FGM)
    - Child neglect
- TB screening/Mantoux testing/Respiratory clinic referral
- Unscheduled Immunisations
- Coordination with school nurse/midwifery

Workforce

- Specialist Community Public Health Nurse B7
- Specialist Community Public Health nurses 3x 0.6 B6 WTE
- Administrator 1x 0.6 B3 WTE

Lessons Learnt

- Partnerships and multi-agency working is key, provides opportunities to learn and support each other
- Third sector links are crucial
- Outreach work core part
- There needs to be Investment in services that address the health needs of this vulnerable population that face barriers continued in accessing health care.

Sexual Health Outreach Service
Swansea Bay University Health Board

Service Description

The service was established in 2009, undertaken by one nurse covering the Swansea area initially. This nurse led service has developed and expanded since 2012, the sexual health outreach service now supports people across Swansea Bay, Port Talbot and Neath. The service works in partnership with, the prison service, homeless hostels and a range of organisations supporting vulnerable individuals including victims of domestic violence, sex workers, vulnerable children and individuals experiencing homelessness.

Groups supported include:

- Sex Workers
- Individuals experiencing homelessness
- Prison leavers and frequent offenders & Other vulnerable groups

Service Provided

- Sexual Health Screening, including all Blood Born Virus (BBV) and treatment
- Contraception, including the provision of emergency contraception
- Cervical Screening
- PAS Referral
- PREP and PEP
- Vaccinations – Hepatitis B (Hep B), Human Papilloma Virus (HPV)
- Mental health support
- Harm reduction
- Wound care
- Safeguarding
- Housing
- Access to GP

Workforce

- 1x Nurse B7 0.8 WTE
- 2x Nurse B6 0.8 / 0.6 WTE

Service Volume and Caseload

- 500 / year

Lessons Learnt

- Clear pathways for referrals is required
- Reinforce the importance of correct coding
- Promote the role of outreach to ensure and sustain delivery to vulnerable groups
- Requires a dedicated team

Support, Wellbeing, Advocacy and Enablement (SWAN) Project Swansea Bay University Health Board

Service Description

SWAN is a project run by Women's Aid. The project supports women who are sexually exploited in Swansea, aiming to improve the safety and well-being of women.

The service is based in the Swansea Domestic Abuse One Stop Shop, 35-36 Singleton Street Swansea offering 1:1 appointments, outreach provisions and crisis support.

Groups supported include:

- All sexually exploited women in Swansea, including street sex workers, parlour sex work, online and Cam work.

Service Provided

The service offers the following:

- Personal safety advice
- Comdoms, food, clothing and other essential items
- Access to Ugly Muges reporting and alerts to promote safety
- Advocacy and support to address individuals' needs
- Help to report concerns or crimes to the police

Women are also supported to access the following:

- Housing options
- Sexual Health Service
- Mental Health Service
- Drug and Alcohol Agencies
- Sexual Assault Referral Centre

Workforce

- Three support workers 2.5 WTE
- One volunteer coordinator 0.7 WTE
- One administration support 0.4 WTE
- One shift lead 0.2 WTE

Service Volume and Caseload

- 125-190 women/ year

Lessons Learnt

Collaboration and close networking with health and social care, police, council departments and other 3rd sector organisations is the key

Nurse Led Health Inclusion Service
Aneurin Bevan University Health Board

Service Description

Established 2020

Nurse-led trauma informed service collaborating with various health, social care, education and 3rd sector organisations.

Steering Group established, comprising of different healthcare professionals and service user groups, Inclusion Health HB executive lead.

Groups supported include:

- People Experiencing Homelessness
- Roma, Gypsy and Traveller Communities
- Refugee and Asylum Seekers
- Sex workers

Service Provided

- Initial health assessment and follow-up reviews
- Person centred care delivered and adapted to meet individual need
- Assist with registration with General Practice
- Staff trained in Eye Movement Desensitisation and Reprocessing therapy (for PTSD treatment)
- Clinics held at multiple locations to target different groups e.g. Eton house, Pobl, Gwent Drug and Alcohol Service, Schools, General Practice

Workforce

- Senior Nurse- 1WTE B8A
- Mental Health Nurse-1WTE B7
- General Nurses -2WTE B6
- Health Care Support Workers 3 WTE B3
- Administrator 1WTE B3

Service Volume and Caseload

- 1560 / year

Lessons Learnt

- Importance of staff being trauma-informed trained
- Three staff trained in Narrative Exposure Therapy proving an invaluable tool
- Strengths of substantively employed HB staff and cross divisional support
- Monthly team supervision for vicarious trauma and ongoing well-being
- Executive-level support in addition to Public Health team and primary care director

Caerphilly County Borough, Homeless Health Service
Aneurin Bevan University Health Board

Service Description

Established In 2020 by an Advanced Nurse Practitioner and a General Nurse in collaboration with the cluster.

The service is delivered at Oakfield Surgery through a Local Enhanced Service for people experiencing homelessness and not accessing services in Newport.

A whole practice and multidisciplinary team approach, along with Partnership working with homeless charities and councils, ensures all-around care.

Service Provided

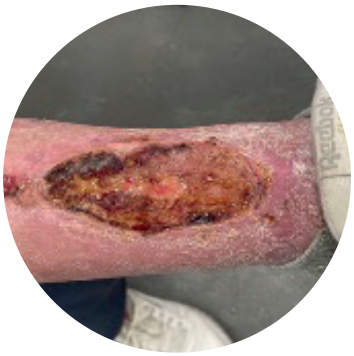
- Open door, non-judgemental service
- Health screening
- Full physical health check
- Full Blood check
- Admin team identify patients' health history by contacting previous GP
- Follow-up appointment arranged to discuss results and additional health needs
- Appointments offered in surgery or outreach
- Signposting to other services and therapies

Workforce

- Advanced Nurse practitioner B8 (0.2WTE)
- Admin support (0.2WTE)
- In addition to the above, patients can be seen by any GPs in the surgery if required.
- Co-developed and informed by experiences of patients

Service Volume and Caseload

- 211 patients since 2020 (121 moved to other areas.
- 90 current patients (permanent)
- Approx. 5 new assessments every month = an estimate of 60 new assessments per year



Lessons Learnt

- 'Hidden Homelessness' is a challenge. If people sleep out of sight in woods or fields, they cannot access services (e.g., A&E) several bus rides away.
- Non-judgemental, passionate and supportive staff are crucial to building trust and creating accessible and acceptable services.
- Think differently about healthcare and access. Talk to patients and partner agencies to co-create services that are fit for purpose.
- Co-production and support from a wide range of organisations is essential to overcome barriers.
- Supportive General Practice colleagues and easy and simple processes and pathways, such as an easy registration process, are critical enablers to a successful service delivery.
- Health Board Executive / Commissioning support enables the security of services.

Community Wellness Model
Betsi Cadwaladr University Health Board

Service Description

The Community Wellness Model includes co-designed and delivered programs for communities in most need. Programs target individuals with complex health and social care needs.

The model is piloted in the East Area of BCUHB, Wrexham and Flintshire and provides support to the following:

- People experiencing homelessness
- People in contact with the criminal justice system (including severe offenders and ex-offenders)
- People with complex or recurring mental ill health and addiction
- Asylum seekers and refugees
- People who are socially isolated

Service Provided

- In reach – 2 hostels
- Open access drop-in- providing activities for social connections, a timetable of therapeutic interventions, e.g. arts, storytelling and nature activities, whilst receiving access to professional health, wellbeing and crisis support
- Health checks, GP time, bespoke wellness programmes
- Primary care and Community-based trauma coaching and counselling – one-to-one and group
- Group programmes focusing on emotional wellness, creative recovery, prevention, education and lifestyle medicine
- Tailored support to severe offenders, mental health patients, refugees, and asylum seekers needing language and learning assistance

Workforce

The service is not currently funded.

2-year pilot identified staff requirements in a £250.000 business case:

- 1 WTE Business Lead
- 1 WTE Clinical Lead
- 1 WTE Operational lead
- 2 WTE Health Inclusion GPs
- 1 WTE Chronic disease nurse
- 1 WTE Community Navigator and Community Champions Lead
- Freelance Therapeutic Interventions Facilitators and Practitioners

Service Volume and Caseload

- Community connection Programme drop-in: 50 individuals/session
- Primary Care Root Cause and Recovery Programme: 200 patients over six months pilot

Lessons Learnt

- Consider Social Return on Investment (SROI) as an approach to evaluating broader impact
- A trauma-informed approach acknowledges some of us with complex needs and individuals in trauma survival states may not be ready to engage in formal clinical settings
- Collaborate with partner organisations to build trust, create partnership approaches, and improve joint planning
- Responsibility and sponsor at board level can help