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OAK FOUNDATION

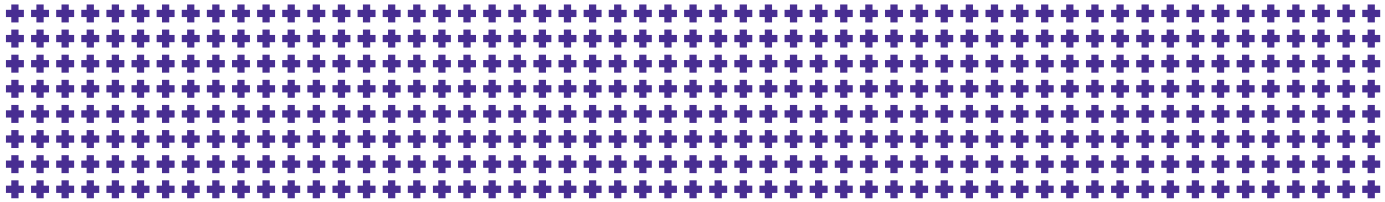
Qni The Queen's Nursing Institute

Homeless and Inclusion Health Programme Evaluation Report 2021

Executive Summary

Contents

Authors: Professor Margaret Greenfields, Dr Zana Khan



Executive Summary

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). (Oak Foundation Grant agreement OCAY-16-524):

Key components consisted of an analysis of respondents to a survey of responses to a survey sent to the 1315 (as of September 2020) members of the homeless and inclusion health network.

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 members of the network 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 Homeless and Inclusion Health Network and the support of the QNI more generally.

Survey findings

An online survey was devised by the Nurse Lead supporting the QNI Homeless and Inclusion Health Network, with input from the Director of Nursing Programmes (Innovation) and evaluators to ensure relevant additional data was captured. This was distributed in September 2020 to all 1315 members of the Homeless Health and Inclusion Network. In total, 55 completed responses were received.

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

- 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')
- 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

Client groups supported

- 69.6% supported people living in hostels
- 65.2% supported rough sleepers
- 63% supported clients with addictions
- 41.3% supported families in temporary accommodation

Role in research and training on inclusion health

7.27% indicated that they are currently involved in any form of research with inclusion health groups
51.8% reported delivering education or training on inclusion health

Key concerns in relation to the respondents' service/professional role

- 94.6% reported that they required access to ongoing professional development or specialist training to support them in their role
- 85% of respondents reported that inclusion health was underfunded in their area
- 53% 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
- 51% of responses indicated uncertainty over future funding and sustainability of their service
- 47% referred to under-staffing or problems recruiting staff

> The peer-to-peer support available through the Homeless and Inclusion Health Programme network was seen as invaluable.

- 37% reported that their line manager was a specialist in, or had knowledge of inclusion health
- 36% indicated they were concerned about lack of training, learning resources and access to continuing professional development CPD

Positive aspects of the respondents' service/role

- 86% felt that they were supported by their management in undertaking their post, however the peer-to-peer support available through the Homeless and Inclusion Health Programme network was seen as invaluable
- 60.7% reported that training and development in inclusion health could be acquired through their employer
- 56% indicated that their service was permanently funded

Value of the HIHP

- 72% indicated that they made direct use of guidance and resources prepared and disseminated by the QNI/HIHP on working with inclusion health groups during the Covid pandemic
- 71% indicated that they had received direct support in their role from the QNI and HIHP in the previous year such as accessing resources, attending training events, conferences or network meetings
- 67% 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
- 52% were directly working for an inclusion health service, and reliant on accessing specialist information, training and knowledge exchange through the HIHP as well as similar professional groupings such as the Faculty for Homeless and Inclusion Health. Having access to good quality resources, training and a network of supportive practitioners was seen by many as extremely important

Continuation of HIHP support by the QNI

- 98% indicated that they wished the programme to continue
- 72% of respondents indicated that they would be interested in applying for the nurse-led inclusion health innovation programme, should this be offered by the QNI again
- 58% indicated that the programme was 'vital' to their work
- 37% indicated that it was 'very important' to their role
- 5% indicated 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.

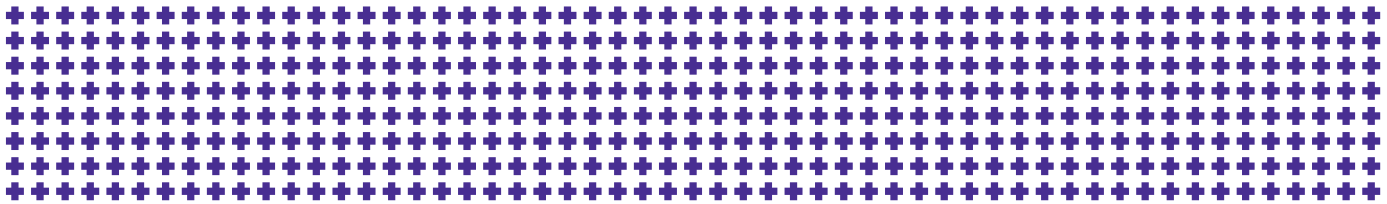
Focus groups and interviews with frontline clinicians and strategic leads

One focus group (n=6) and a total of 10 individual interviews were undertaken with frontline 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 consider their views on the value of the HIHP overall.

First contact with the QNI/Homeless and Inclusion Health Network and duration of contact

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, whilst the majority of other respondents cited word of mouth recommendations about the HIHP network from colleagues or on a few occasions coincidental contact at a conference or event.

The role of the HIHP Nurse Lead has been strongly identified as supporting dynamic growth of the Network and Programme more widely, 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.



Participants 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 that they would find difficult to access otherwise. There is a perception that the quality of supportive relationships offered by the HIHP/QNI team is unique.

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 HIHP more generally. Particular mention was made of the value of the Special Interest Groups in which sub-groups of network members meet to explore particular challenges and issues impacting certain client groups, e.g. Gypsy, Roma, Traveller, Boater and Showmen services users and families experiencing homelessness.

The importance and added value to their role of 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.

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 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.

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 how such opportunities had improved the service delivered to clients as a result of these opportunities.

Participants in localities that were more isolated from the central hub of London were particularly likely to refer to the value of being able to contact the HIHP Nurse Lead for advice, support and access to specialist knowledge or contacts.

Special interest groups/specialist sub-networks and the provision of both clinical information sharing and 'moral support' were frequently mentioned by attendees, which is testimony to the high value that is placed on the HIHP/QNI's support for these activities.

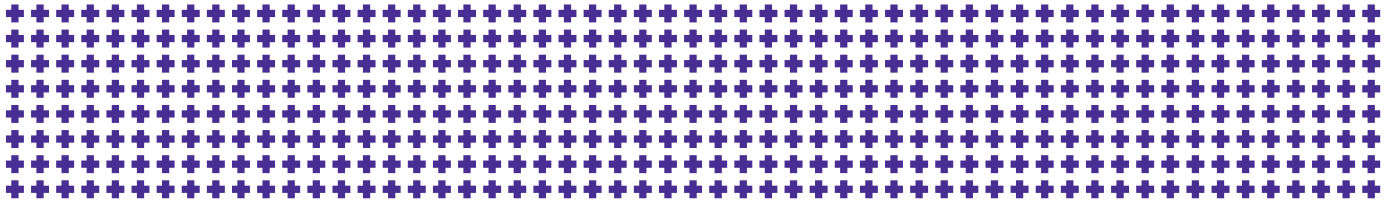
Value of the HIHP

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.

Over and above the learning opportunities provided by conferences and networking opportunities, 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.

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 the perception that working with some groups was perceived of as stigmatising, was also discussed. As such, this slightly 'outsider status' in relation to clinical work, even sometimes when compared to other community nurses, underlined



the benefits articulated earlier, of membership of a specialist network of 'like-minded practitioners'.

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. However, approximately 60% of participants referred to their non-inclusion health peers as lacking a general understanding of the holistic and complex nature of their role.

The HIHP as a nurse-based resource or open to other professions
Amongst the clinical focus group there was an emphasis on retaining the HIHP as a specialist nurse-focused programme. However, a sub-group of respondents reflected on the potential and importance of expanding the network and offer to include other professions.

Clinicians' opinions on the most useful and effective elements of the HIHP
Participants 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.

Out of the 10 seed-funded nurse-led homeless and inclusion health projects funded under the auspices of this programme, only one of the projects would have commenced without HIHP support (Bryar, 2020). Seven have received ongoing funding based on the success of the projects, whilst three have further expanded their service and remit.

Respondents who had been actively involved in seed-funded innovation projects stated that without the QNI/HIHP support, their innovation project work would not have taken place. These funded projects have had considerable reach, and enhanced the lives of numerous service users, as well as facilitating the exchange of specialist knowledge.

The overall suite of activities funded by the HIHP has created a standard of best practice and acts as a catalyst for enhancing inclusion health good practice and education.

Dissemination of learning/access to specialist practitioners
Five out of the 10 funded nurse-led innovation projects had demonstrable national level impacts on inclusion health. This 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.

Impacts on clinical practice arising from membership of the HIHP
Participants referred to how learning about effective interventions had influenced their own practice or supported the development of new spin-off activities, such as 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 opportunities that arose through the HIHP encouraged them to

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

pursue opportunities to create networks of interdisciplinary practice with Non-Governmental Organisation (NGOs), local authorities, housing and education officers, as well as clinical practitioners.

Formal educational opportunities
Practitioners who had received QNI/Company of Nurses funding to participate in the University College London (UCL) Inclusion Health Module 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, through which participants engage in learning opportunities and then develop and share materials for use by other HIHP members.

The inclusion health module formed part of the curricula of a Level 7 (Master's Degree) programme. There was a requirement by the QNI that to be eligible for funding, participants should already be nursing graduates. This threshold qualification could be seen as a barrier to learning for older, highly experienced nurse practitioners who were not graduates.

Suggestions for improvements
An overwhelming majority of participants stated that all that was required was 'more' of what they were receiving from the HIHP.

Several respondents commented that there is only one one staff member focused on the HIHP (HIHP Nurse Lead)), who works part-time, and thus indirect impact on service users could be enhanced through additional resourcing, as well as stressing the need to consider succession planning in due course.

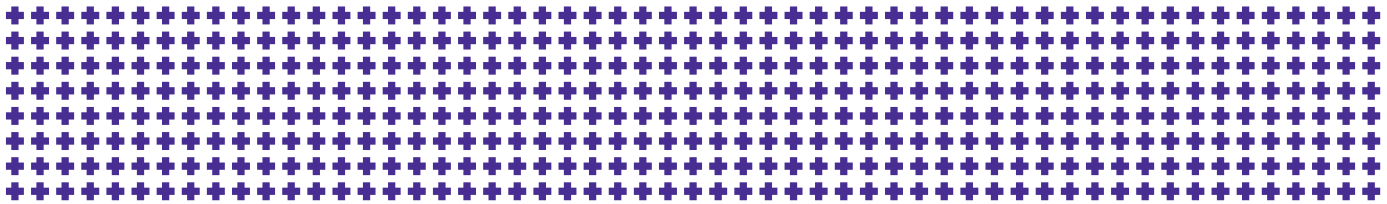
It was emphasised that it would be extremely helpful to develop resources and foreground homeless health matters impacting Black, Asian and Minority Ethnic (BAME) service users (and also staff). The theme of resources tailored to specific cultures and communities also emerged quite strongly in interviews and focus groups.

To further upskill special interest groups (especially for those practitioners working in isolation), it was proposed that online lectures or experts/specialist speakers should be included, particularly for frontline staff in widespread geographical locations.

A further suggestion was for the development of 'bite-sized' videos, as well as 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.

The impact on respondents, service user and other practitioners, if the HIHP was not funded
There was some sense of anxiety articulated by a number of participants should the HIHP cease to exist if funding to support the activities was no longer available.

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. The strongest impacts and concerns were noted by those individuals outside of London, and those who were particularly reliant on the HIHP for access to up-to-date training, support and resources.



Additional developments within and across special interest networks
A number of respondents (n=4) made specific requests/suggestions on the ways in which the existing special interest groups could be developed, or expanded to provide opportunities for non-clinical specialists such as policy agencies to attend/speak at such network meetings. One respondent also requested hearing from individuals who had lived experience of service use, within focused and themed sub-group meetings.

A mechanism whereby practitioners working with quite diverse communities of service users from across the inclusion health categories, could be linked into specialists with 'specific groups' was also mentioned as desirable by several respondents.

Expansion of service/marketisation of the HIHP
The need to raise awareness more generally about the QNI and HIHP was mentioned on a number of occasions in interviews and focus groups.

One respondent stressed the need for voluntary outreach groups to be able to access high-quality training which could they felt potentially be delivered by the QNI. Access to funding to seed-fund or support projects working with particular communities was also felt to be helpful.

Another interviewee advocated for the HIHP to create and develop links to universities who offer nursing training, so as to embed good practice and awareness of inclusion health at the pre-registration stage.

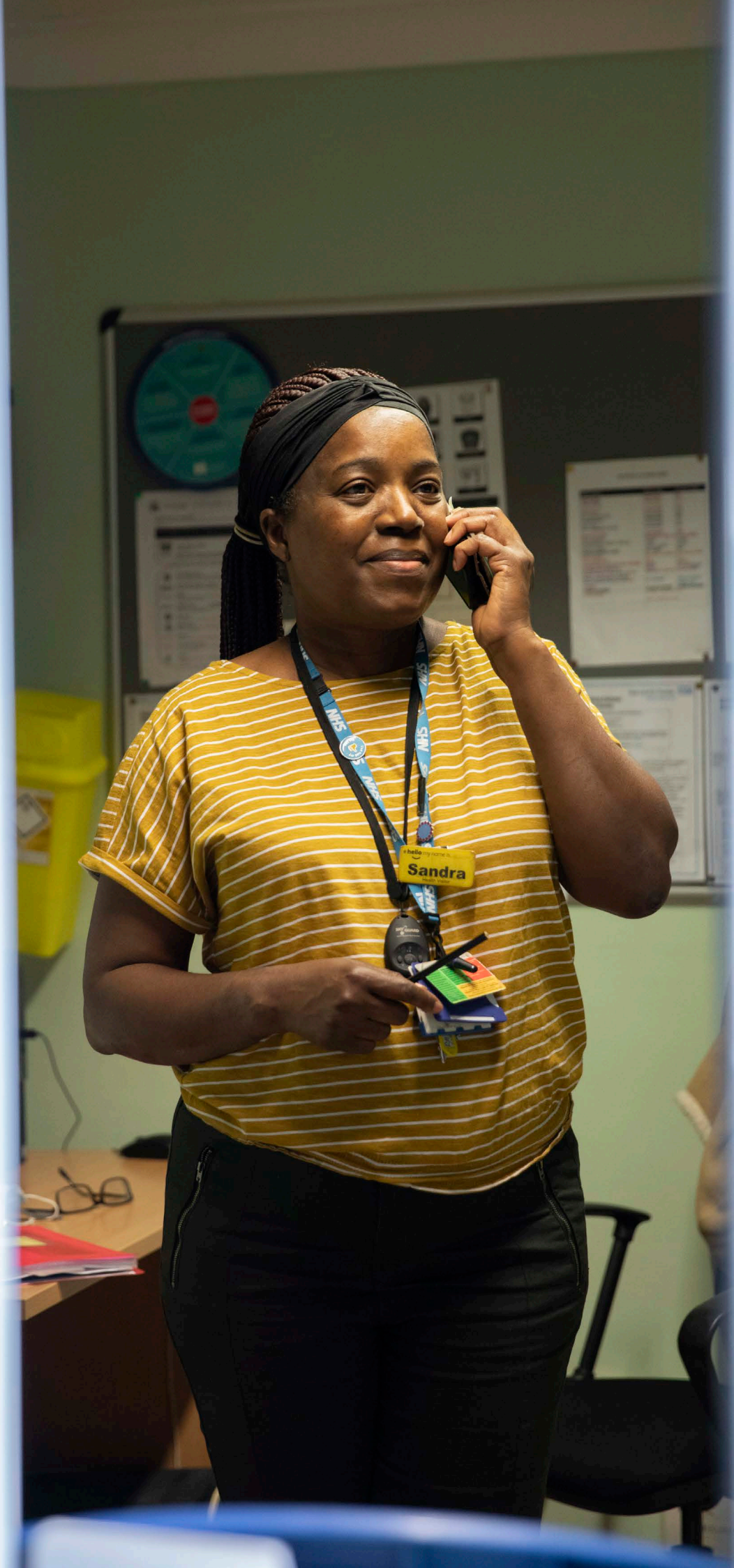
Strategic leads/policy focused practitioners' findings

A second focus group with nine key strategic leads from major external agencies was also held. In addition, four interviews with strategic leads (n=5) as one interview involved two participants) took place. This focus group and interviews were 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 for the Programme cease.

Duration of contact with the QNI/HIHP
Strategic leads (other than two health professionals who had been closely linked to the HIHP since inception in one case, being the co-initiator of the programme) had typically became aware of the HIHP as a result of word of mouth professional contacts, or encountering the QNI at a conference; confirming the impression that the HIHP could increase their reach and networks by organising a strategic campaign to raise awareness of the services offered.

Access to website resources/newsletter
There was a strong emphasis amongst strategic leads 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 HIHP 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.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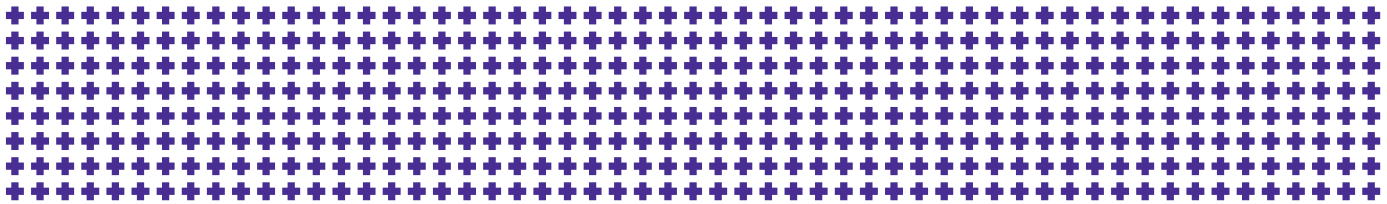


Conferences and special interest group events
NGO strategic leads largely suggested that this aspect of the HIHP offer was seen as too clinical and specialist for their staff members, requiring perhaps a more generalist 'on the ground' approach to be more accessible for non-clinicians.

In contrast, clinically trained strategic leads 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 and Inclusion Health.

Further, amongst clinicians in strategic roles there was a dual focus on the value of the network 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.

Developing and foregrounding nurses' experience
The theme of perceived hierarchies and that nurses' voices may be suppressed or over-ridden by doctors or senior managers 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.

Stigmatisation and precarity
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. Thus, having a very old and deeply respected body such as the QNI championing 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.

Value of the HIHP to other stakeholders and potential to expand the HIHP membership
There was a strong focus on moving beyond expanding the HIHP to specific clusters of practitioners who are working broadly in related community fields but who are not closely engaged with the Homeless and Inclusion Health Network to effectively working to mainstream inclusion health throughout the sector.

It was also acknowledged that there is a need to ensure that the emphasis on Inclusion Health as a nursing specialism is retained within the HIHP, to avoid 'disenfranchisement' of highly experienced and dedicated inclusion health nurses.

Some participants flagged up the importance of retaining separate organisations largely focused on different disciplines, e.g. broad inclusion issues, delivery of accommodation, nursing, etc. rather than developing a larger centralised collective, whilst simultaneously emphasising the value of bringing different perspectives to lobbying and policy development discussions.

Specific suggestions for developing the HIHP
It was suggested that invitations were sent to include a small number of named NGOs whose work had synergies with particular special interest groups as a way of expanding and developing the HIHP and adding value to the work of particular sub-groups.

> It was identified that there is relatively limited visibility of the HIHP offer for those who are outside specialist practitioner networks, or who are not explicitly introduced to the QNI's work.

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 seen as an area for future development.

The precarity of homeless and inclusion health 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 especially ethnically diverse communities including vulnerable migrants, refugees and asylum seekers.

Visibility of the HIHP and suggestions for enhancing membership/public knowledge of the HIHP
It was identified that there is relatively limited visibility of the HIHP offer for those who are outside specialist practitioner networks, or who are not explicitly introduced to the QNI's work through strategic group membership.

It was noted that because of short-term and limited funding, the role of the HIHP Nurse Lead was inevitably constrained. Within these constraints, it was therefore seen as extremely challenging to grow visibility and membership of the programme further.

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 of the broad HIHP. Additionally, it was proposed 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.

The concept of linking the QNI/HIHP into pre and post registration training was again highlighted.

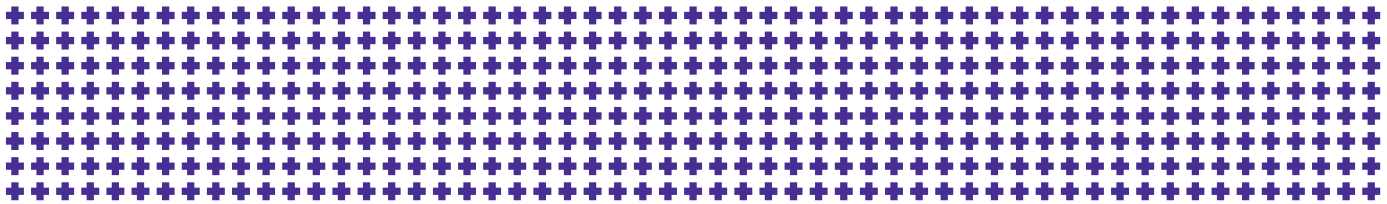
Participants emphasised that without having a dedicated resource, which included marketing and a social media drive, it was necessary to opportunistically publicise the inclusion health work of the QNI whenever possible.

Future direction of the HIHP
There was an emphasis on the need to maintain the production of the highly valued resources, to ensure ongoing financial and practical support for the Homeless and Inclusion Health Network and to ensure the longevity of special interest groups and growing sub-groups, including mental health and [working with services users with] TB.

The role of the QNI in foregrounding policy and making use of their excellent networks to develop and disseminate evidence-based knowledge was also highlighted as an area to be continued and developed throughout the sector.

A major area for expansion which was the subject of considerable interest, was the opportunity 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 to aid them in recognising particular health conditions or basic care.

Provision and delivery of rapid response type specialist training impacting inclusion health groups was suggested, 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.

It was noted that there is clear scope to expand on detailed specialist consultancies engaging with transferable models of expert knowledge and development of services in other regions and localities in the UK away from central hubs which may already have greater resources and expertise available.

There are relatively large gaps in coverage where membership of the HIHP is low and potential exists to both expand the network of members in those areas, as well as delivery of training and supporting service expansion by working with commissioners.

The lack of security in relation to funding and limited capacity within the QNI was highlighted, with QNI staff members emphasising that it would be possible to expand and develop their work more effectively if funding existed to enable the HIHP Nurse Lead to be employed for additional days.

Collaborative working with other organisations/strategic partners
Participants suggested encouraging greater awareness of the HIHP amongst their networks and to potentially share opportunities, for example inviting 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 HIHP has already foreseen this potential, 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.

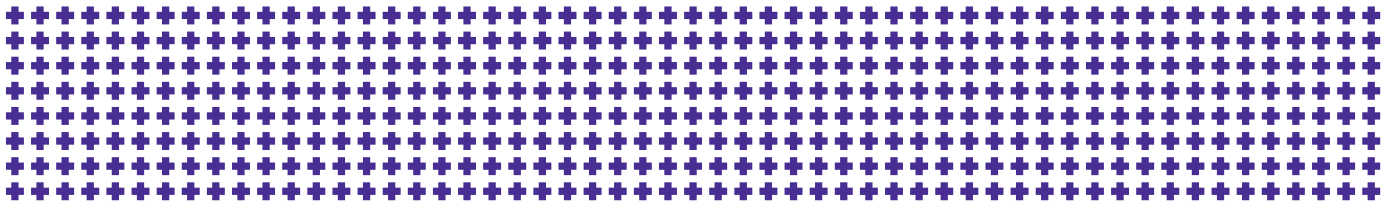
Perceived impact on the sector should the HIHP cease to operate
Participants were adamant that they considered it important that the high-quality service provided by the HIHP should continue.

When asked to consider to whom practitioners could be referred should the HIHP come to an end, there were limited recommendations made, (predominantly Pathway, London Network of Nurses and Midwives Homelessness Group) and these did not cover all areas of the UK.

The key challenge to maintaining the service was clearly identified as the problem of obtaining sustainable funding, and the push-back from Central Government/NHS in relation to funding the service. Considerable debate arose over the fact that Central Government argued that charitable support was required to ensure the delivery of services such as the HIHP, whilst conversely, 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 with little clarity over where funding would come from once a particular grant programme ended.

Despite this, it was stressed by the Director of Nursing Programmes (Innovation) at the QNI, that even in a worst case scenario, in recognition of the critical importance of the HIHP and Network, the service would somehow manage to operate at a basic level, although not with the level of support and activity currently convened by the HIHP Nurse Lead.

Future ambitions for funding the HIHP
Representatives from NGOs all commented on the problematic nature of obtaining sustainable funding within their sector.



There were mixed views on whether it was more desirable for the HIHP to be funded from statutory service monies, with many participants noting the value of being an independent voice able to lobby for change around inclusion health, which it was felt would be more difficult should inclusion health work come on-stream as a Central Government funded workstream.

Following some considerable discussion 'blended funding' was the preferred option going forward, whereby the HIHP would be core-funded by a central Government grant, but additional income could be 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.

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
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 HIHP.

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.

Although staff capacity and resource remain exceptionally constrained, regular meetings have taken place throughout the period of the pandemic in particular, with online group meetings and ongoing email and phone support provided by the HIHP Nurse Lead being widely acknowledged as especially impactful in relation to rapid dissemination of knowledge and best practice in supporting particular groups.

The reduction in isolation and stress afforded by membership of the network and attendance at special interest group meetings was highly appreciated by practitioners, particularly those who are lone workers and clinicians who are isolated from other larger clusters of inclusion health practitioners or based outside urban areas.

Additional funding to support the work of the HIHP more generally would support development of the learning network and assist in the growth of regional sub-groupings of specialists.

All participants stated that the free-to-access, high-quality and up-to-date resources provided by the QNI are exceptionally valuable for professionals working in inclusion health – specialist information would not have been otherwise available to them. It was repeatedly emphasised that new resources are regularly and responsively developed to meet the needs of practitioners and highlighted in the strategic lead focus group that professional bodies such as the RCN, Pathway and leading NGOs routinely use such materials and direct network members to the QNI resources.

> 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.

One especially strongly identified added value of HIHP membership consists of the growth of a coherent professional identity as inclusion health specialists, which participants in all interviews and focus groups 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 was highlighted 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.

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

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.

There is already a generally high level of working with other key agencies, although often other organisations and professional bodies rely on the 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 is the lack of staff capacity and the degree of stretch.

A tension can be seen to exist between the desire for the QNI/HIHP network and programme to remain a free-to-access professional network that provides resources for practitioners at no cost and the lack of core funding to support the HIHP.

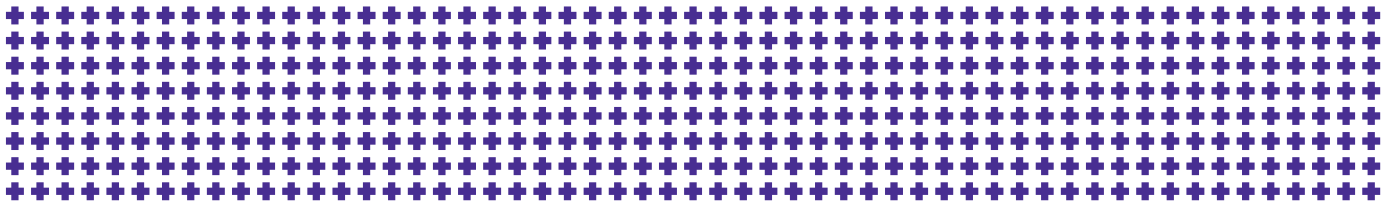
There is a challenge involved in striking a balance between maintaining an independent (at times critical) professional voice on inclusion health, and the impact should the QNI receive core, central Government funding for their health inclusion work. That a core stream of inclusion health work is seen by external funders as the responsibility of central Government and statutory agencies has created a particular lacuna in access to funding to support the HIHP. There may be some limited potential for funding to come on-stream in the future, although this would need to be linked to tailoring service provision and meet the needs of newly developing policy and practice opportunities.

All of these activities would, however, require access to greater resource to support the HIHP 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 HIHP 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.

Recommendations for the HIHP

There is a need to obtain core funding to support the HIHP. Ideally this will permit a full-time role (or job share) to support the HIHP Nurse Lead to grow the network and increase income and impact generating activities.

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. Consideration could also



be given to provision of funded internships to work with the HIHP Nurse Lead. Given the complexity of the role, it is fundamentally important going forward that the HIHP Nurse Lead role continues to be held by an experienced nurse practitioner with a high level of experience and knowledge of the sector.

There is a very clear need to enhance awareness of the QNI and the HIHP. Expanding and developing public awareness of the HIHP and resources will require dedicated time and human resource, 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 HIHP within pre- and post-registration training and through dissemination activities e.g., publications in professional journals etc.

It is recommended that there is a need to increase visibility of the diversity within inclusion health work of the QNI and to ensure greater visibility of BAME service users and staff as well as enhanced emphasis on intersectionality in resources, training and network development.

It is also strongly recommended that there is a need 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/HIHP membership further, given the lack of visibility and voice of many BAME health professionals within this particular discipline.

Outreach to wider groups of nurses beyond those working in community settings is needed. 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 HIHP if they are not Queen's Nurses, given that some lack of clarity was found to exist over the parameters of membership of the HIHP, or ability to apply for support for undertaking training modules.

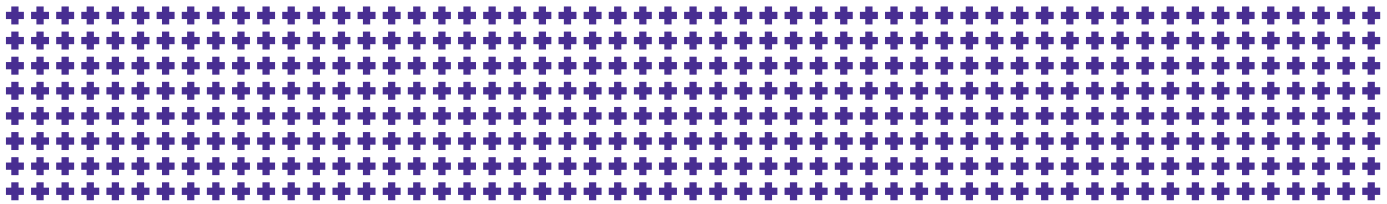
There is a clear potential to expand and focus on regions with low levels of engagement in the HIHP. In turn, developing new regional sub-groupings, may also encourage special interest group meetings to take place with input from NGOs and commissioning groups, local commissioners and local authority networks, which over time may support income generation through delivering training, consultancies or strategic developments at local and regional levels.

It is strongly recommended the use of online meetings/conferences is continued post-pandemic, given restrictions on funding for travel and work-stretch impacting inclusion health practitioners.

It is recommended that work is undertaken to enhance engagement across the nations of the UK, as well as exploring internationally.

The QNI website should ensure that inclusion health resources are more visible and accessible. 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. In response to this recommendation we are aware that since earlier drafts of this evaluation were prepared, the QNI website has been reviewed and the HIHP


hello my name is...
Kendra
Nurse Practitioner
NEXT GENERATION NIGHTINGALE
Guy's and St Thomas'
NHS



materials are compiled in a single section linked to the mainsite. QNI staff have identified that a separate micro-site (should resources become available) would enable the HIHP materials to be most effectively showcased.

A clear strategy of collaborative working with other key agencies should be developed, including reaching out to practitioners working in social care agencies, as well as volunteering with NGOs, charities and other organisations.

Training and development should be further developed, including 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 the Royal Colleges, including 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 etc.

Elements of the training, such as consideration of the social determinants of health and relevant datasets, as well as clinical care, should be made more accessible to a wider range of nurses and other specialists, linked to an increased emphasis on marketing of the HIHP offer.

Income could be generated 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 HIHP Nurse Lead role. The network of consultants would need to expand to provide expertise at a competitive commercial rate.

Collaborative funding applications for research with other key agencies or universities could be developed, as well as exploring opportunities from new streams of funding through central Government.

A renewal of the seed-funding for nurse-led inclusion health innovation projects should be reintroduced, finances permitting.

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 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, with 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.

The Queen's Nursing Institute
1A Henrietta Place
London W1G 0LZ

020 7549 1400
mail@qni.org.uk
www.qni.org.uk

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Patron HM The Queen