Burdett Trust for Nursing

Qni The Queen's Nursing Institute

Supporting People Experiencing Homelessness with Diabetes

Guidance for nurses and allied workers

The Queen's Nursing Institute

The Queen's Nursing Institute is a charity dedicated to improving nursing care for patients at home and in the community.

We work with nurses, managers and policy makers to make sure that high quality nursing is available for everyone in their homes and communities. Our aim is to ensure that patients receive high quality care when and where they need it, from the right nurse, with the right skills.

Today we improve nursing in the home:

- By funding nurses' own ideas to improve patient care and helping them develop their skills through leadership and training programmes.
- Through our national network of Queen's Nurses who are committed to the highest standards of care and who lead and inspire others.
- By influencing government, policy makers, and health service planners, and campaigning for resources and investment in high quality community nursing services.
- By supporting community nurses working with people who are homeless through our Homeless and Inclusion Health Programme which provides news, guidance and workshops.
- By listening to nurses and developing resources and guidance to support them.
- By offering financial assistance to community nurses in need and providing grants for community nursing courses.
- By encouraging social interaction between current Queen's Nurses and retired Queen's or community nurses through our telephone project, 'Keep in Touch'.

Contents

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With thanks to:

Introduction

This guidance was produced at the end of a 15-month (April 2023 – June 2024) Burdett Trust for Nursing funded collaborative project which examined ways to improve the nursing and allied health care of people experiencing homelessness with diabetes.

The guidance accompanies a Fairhealth E Learning module and Pathway report that were also produced as a result of the project.The steering group for the project involved Inclusion Health and Specialist Diabetes Nurses, a Diabetes Consultant, a Specialist Inclusion Health GP, a Dietician, an Optometrist, a Podiatrist, an Occupational Therapist and Experts by Experience.

Brief overview of diabetes

Diabetes is a condition caused by a lack of insulin or a reduced ability to respond to insulin. This causes a person's blood sugar to become too high. Insulin is a naturally produced hormone in the body that helps maintain blood sugar levels and moves sugar from the blood into the organs and tissues where and when it is needed. When blood sugars are high, sugar levels in the organs and tissues are low, and this can create both short- and long-term problems. The proportion of adults with doctor-diagnosed diabetes in the UK was 7% among men and 5% among women in 2021 (NHS Digital, 2021).

The symptoms of diabetes are:

- Passing urine frequently, especially at night.
- Feeling really thirsty.
- Feeling more tired than usual.
- Losing weight unintentionally.
- Genital itching or thrush.
- Cuts and wounds taking longer to heal.
- Blurred eyesight.
- Increased hunger.

There are two main types of diabetes. However, there are other types including Type 3c and gestational diabetes.

Type 1 diabetes

Type 1 diabetes – This is a genetic condition where the body's immune system attacks and destroys the cells that produce insulin

Type 2 diabetes

Type 2 diabetes – This condition occurs when the body stops producing enough insulin, or the body's cells stop reacting to insulin properly. This generally happens in later life and is usually associated with an increase in body weight but not always.

Type 3 diabetes

Type 3 diabetes – This type of diabetes occurs because of an illness or condition that affects the pancreas. The pancreas is the organ that produces insulin, and some digestive enzymes. In this type of diabetes people have a combination of both high sugars and malabsorption. This type of diabetes is also called pancreatogenic diabetes mellitus.

Gestational diabetes

Gestational diabetes – If someone develops high blood sugar during pregnancy this is known as gestational diabetes. This usually goes away after giving birth.

In the general population of the UK, over 90% of all adults with diabetes have Type 2.

‘There is evidence that there are higher rates of both Type 1 and Type 3 diabetes in homlessness populations than in the general population.’

However, there is evidence that there are higher rates of both Type 1 and Type 3 diabetes in homelessness populations than in the general population.

Complications of diabetes

Having diabetes increases the risk of acquiring many other health conditions including heart disease, stroke, dementia, nerve damage, foot ulcers, blindness, chronic kidney disease, skin problems, blood circulation difficulties, muscle wasting and damage to joints.

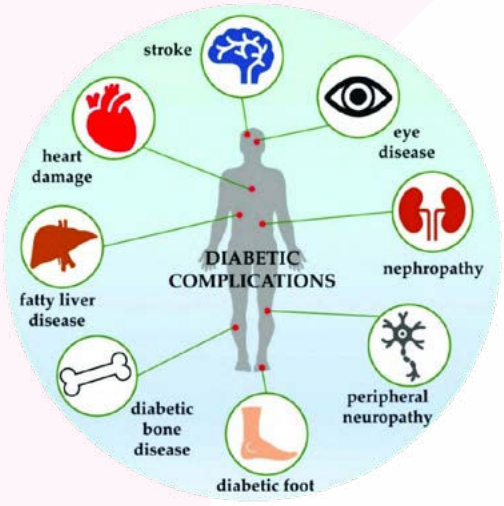


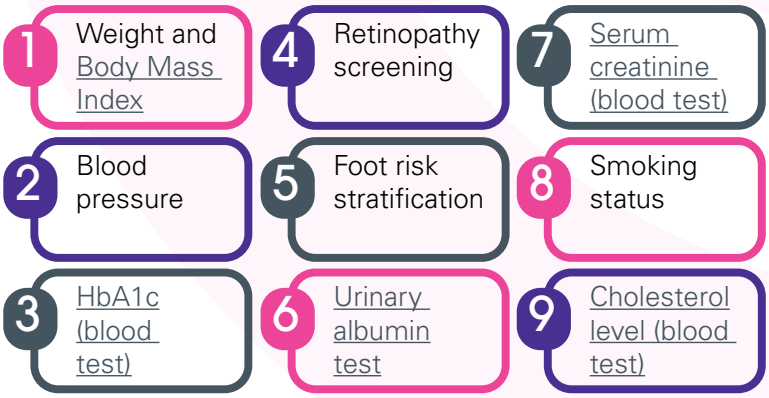
Photo courtesy of: https://www.researchgate.net/figure/Selected-secondary-complications-associated-with-T2DM_fig1_353975874

The 9 Key Care Processes

NICE guidance recommends that all people with diabetes have the 9 Key Care processes completed every year to help reduce the risk of complications.

Type 1 diabetes in adults: Quality standard [QS208] Published: 02 March 2023
Type 2 diabetes in adults: Quality standard [QS209] Published: 02 March 2023

The 9 Key Processes of Care Measurements



We will return to the 9 Key Care processes later.

Literature review

A review of journal articles was conducted on homelessness and diabetes in 2024 to understand current knowledge around the topic.

Medline, Cinahl and Google searches were undertaken to identify articles focusing on both diabetes and homelessness. 34 papers were found with the majority coming from Canada and the United States, some from the UK, and one from China. The period covered was 2000-2024.

The following themes were identified:

The prevalence of diabetes in homelessness populations is unclear: the reported prevalence of diabetes in people experiencing homelessness is variable. Some articles report a higher prevalence than the general population, up to 22% (Benz, 2023; Diabetes Times, 2021; Arnaud et al, 2010), some about the same (Bernstein et al, 2015; Scott et al, 2013), and one lower (Lewer et al, 2019).

Homelessness poses numerous barriers to managing diabetes: challenges include poverty, accessing appointments, medication storage and management, but consistently the greatest of these is the challenge of getting healthy food (Burki, 2022; Campbell DJT et al, 2020; Campbell RB et al, 2021; Grewal et al 2021; White et al, 2016; Bellary, 2011; Hwang & Bugeja, 2000).

Homeless adults with diabetes report that management is difficult: most homeless adults with diabetes report difficulties managing their disease. This is due to practical barriers above, but also due to co-occurring mental health, and addiction challenges (Wiens et al, 2022; Grewal et al, 2021; Asgary et al, 2022).

Poor blood sugar control and serious complications are common: poor glycaemic (blood sugar) control is common, and people are at a much higher risk of serious complications such as amputations (Asgary et al, 2022; Diabetes Times, 2021; Constance and Lusher, 2020; Campbell et al, 2020; White et al, 2016; To et al, 2016; Arnaud et al, 2010; Hwang et al, 2000).

Many areas are trying to improve diabetes care: practitioners & services have tried or are trying to improve diabetes care for people experiencing homelessness and other hard to reach groups. This is mainly through tailored education and support programmes (Vickery et al, 2024; Vickery et al, 2023; Harte et al, 2022; Chan et al, 2022; Marsh et al, 2022; Savage et al, 2014; Thompson et al, 2014). There has been success, but challenges still remain, and there is evidence that programmes need a lot of tailoring to be successful (Vickery et al, 2024; Vickery et al, 2023; Savage et al, 2014; Thompson et al, 2014).

Innovative, multi-disciplinary, multi-agency approaches are needed: effective strategies for addressing the challenges need targeted innovative, multi-sectored, multi-disciplinary approaches with flexible and well-coordinated models of care (Benz, 2023; Vickery et al, 2023; Wooff, 2021; Mancini et al, 2021; National Health Care for the Homeless Council, 2020; Constance & Lusher, 2020; Campbell et al, 2020; Jones and Gable, 2014; Davachi and Ferrari, 2013; Baty et al, 2010; O'Toole et al, 2010).

Gaps in practitioner knowledge are known to exist: some Continuing Professional Development (CPD) articles have already attempted to address this (National Health Care for the Homeless Council, 2020; Gilani, 2017; Jones and Gable, 2014; Kalinowski et al, 2013), but knowledge gaps still exist.

Experts by Experience provide important insights on what is needed: Experts by Experience have been involved in research and provide differing perspectives to professionals (Campbell RB et al, 2021; Campbell DJT et al, 2021; Grewal et al, 2021).

Peer support can be successful and positive: peer support is noted as a successful and positive intervention in two papers (Chan et al, 2022; Campbell RB et al, 2020).

In addition, a review of safeguarding adult reviews was undertaken.

'Eating healthily, storing medication safely, and maintaining records can be very challenging for someone who lives in one room and is destitute. Unrealistic targets are off-putting.'

Review of Safeguarding Adult Reviews

A key reason to undertake quality improvement in any clinical area is to reduce early and avoidable deaths.

Safeguarding Adults Reviews (SARs) are a statutory requirement for Safeguarding Adults Boards (SABs). Safeguarding adult reviews sometimes take place after deaths if there is a concern that adults have not been safeguarded effectively during their lifetime. Safeguarding adult reviews can also take place when someone is still alive and there is a need to review current practice.

A search was undertaken on the National Network for Chairs of Adult Safeguarding Boards website in their free to access Safeguarding Adult Review (SAR) library to identify reviews of deaths involving diabetes and homelessness. Five cases were identified to aggregate themes:

1. Teeswide Safeguarding Adults Board: Safeguarding Adults Review (SAR) CASE 5/18 JOSH Overview Report Author: Karen Rees 28 November 2019
2. Richmond and Wandsworth Safeguarding Adults Board Safeguarding Adult Review – Jasmine 2020 Independent Reviewer: Sarah Williams
3. Northamptonshire Safeguarding Adults Board Safeguarding Adults Review Jonathan 2020 Overview Report. Author Bruno Ornelas. Agreed 2nd March 2021
4. Safeguarding Adults Review Safeguarding Enfield Lorraine Stanforth March 2023
5. Teeswide Safeguarding Adult Board James Safeguarding Adults Review using Rapid methodology (SARR) Overview Report Author: Karen Rees 11th October 2023

The themes identified in these SARS were:

- **High clinical risks** related to diabetes and alcohol / substance misuse and mental health
- **A lack of referral for Section 42** (Care Act 2014) safeguarding reviews
- **A lack of understanding of the risks** of homelessness within hospital staff and situations
- **Multiple A&E attendances / admissions** not resulting in a coordinated plan
- **Evidence of a lack of ability to assess mental capacity** in complex scenarios – particularly in cases where there are issues with executive function
- **A need for easier read materials** to support patients
- **A lack of understanding of self-neglect** and related failures in safeguarding
- **A need for more robust multidisciplinary team processes** with robust risk management and identified leadership
- **A need for trauma informed care**
- **A lack of clear identification of communication and cognition difficulties**
- **A lack of connection** between services
- **A failure or lack of transition services** for young people leaving care
- **Specific risks related to diabetes** – e.g. overdoses of insulin and co-concurrent eating disorder.

The 'Expert by Experience' voice

In addition to the expected practical access barriers to primary and secondary care (e.g. no address for appointments, language, literacy, cognition and memory, mental health, addictions etc.), three key themes emerged from interviews with patients, and input from the Experts by Experience.

'Don't tell me off' – Language, and a sensitive approach and delivery really matter in terms of how a patient is able to engage with their diabetes.

'Don't tell me to do something I can't do' – Eating healthily, storing medication safely, and maintaining records can be very challenging for someone who lives in one room and is destitute. Unrealistic targets are off-putting.

'Don't just give me a leaflet' – Diabetes really isn't that simple. Repeated explanations may be needed, taking account of language, literacy, and information processing issues.

Insensitive delivery in these areas has caused disengagement after a patient has accessed services, not before.

Illustration courtesy of Jolie Goodman

Visits to areas of best practice

Within the project several visits were undertaken to areas of best practice. Two are discussed here.

Project 1

Lynne Wooff, Diabetes Specialist Nurse, with Joanne Dickson, Advanced Clinical Practitioner and Team Lead, Rebecca Lace, Advanced Clinical Practitioner and Dr Harni Bharaj, Diabetes Consultant

Lynne is a Specialist Diabetes Nurse who works in partnership with the specialist inclusion health services in Bolton, Lancashire, to improve care. Work commenced in Autumn 2020.

Above left: ANP Joanne Dickinson, SN Amanda Rainford, ANP Rebecca Lace, Specialist Diabetes Nurse Lynne Wooff, Nursing Associate Annaliese Cavenay, HCA Cheryl Ramsden, Sr Ava Tinsley
Above right: Diabetes Champion Faisa Abdi

‘Language, and a sensitive approach and delivery really matter in terms of how a patient is able to engage with their diabetes.’

Statistics of project

- Patients seen so far = 45
- Patients currently on caseload = 28
- Number of patients that have been Type 1 or Type 3c = 23 (51%)

Key elements of the work have been:

- A diabetes and homelessness Multi-Disciplinary Team that meets 8 weekly and comprises a Diabetes Consultant, the Homeless and Vulnerable Adult (HVAT) Team, the Health Improvement Practitioner / Diabetes Champions coordinator, retinal and foot screeners, hostel managers, a ‘Homeless friendly’ representative and a Healthwatch representative.
- Diabetes Community Champions / Health Improvement Practitioners delivering sessions quarterly in the three homeless hostels and Emmaus in Bolton.
- Routine screening via HbA1c at homeless hostels and dressings clinics.
- All patients found to have diabetes offered a full assessment covering all nine diabetes key care processes. Annual screening checks undertaken with partnership from Podiatry and Optometry as needed.
- GPs sent letters covering all results and action plans, and flagging hostel addresses.
- Homeless hostel admission sheets amended to include questions about diabetes.
- Referrals to Diabetes Specialist Team received directly from within the hostels.
- Rolling training program for hostel staff across all 4 sites completing Sanofi Cares diabetes education programme
- Links made with Emergency Department (ED) clinical lead to improve referral to HVAT in-reach team and Homeless hostel addresses supplied to the ED for flagging.
- Development of a No Fixed Abode (NFA) blood order set (HbA1c / Lipids) for ED.
- Pop up cervical screening and bowel screening information sessions run alongside the diabetes community champion sessions.

Outcomes

As a result of this work, 23 patients (82%) have completed their nine diabetes care processes at the time of publication. Among other key outcomes, six patients (21%) have been provided with Continuous Glucose Monitoring (CGM) technology.

Next steps

Lynne has now been granted NHS England funding to formally work alongside the Homeless and Vulnerable Adults Team 1 day per week for 18 months. The outcome data will hopefully form the business case for ongoing funding.
For more information email: lynne.wooff@boltonft.nhs.uk.

Project 2

Becky and Laura work for St Helens Diabetes Specialist Outreach Team. St Helens in Merseyside has some of the most deprived wards in England. Life expectancy is poor and wellbeing worse, and less than 50% of local people with Type 1 and 2 diabetes achieve their treatment diabetes targets. The team doesn’t carry a caseload, but supports other teams to manage diabetes better.

Above left: Laura Walmsley with day centre manager Nick Dyer at the Teardrops Day centre
Above right: Diabetes Week 2024: L-R Miu (Diabetic Eye Screening Programme), Helen (Principal Podiatrist), Olivia (Diabetes Dietitian), Laura and Becky (Diabetes Specialist Nurses)

The team works across:

- Primary care including GP practices
- Care homes
- Inpatient mental health units
- Outreach clinics in homeless centres and other venues with vulnerable service users.

In terms of homelessness, specifically, the team offers monthly outreach diabetes clinics at the Salvation Army, YMCA, Teardrops and Hope House (homeless charities) and Change Grow Live (a drug and alcohol misuse charity).

Outreach clinics provide:

- Point of care HbA1c tests to diagnose and / or assess known diabetes control.
- Proactive identification of anyone with impaired glucose regulation (IGR) 'pre diabetes', and the provision of relevant advice.
- Education to help reduce the risk of diabetes and to better understand the signs and symptoms of diabetes.
- Advice on medication support to GPs / nurses / support workers.
- Support for people with complex diabetes to help them access annual reviews, screening, mental health support, addictions support, smoking cessation and healthy eating advice.
- Supplies of blood glucose meters, hypo stop and information leaflets.
- Advice on use of CGM as appropriate.

In addition, the team provides training to staff in all the above sites, upskilling carers, support workers and clinicians in a variety of settings. This is a key part of their work.

Finally, the team also runs events. For example, the team recently delivered its first 'Diabetes Drive Week' as part of Diabetes Week 2024 which facilitated outreach dietitian support, podiatrist-led footcare and eye checks to vulnerable people. 44 people were seen.

For more information email: diabetesspecialistoutreachteam@sthk.nhs.uk

You can read about other best practice work in Bournemouth, Liverpool, and Plymouth in the Pathway report.

Similarities in projects running in the areas of good practice were:

- Strong partnership working between specialist and inclusion health and homelessness services.
- Outreach to settings where vulnerable patients are.
- Audits of care and understanding of data.
- Training of homeless hostel and outreach staff.
- Use of Continuous Glucose Monitoring to improve blood sugar management.
- Partnership working with eye screening and podiatry services to improve outcomes.
- A clear focus on prevention.

Supporting the management of diabetes in homelessness settings

As a result of visits to the areas of best practice, wider workshops with practitioners and also discussions within the steering group the following areas emerged as key topics for additional guidance.

Monitoring of blood sugars when a person is homeless

Blood sugar levels (or blood glucose levels) are a measurement of the amount of glucose (sugar) that is in the blood. Blood sugar levels need to stay within as normal a range as possible, to reduce the risks of developing diabetes complications.

'Not all people with diabetes will need to check their blood sugars every day if their diabetes is stable. However daily measurements will be required if someone is on insulin or on the tablets, which can predispose someone to hypos.'

Target range

- The target range of blood sugar for most people is between 4 and 7 mmol / l (millimoles per litre).
- For people on insulin blood sugars can run higher. It is recommended that 70% (7 in 10) of glucose readings should be between 4 and 10.

Blood sugar monitoring also helps to avoid acute emergencies:

'Hypos'
A hypo (or hypoglycaemia) occurs when the blood sugar level drops too low. This can happen as a result of taking some diabetes medications, and is more likely if someone hasn't eaten, has exercised, or if they are drinking alcohol.

Diabetic Ketoacidosis Diabetic ketoacidosis (DKA) is a serious condition that can happen in people with diabetes. This is where the blood sugars are very high (hyperglycaemia), but tissue sugars are low. As a result, the body starts to break down fat which causes ketones to build up in the blood. High levels of ketones cause the blood to become acidic and this can be life threatening (sometimes requiring treatment in an Intensive Therapy Unit). Ketones can be identified in the urine or blood.

Hyperglycaemic Hyperosmolar Syndrome (HHS):
This is another condition where blood sugars can run very high. This generally happens in Type 2 diabetes. In this case there may be enough insulin to prevent diabetic ketoacidosis, but not enough to keep the blood sugars in range. Blood sugars can run very high, but no ketones will be present in the urine.

Not all people with diabetes will need to check their blood sugars every day if their diabetes is stable. However daily measurements will be required if someone is on insulin or on tablets, which can predispose someone to hypos (sulphonylureas e.g. Glicazide).

There are two main methods of measuring daily glucose levels:

1. Daily finger prick tests

This is the most common form of monitoring. However, finger prick test can be quite challenging both in terms of performing the tests and interpreting the results. A patient needs to have the dexterity to be able to do this, and the organisational skills to both record and act on the results. Whilst this is achievable for many people, it is not be realistic for some.

2. Continuous Glucose Monitoring (CGM)

CGM devices monitor diabetes without the need for blood tests. The devices measure the amount of sugar in the fluid surrounding the cells on the surface of the skin. There are two main devices available which work in slightly different ways: Libre and Dexcom. Each device comes with information and company support. The sensors are available on prescription. Healthcare professionals can undertake training on how to review the data.

NICE guidance NG17: Type 1 diabetes in adults: diagnosis and management recommends that all adults with Type 1 Diabetes are offered CGM. In some areas patients with other types of diabetes can also be offered CGM.

If an individual gives permission, their glucose monitoring data can be shared with a relevant health care professional and can be accessed remotely. The sensor is attached to the skin and lasts 14 days. The data can be accessed via the patient's mobile phone, or the company can provide a handset for monitoring including by a health professional. The CGM data can help people identify changes in their glucose levels in real time. In addition, by sharing data with healthcare professionals, a shared care approach to help a person identify their own needs can be developed, whilst also providing emergency clinical advice and support. CGM data can also be shared with families/carers.

People experiencing homelessness should not be discriminated against and should be given every opportunity to access CGM. If a patient experiencing homelessness with Type 1 or other insulin dependent diabetes is not on a CGM, talk to the local Diabetes Specialist team to see if a device can be provided for the individual.

Monitoring the 9 Key Care processes

Monitoring all the care processes should result in action if abnormal results are found. Patients should be told that they need an annual health check during which these tests should take place, and be educated to ask for this if it has been missed (e.g. due to geographical moves, language, literacy etc).

Key Care process target values commonly discussed with patients

Body Mass Index (BMI) should ideally be between 18.5-24.9 for people from a Caucasian background or 18.5-22 for people from a Black and Asian background. A BMI above this should prompt discussions on nutrition and weight loss education and support, and exercise.

Blood pressure target should usually be maintained below 140/90mmHg for people with diabetes, or below 150/90mmHg if a patient is aged 80 years or above. For some people with kidney disease the target may be below 130/80mmHg. If the blood pressure is regularly above these levels it will need to be managed with blood pressure lowering medication (anti-hypertensives) e.g. ACE inhibitors, because high blood pressure has a direct effect on the development of Chronic Kidney Disease and retinopathy.

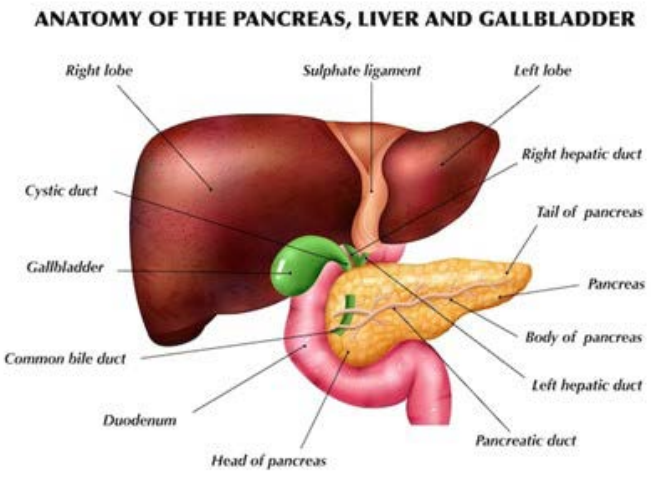
HbA1c measures the average blood glucose (sugar) level over a period of two to three months. If a person has diabetes, the ideal HbA1c level is 48mmol/mol (6.5%) or below. However, if a person is on insulin therapy the target HbA1C level is likely to be higher - the target will be set by the clinician looking after the patient.

Cholesterol levels are generally recommended to be lower in someone with diabetes. The overall target value for Total Cholesterol is under 4.0 mmol/l (in the general population this is 5.0mmol/l). Similarly, the breakdown values are recommended to be lower: Low Density Lipoprotein (LDL – 'bad cholesterol'): below 2.0 mmol/l; High Density Lipoprotein (HDL – 'good cholesterol'): at least 1.0 mmol/l (men) or 1.2 mmol/l (women); Triglyceride levels: less than (or equal to) 1.7 mmol/l. Levels above this will need management with statins.

Note that urinary albumin tests may feel difficult to obtain if a person is experiencing homelessness, particularly as it is recommended for this to be an Early Morning Urine. However, this test is often an early sign of kidney disease and should be prioritised if possible.

Type 3c diabetes

Type 3c diabetes occurs as a result of an illness or condition that affects the pancreas. The pancreas is the organ that produces insulin, which is the naturally produced hormone in the body that helps maintain blood sugar levels.



Picture courtesy of: https://www.freepik.com/free-photos-vectors/pancreas

'If a patient experiencing homelessness with Type 1 or other insulin dependent diabetes is not on a CGM, talk to the local Diabetes Specialist team to see if a device can be provided for the individual.'

Examples of the conditions that can lead to Type 3 diabetes include:

- acute pancreatitis
- chronic pancreatitis
- pancreatic cancer
- cystic fibrosis
- haemochromatosis

Type 3c can also develop if the pancreas has been removed because of any other damage or condition.

People who drink too much alcohol are very susceptible to pancreatitis and this is the main reason why Type 3 diabetes may be more common in people experiencing homelessness than in the general population.

Specific issues related to Type 3 diabetes

As well as insulin the pancreas also produces enzymes which break down the food we eat. Therefore, people with Type 3c diabetes may not be able to digest their food. This is called pancreatic exocrine insufficiency (PEI).

Specific symptoms of Type 3c diabetes include:

- losing weight unintentionally
- stomach pain
- frequently passing wind
- diarrhoea
- Steatorrhoea (fatty poo) can look bulky, oily, pale orange/yellow, be foul-smelling and runny
- Poo can also float and be difficult to flush away and may stain the toilet bowl.
- low blood sugar.

Some people can get a wrong diagnosis of Type 2 diabetes, because Type 3c isn't as well known and the term 3c isn't always used.

The treatment needed for Type 3c diabetes is variable depending on the level of damage to the pancreas. Some people will be treated similarly to people with Type 2 diabetes. The first line treatment will be Metformin. Metformin works by helping the insulin that is naturally produced to work better. For others they will be treated similarly to people with Type 1 diabetes, and be started on insulin immediately.

Many people with type 3c diabetes require insulin at an earlier stage compared to people with Type 2 diabetes to help manage their blood sugar levels.

Other treatments needed in Type 3 diabetes

Pancreatic enzyme replacement therapy

If a person with Type 3 diabetes also develops pancreatic exocrine insufficiency, they will need medications to help them digest food. These medications include enzymes normally produced by the pancreas.

Such medications are called Pancreatic Enzyme Replacement Therapy (PERT). PERT aims to improve fat, protein and carbohydrate absorption, thus reducing the symptoms above. They are available in capsule or powder form. PERT is given alongside meals, snacks and milky drinks. PERT should ideally be given as a part of a nutrition plan developed and managed by a specialist dietitian.

There are four different types of enzyme medicine available: Creon® Pancrease® Nutrizym® Pancrex®. These are extracted from pork products, but vegetarian alternatives are available.

Vitamin and mineral supplements needed in Type 3 diabetes

As people with Type 3c diabetes have trouble absorbing food, deficiencies of vitamins and minerals may result. In particular fat-soluble vitamins (vitamins A, D, E and K) are found in foods containing fat, and may be particularly poorly absorbed.

This can cause problems with:

- Sight problems (particularly in the dark)
- Bone problems – osteoporosis
- Increased infections
- Bruising
- Poor wound healing
- Neurological (nerve) symptoms
- Muscle weakness and fatigue

The NICE guideline for pancreatitis recommends that people with chronic pancreatitis are offered monitoring of their nutritional status every 12 months with clinical assessment, blood tests, and treatment of any vitamin and mineral deficiencies. NICE guideline 104: Pancreatitis

Mental health

People with diabetes can be more at risk of developing depression, due to challenges associated with the condition. Diabetes UK suggests that 40% of people with diabetes struggle with their psychological wellbeing after being diagnosed as a result of the diagnosis, and overall people with diabetes are twice as likely to experience depression.

Other mental health concerns related to diabetes:

Diabetes distress and burn out

Diabetes distress occurs when a person feels frustrated, defeated or overwhelmed by diabetes. This can lead to 'burn out' - when people struggle to engage with all the many daily diabetes tasks they are asked to perform. This may include not checking their sugars, not taking medication correctly, not looking after themselves and not concentrating on their own wellbeing and nutrition.

Suicide and self-harm

One of the main risk issues for people with diabetes and severe mental health problems is that people on insulin have a readily available mechanism to end their life.

People with diabetes have double the risk of suicide or intentional self-injury compared with the general population, but this may be higher. It is thought many attempts at suicide may be mistaken for an accidental 'hypo' or Diabetic Ketoacidosis (DKA). A historical study of 160 cases of insulin overdose leading to severe hypo found that 90% were either suicidal or parasuicidal and only 5% were actually accidental (Russell et al, 2009).

Suicidal and self-harm behaviour in people experiencing homelessness with diabetes is documented (and appears in one of the SARS). This is an important risk to be aware of given that suicide rates in homelessness populations are known to be high. For example, the Office for National Statistics (ONS) recorded 13.4% of all deaths of people experiencing homelessness to be related to suicide in 2021 (ONS, 2021).

Disordered eating

People with diabetes are asked to think about their diet a lot, and in many cases, this will lead to positive health gains. It is important however to recognise that some people can spend quite a lot of time thinking about the need to manage their diet, and this can be tiring for them, and can lead to obsessive thinking.

Separate from this, there is a high prevalence of formal eating disorders in people with diabetes. In one US study of women and girls with Type 1 diabetes 32.4% met the criteria for an eating disorder (Colton et al, 2015), and between 2.5% and 25.6% of people living with Type 2 diabetes are estimated to have a binge eating disorder (Yahya et al, 2022). The Burdett project and SARS revealed such disorders are also common in homelessness populations with diabetes.

Type 1 diabetes and disordered eating (T1DE)

People with Type 1 diabetes have generally lost weight when they are first diagnosed. This is because without insulin the breakdown products of food stay in the blood, and do not get transferred to the tissues where they are needed.

‘The language used by healthcare professionals has a known impact on all people living with diabetes. Good use of language can lower anxiety, build confidence, and educate. Bad use of language can be stigmatising, hurtful and leave people feeling ‘told off’, as we saw earlier.’

Some people with diabetes reduce the amount of insulin they take to try to deliberately control their weight. This can cause acutely high blood sugars and lead to a Diabetic Ketoacidosis. In 2024, a Parliamentary Inquiry report highlighted the risks associated with this condition, and called for essential changes to be made to provide effective care.

Binge eating

Binge eating is when someone frequently eats a large quantity of food in a short space of time, with little control over this. In diabetes this can make the blood sugar go very high. Some people make themselves sick afterwards. Such behaviour may have started before the diagnosis of diabetes or after, but needs attention and support.

People experiencing homelessness with diabetes should have their mental health assessed, and be proactively referred for mental health and/or psychological support.

Language matters – the use of sensitive and accessible language

The language used by healthcare professionals has a known impact on all people living with diabetes. Good use of language can lower anxiety, build confidence, and educate. Bad use of language can be stigmatising, hurtful and leave people feeling ‘told off’, as highlighted earlier.

NHS England has produced this guidance: Language matters: language and diabetes to support learning in this area. The guidance gives many specific examples of collaborative and encouraging communication, and how this differs from the types of communication people are often faced with. Learn more about the Language Matters Diabetes movement here. The guidance also emphasises the need for cultural competence whilst also not making assumptions about people on the basis of their culture, ethnicity or background. The use of sensitive language also needs to extend to the provision of education, and any educational materials.

Written resources should also be accessible, and preferably easy read. Take time to read about NHS Information Accessibility standards.

Groundswell has created 2 accessible leaflets to educate people experiencing homelessness about diabetes:
https://groundswell.org.uk/wp-content/uploads/2024/06/Groundswell_Diabetes_WEB.pdf
https://groundswell.org.uk/wpdm-package/managing-diabetes-health-guide/

Diabetes and addiction

Use of long-acting insulin in people with addiction

If people have diabetes requiring insulin also have an addiction, they are more likely to forget to take their insulin doses or eat erratically. This puts them at greater risk of high or low blood sugar levels and Diabetic Ketoacidosis.

People with diabetes who require insulin therapy will often be prescribed a long-acting (basal or background) insulin to be taken daily, as well as rapid or short acting (bolus) insulin to be taken with meals. However, it is sometimes suggested that people with an addiction who need insulin are only prescribed the Long Acting insulin which is given once or twice a day, does not need to be given with meals, and stays in the body for longer. However, there are some risks of a hypo if people do not eat at all. Such long-acting insulin typically last 24 hours. There are also some very long-lasting insulin preparations available which can last up to 72 hours, e.g. (Triseba / Toujeo). Using ultra-long insulin means people will have insulin in their system even if they miss a dose of insulin or take their next dose late.

Having some insulin in the blood significantly reduces the risk of DKA. Diabetes specialists will make the decisions on the type of insulin needed, but it is helpful if there is awareness of the different types of insulin.

Running HbA1c higher in addiction

In the case of people with addictions it may be that specialists are happier with a higher HbA1c that might normally be aimed for.

Targets for HbA1c levels will be individualised by specialists to take account of all the many factors that contribute to managing diabetes – including home circumstances, educational levels, emotional and psychological disturbance, and access to healthcare professionals and medication. Targets may change as circumstances change. Approaches to management will focus on sustaining adequate insulin levels to avoid DKA, but also being cautious to avoid levels that risk hypos.

Monitoring of blood sugars in people with opiate addiction

There is evidence that opiates can have a short- and long-term effect on blood sugars (Koekkoek al, 2022). This needs to be taken into consideration in this population when screening for diabetes, and managing diabetes. It may be appropriate to take HbA1c measures more often.

Management of people who rough sleep

Sometimes, despite everyone's best efforts, patients remain on the streets. This can be for a variety of reasons, but often includes complex mental health issues, and addiction issues, and/or complex immigration issues.

A clinical practitioner may be able to advocate for appropriate independent housing via a letter or email to the Local Authority say that a patient is in priority need for housing, if this feels appropriate. However, this may not work if someone has moved from the local area they have a connection to, or have no recourse to public funds. It may also be possible to refer someone with no recourse to public finds for a Care Act 2014 assessment if they have care and support needs around their diabetes.

Aside from this, pharmacists can be really helpful partners when supporting someone with diabetes who is rough sleeping. Pharmacies can hold extra insulin pens for people, and contact case managers when a patient turns up for medication – particularly if a person is also on supervised consumption of opiate substitution.

Cool bags for insulin pens are also available to help people on the move maintain a steady temperature for their insulin, although these are not funded by the NHS e.g. FRIO packs can be purchased online. Freezer packs in cool bags **should not be used** as they will freeze the insulin. If the insulin has just come out of a fridge, it could be carried in a standard cool bag without freezer packs. However, insulin is normally ok in a standard bag kept away from extremes of temperature for short periods.

Nutrition

Patients with diabetes should be screened for both their nutritional status and their level of food security.

Nutritional status screening

This is commonly undertaken using the Malnutrition Universal Screening Tool (MUST, BAPEN 2003). However, this can fail to pick up malnutrition, e.g. in people who drink alcohol and have ascites who therefore have a normal weight. The St Andrews Nutrition Screening Instrument (SANSI, Rowell et al 2012) can be a better tool as it was developed for mental health settings. Practitioners may also want to consider testing for grip strength (which is a measure of sarcopenia, and a useful marker of nutritional status) cheaply and easily using a handgrip dynamometer (Sousa-Santos and Amaral 2017).

Food security screening

Simple food security screening can be undertaken using the following questions.

In the past month, how often have you [ask question below] …because you couldn't afford or access food?

	Question	Often	Sometimes	Never	Don't know
1	Reduced the size of your meals or skipped meals				
2	Not eaten for a whole day				
3	Not eaten despite feeling hungry				

'If people have diabetes requiring insulin also have an addiction, they are more likely to forget to take their insulin doses or eat erratically. This puts them at greater risk of high or low blood sugar levels and Diabetic Ketoacidosis.'

Screening should result in the identification of the support needed. Ways to support a person experiencing homelessness with diabetes to improve their nutritional status include:

- Referring them to a dietician for support
- Encouraging them to take up any healthy eating / cooking programmes that are available locally. These can be available through NHS diabetes or other health services, or may be charitably provided
- Giving them written resources which might help them to eat healthily in their current circumstances (see below)
- Providing healthy snacks when you see a patient for them to take away (boiled eggs can be a healthy, easy to take away snack)
- Providing a daily vitamin and mineral supplement
- Providing nutritional supplements (these can be provided at pharmacies on supervised consumption if someone is already on supervised opiate substitution)
- Getting Occupational Therapists involved to support understanding and behaviour change around nutrition
- Support a patient's application to access housing with separate kitchen facilities, emphasising the need for someone with diabetes to be able to eat healthily to avoid the complications of their illness.

Below are resources which can support someone with limited kitchen facilities, and finances to cook healthily.

- Diabetes UK: Dietary Guides for People with Diabetes who are Homeless or in Temporary Living
- University of Edinburgh students: Cooking without a Cooker
- How to Cook without a Kitchen is also available on line and may be useful.

Eye Care

Diabetic retinopathy poses a severe health threat to the already vulnerable homeless population. It is the most prevalent diabetic eye condition, and affects up to 80% of those who have had diabetes for 20 years or more. NHS guidance states diabetic eye screening should take place every year, or every two years if the last two tests were clear. The nature of diabetic eye disease lies in the fact that it is often asymptomatic in the early stages.

People experiencing homelessness have significantly lower rates of diabetic eye exams compared to their housed counterparts (Davis et al, 2017). People experiencing homelessness need to be given support to access eye screening. Simple visual acuity screening can be undertaken pending retinopathy screening by inclusion health nurses or GPs.

Patients can also be given advice on how to look after their eye sight.

Foot care

There is a direct link between poor glycaemic control (High HbA1c) and risk of diabetic foot ulceration and foot, limb or amputation. Diabetic foot screening needs to be carried out at least once a year. This may be needed more depending on the risk.

Diabetic foot screening is a quick, simple, evidence-based way to assess risk. Screening assesses circulation (via the location of the dorsalis pedis and posterior tibial foot pulses) and sensation using a 10g monofilament on seven sites. If a patient has struggled to access specialist care, screening can be undertaken by any primary care professional. A screen usually takes around 10 minutes and is not painful or invasive.

Two short training videos on how to undertake foot screening are available here:

- Royal College of Podiatry: Diabetes Foot Screening
- Northamptonshire Healthcare NHS Trust: How to carry out a Diabetic Foot Check and an Annual Diabetic Foot Screen

Patients should also be provided with clean socks, well fitting shoes, and be given advice on the risks of not looking after their feet.

Safeguarding people who self-neglect

Self-neglect is a safeguarding category in the Care Act (2014). Self-neglect is described as an extreme lack of self-care. It is sometimes associated with hoarding and may be a result of other issues such as addictions. It implies a lack of self-care that threatens personal health and safety. It includes neglecting to care for one's personal hygiene, health or surroundings, and also the inability to avoid future harm as a result of self-neglect. It often involves a failure to seek help or access services to meet health and social care needs and an inability or unwillingness to manage one's personal affairs.

The concept of self-neglect can be subjective, but a practical way of assessing if the self-neglect requires safeguarding is when the self-neglect is considered to be imminently life threatening. For example, a person with substance misuse needs who is not taking their regular medication for diabetes is putting their life at risk. Practitioners working with people experiencing homelessness with diabetes frequently mention this as a challenge, and safeguarding adult reviews suggest this is a common occurrence.

Patients who are self-neglecting in this way should be referred to safeguarding requesting a Section 42 enquiry, and the commencement of the Team around the Person process. This should happen regardless of whether someone has an addiction, recourse to public funds or mental capacity to make decisions.

Deprivation of Liberty Safeguards procedures should be considered for repeat attenders at A&E where it is not possible to assess mental capacity effectively or there are concerns regarding executive capacity.

For further information access this London Network of Nurses and Midwives Homelessness Group (LNNM) guidance: Identifying and working with Self-Neglect in people experiencing homelessness

Screening for diabetes

Screening for diabetes is not currently recommended in the general population. However, there is current evidence that there is a lot of undiagnosed diabetes in the general population (ONS, 2021) so this could change. A Learning Disabilities Mortality Review (Leder) diabetes briefing has suggested that it may be relevant for Learning Disability settings as people are less able to articulate their symptoms. NHS guidance also states that all people with severe and enduring mental health issues should have an annual health check including HbA1c.

On account of all these issues it may appropriate to institute local screening for diabetes using an HbA1c test in homelessness populations if local funding models allow this.

Training for non-clinical and non-specialist staff

Training non-clinical support staff can improve outcomes for people experiencing homelessness with diabetes. The following programmes are available free and on-line.

For hostel and day centre workers and informal carers:

- Sanofi Cares - National Diabetes Care Home Training Programme
- Cambridge Diabetes Education Programme Diabetes 10 Point Training – Adult Social Care Workers – Suitable for staff working in care homes, nursing homes or as home care workers have access to basic diabetes training that is relevant to their role.

Undertaking your own quality improvement (QI) project

Having read through this guidance you may now want to take your own quality improvement (QI) project. QI project resources were created in the Burdett project to assist staff seeking to do this. Two examples of audits that were undertaken using these resources as part of the wider project are profiled below. Resources are provided for both homeless and inclusion health staff and specialist diabetes nurses.

'There is a direct link between poor glycaemic control (High HbA1c) and risk of diabetic foot ulceration and foot, limb or amputation. Diabetic foot screening needs to be carried out at least once a year.'

Homeless and inclusion health nurse QI project
The project resources include directions to undertake a short clinical audit, and a small number of patient discussions. Instructions for the audit, a template Excel sheet for data collection, and a form to support the patient discussions are all provided.

Specialist diabetes nurse QI project
This project resource is a series of structured questions which will support you to identify barriers to access to your service for people experiencing homelessness and other vulnerable groups.

Examples of quality improvement projects using the tools
Leeds West Yorkshire: Rebekah Besford, Clinical Lead Nurse Homeless Health Inclusion Team (HHIT), Leeds Community Healthcare Trust

Above: Diabetes Nurse Rachael Scott, Pathway Team Lead Rebekah Besford, Outreach Nurse Angelique Denys, Inclusion Health Integration Lead Liz Keat, Advanced Podiatrist Nina Davies, and Specialist Podiatrist Lynda Dexter

In her own words, *'I am the team lead for the Homeless Health Inclusion Team (HHIT) team in Leeds. This team is a hospital in reach team using the Pathway model which works within the Leeds hospitals to deliver safe, effective and sustainable discharges for people experiencing homelessness. The team also provides clinical support to specialist intermediate care step down beds.*

I identified 8 patients that the team had seen in the last 6 months with diabetes. Their records were audited, and 3 patients were also asked for their views on treatment using the 'Discussion starter' form by team members.'

The audit and patient discussions identified:
- the struggles our patients were facing managing their diabetes
- gaps in knowledge of diabetes in the team
- a lack of Type 3c diabetes diagnosis in Leeds
- patient views did not match how professionals observed the patient's understanding and management of their diabetes

Following the audit a meeting was then held to bring together all the people involved in improving diabetes care in Leeds.

Next steps for the HHIT team:
- Use of SystmOne team templates to develop a coherent approach to the 9 key care processes
- Clinical members of the team to receive specific training on completing diabetic foot checks in hospital
- Development of a systematic approach to nutritional screening in the team.

To get in touch with Rebekah email: rbesford@nhs.net

Salford, Greater Manchester: Susie Goodwin, Diabetes Specialist Nurse, Salford Royal NHS Foundation Trust

Above: Susie Goodwin presents her project at sharing best practice day on diabetes and homelessness

In her own words: '*We are a large team of 23 staff, covering the city of Salford with two Diabetes Consultants, 12 Diabetes Nurses, five Diabetes Specialist Dieticians, and four Diabetes Health Advisors. Within this we have a community service, offering several specialist clinics across Salford, e.g. newly diagnosed T1DM clinics, young person clinic (T1DM), pump clinic, pre-pregnancy clinic.*

I chose to look at how our service currently serves patients experiencing homelessness, including those with complex needs.'

The audit revealed:

- Homelessness is not routinely recorded on our clinical system.
- Rough sleepers are often lost to follow up as we have no way of making contact.
- Patients are often discharged from our service after having two DNA's (missed appointments) which results in an automatic discharge.
- Although we do have a named GP in our area who has a caseload of homeless patients (mostly rough sleepers), not all people experiencing homelessness are registered there.
- We mostly only identify patients as homeless after they are admitted to hospital. This is usually when they are in crisis with DKA.
- We offer a comprehensive education programme to patients and their support network, but people experiencing homelessness with complex needs were not accessing this.
- We have access to refer to psychology if required with a structured programme provide by the Six Degrees Social Enterprise. This offers support in living with diabetes and other chronic conditions – many patients have been referred but often appointment letters have failed to reach them.

Proposed actions going forward:

- Housing status to be recorded routinely within the clinical notes
- Education for local hostel staff / shelter staff to be commenced
- Setting up of a monthly pop-up clinic – offering point of care HbA1c testing, blood glucose monitoring, advice and education within hostels / day centres
- Proactive offering of technology options to people experiencing homelessness to ensure quality care for all.

To get in touch with Susie email: salford.diabetescare@nhs.uk

'Ask whether homelessness services need any training or support. Consider building relationships at these sites by training diabetes champions. In exchange ask them to train you regarding homelessness issues in your area.'

Final top tips for improving care

Finally, as a result of the project the following three lists of top tips for improved care were developed.

1. Specialist diabetes services

Service development

- Undertake an 'access to care' audit for your service like the one in this report, and create a plan to improve accessibility of your service
- Record (and code) housing status in hospital core information (try to enable this, if this is not currently possible)
- Make contact with and visit other specialist diabetes nurses undertaking outreach work to gain tips for your own work.

Patient Assessment

- Ask about and record information about housing circumstances and access to food during assessments – e.g. kitchen facilities, food and medication storage, access to free food provision etc
- Ask about storage of medication

Patient Management

- Brush up on Type 3c diabetes
- Consider whether there is enough use of pancreatic enzyme replacement therapy – this could be a good Quality Improvement Project in multiple areas
- Offer use of CGM monitoring technology wherever possible
- Use longer acting insulins and work with higher HbA1c levels for people with more complex lives
- With patient consent, include a patient's support worker in their care.
- Proactively offer referral to healthy eating / cooking skills groups for people experiencing homelessness if these are available.
- Stock cooking guides that are relevant to people with limited access to a kitchen.
- Proactively offer referral to dietician support.
- Screen for mental health difficulties and diabetes distress, and proactively refer to Psychologists / mental health support. Consider overdose risks and eating disorder risks within screening.
- Take time to educate patients about diabetes, the treatment of diabetes, healthy eating, eye health and foot care.
- Stock easy read materials regarding diabetes, the treatment of diabetes, and healthy eating, and know where to access information in other languages.

Linking in with homelessness services

- Make contact with your local community inclusion health service. If you do not know who there are many are listed here. Visit them if possible. Investigate whether outreach to particular populations could be useful and possible.
- Make contact with any homeless day centres and hostels you have in your area. If you do not know who they are try a postcode search on 'Find a Service' on the Homeless Link website. Ask whether they need any training or support. Consider building relationships at these sites by training diabetes champions. In exchange ask them to train you regarding homelessness issues in your area

Other links

- Link in with your local addictions team / undertake training in this area.
- Link in with your hospital based homeless team if you have one locally e.g. those supported by the Pathway Partnership Programme.

Training

- Undertake NHS trauma informed care training.
- Undertake Language Matters Diabetes training.

2. Inclusion health services

Service development

- Undertake an 'clinical care' audit for your service like the one in this report
- Make contact with your local specialist diabetes service and invite them to visit. Explore how you can work in partnership together.
- Make contact with local optometry and podiatry screening services to see how screening can be improved.
- If community dietician support is not available to individuals you care for, record the number of referrals you would have made and take this to commissioners

Screening

- Routinely screen for diabetes annually using an HbA1c test if possible
- Undertake routine nutritional screening using a validated tool, and ask about access to food / food security during assessments.

Patient management

- Refer to specialist diabetes services even if you think a patient will not go.
- Refer to dieticians.
- Find out about healthy eating / cooking skills groups in your area, and refer clients to these wherever possible.
- Consider also referring to Occupational Therapy to support individuals to improve their skills around healthy eating (including shopping and cooking)
- Upskill to be able to undertake opportunistic basic eye screening and foot screening for patients who are finding repeated engagement difficult.
- If you think your client is self-neglecting, refer to safeguarding and proactively call case conferences including both primary and secondary care colleagues as well as other relevant partners.
- If your client is regularly attending A&E see this as a 'red flag'. Make contact with A&E and secondary care services to develop a plan.
- Use social prescribers to investigate options for increasing activity levels e.g. exercise on prescription, gardening groups
- Offer smoking cessation support
- Take time to educate patients about diabetes, the treatment of diabetes, healthy eating, eye health and foot care.
- Stock easy read materials regarding diabetes, the treatment of diabetes, and healthy eating, and know where to access information in other languages.
- Consider introducing routine use of micronutrient cover (vitamin and mineral supplement)
- Work with pharmacists to explore options for better supporting rough sleepers, and consider purchase of cool bags
- Ask about use of CGM monitoring technology if this will benefit the client
- Suggest use of longer acting insulins for people with more complex lives
- Consider whether your patient could have Type 3 diabetes and whether pancreatic enzyme replacement therapy is needed

'Find out about healthy eating / cooking skills groups in your area, and refer clients to these wherever possible. Consider also referring to Occupational Therapy for support in this area.'

Supporting patients to access housing

- Consider whether you can support access to housing by demonstrating your client is 'priority need'
- Consider a Care Act referral for a client with No Recourse to Public Funds with diabetes.

Training

- Learn about Type 3c diabetes
- Update about self-neglect as a safeguarding issue.
- Read about 'diabetes distress'. Consider what mental health effects diabetes is having on your client, and refer appropriately. Learn about overdose risks and the links between diabetes and eating disorders.
- Undertake NHS trauma informed care training.
- Undertake Language Matters Diabetes training.

Support for hostels and day centres

- Support hostels and day centres to have a diabetes champion (in partnership with specialist diabetes services if they are willing)
- Review any food provision available at day centres / hostels, and offer to support a review

3. Hostel workers and support workers

Assessment of patients

- Ask about whether clients have a past history of diabetes
- Ask clients with diabetes about how they are coping with their illness. You could use the Diabetes Discussion form in this report to do this.
- Consider the medication storage needs of your client and ensure storage options are safe – shared, public fridges should not be considered for insulin

Supporting management

- Consider attending appointments with diabetes team/inclusion health services to support service users and gain understanding of their management. You can also provide extra information to healthcare teams on how they are managing their diabetes to support better clinical management.
- Encourage patients with diabetes to attend their annual checks and screening appointments.
- Store glucose gel and ensure emergency training includes dealing with hypoglycaemia
- Review any food provision available to clients where you work, and ask health care professionals to support a review. Consider whether any changes can be made.
- Find out about healthy eating / cooking skills groups in your area, and refer clients to these wherever possible.
- Stock cooking guides and dietary advice sheets that are relevant to people with limited access to a kitchen.
- If you think your client is self-neglecting, refer to safeguarding and ask colleagues to support to arrange case conferences that include all relevant partners.
- If your client is regularly attending A&E see this as a 'red flag'. Alert relevant health care professionals, and try to make contact with A&E and secondary care services to develop a plan.

Training

- Undertake one of the online diabetes training courses available if you currently have clients with diabetes.
- Consider whether your service would benefit from a diabetes champion and who would be best placed to undertake this role. If appropriate lobby for someone to undertake this role and undertake core training and updates, and link in with appropriate health care professionals.
- Learn about self-neglect as a safeguarding issue.
- Find out about all NHS national screening programmes and support clients to access these.

Conclusion

It is hoped that this guidance has been useful, and will support readers to future deliver improvements in care. The accompanying audit resources can support practitioners to deliver this.

You may now also wish to go on and undertake the Fairhealth E Learning and Pathway report which both provide more detail, and more in depth learning opportunities.

If you would like to connect with the authors regarding your own project we would love to hear from you; please contact:

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'If your client is regularly attending A&E see this as a 'red flag'. Alert relevant health care professionals, and try to make contact with A&E and secondary care services to develop a plan.'

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Acknowledgements

Thanks go out to everyone involved in the project and assisted with the production of this guidance.

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- Anthony Jablonski - Pathway Expert by Experience

'Learn about self-neglect as a safeguarding issue. If you think your client is self-neglecting, refer to safeguarding and ask colleagues to support to arrange case conferences that include all relevant partners.'

- Dr Amanda Young - Director of Nursing Programmes (Innovation), The Queen's Nursing Institute
- Kirit Sehmbi, Homeless and Inclusion Health Network Lead, The Queen's Nursing Institute
- Jane Cook – Chair, London Network of Nurses & Midwives Homelessness Group
- Jolie Goodman - Project Artist
- Jan King - Independent Housing and Health Project Management Consultant
- Kellie Hart, Expert by Experience
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