Providing podiatry services for rough sleepers and vulnerable people

David Hurrell

Citation: Hurrell D (2023) Providing podiatry services for rough sleepers and vulnerable people. *The Diabetic Foot Journal* 26(1): 12–4

Key words

- Diabetes foot ulcer
- Vulnerable people

Article points

1. The rough sleeping and vulnerable people group are faced with many potential complex barriers to engagement with health services. These barriers can vary in both number and complexity on a daily basis. It is essential that care models are flexible, taking into consideration the ever-changing needs of this patient group.
2. Education and a collaborative approach between health, social care, third sector and the patient group themselves is paramount. Facilitating engagement through building trust and forging relationships with these patients will lead to more favourable outcomes.
3. The transient nature of the patient group requires consistent input. This input should be from individuals who fully understand the environment, the competing demands and priorities that this patient group face.

Author

David Hurrell is a Special Podiatrist, Greater Glasgow and Clyde NHS Trust, UK

Homeless individuals and vulnerable people with diabetes often fail to attend out-patient appointments, frequently using unscheduled care, which often results in admission. While working within this environment, it is evident that attendance at mainstream clinics presents significant challenges that most of us would take for granted. Improving understanding of the patient journey would help facilitate effective service redesign. This will support person-centred care models aimed at reducing health inequalities. Developing outreach services which incorporate all relevant aspects of both health and social care would improve access. This would prevent individuals reaching crisis point, leading to better outcomes for patients. Providing specific education in relation to diabetes for both the patient and their support network is crucial. Services provided for this patient group need to adapt and change, and in doing so, this high-risk patient group can be kept safe and supported.

Providing podiatry services to rough sleeping and vulnerable people presents significant challenges. The outreach podiatry service in NHS Greater Glasgow and Clyde requires the establishment of strong relationships with the wider health and social care team, as well as (most importantly) the individuals who require treatment. Patients within this environment are faced with many added issues in relation to their day-to-day living.

A multitude of the aspects of daily living that many of us take for granted become extremely troublesome and detrimental to this vulnerable group of individuals and this impacts on their ability to control long-term conditions. Diabetes is one such condition and within my role as specialist podiatrist working in this environment, I had noticed an increase in people presenting with the condition.

In the hope of addressing these challenges/barriers to engagement, services need to be able to evolve and be flexible in line with competing demands and priorities. In doing this, we can try to optimise care to ensure these individuals are getting the right treatment at the right time.

Treating diabetic foot ulceration in this environment is notoriously difficult — many individuals living with diabetes within this environment have a mistrust of healthcare settings and suffer from mental health/addiction issues. This leads to significant difficulty in facilitating engagement with other services, and has a knock-on effect on outcomes and participation in care plans put in place. This is concerning as we all know that diabetic foot ulceration is best managed with a multidisciplinary approach.

It was appropriate to raise this issue and try to improve pathways and prognosis for this group of individuals. In my capacity as a specialist podiatrist, I was encountering individuals with foot ulceration who required, on many occasions, intensive multidisciplinary input.

Multidisciplinary input is generally available at hospital clinics. However, given the lack of

resources and the transient nature of the lifestyle that these individuals lead, hospital-setting multidisciplinary input is generally unmanageable for them.

It is also apparent that there is a distinct lack of specific information and specific services in relation to diabetes, homelessness and vulnerable people. From my experience, these are issues which need to be addressed. The one-size-fits-all approach for this group of individuals simply does not work.

Homelessness can manifest itself in several ways — it is not as simple as not having a roof over your head. Within NHS Greater Glasgow and Clyde, there are differing types of homeless accommodation. At this moment in time, there are many people staying in bed and breakfasts. We have numerous homeless accommodations with varying elements of support, temporary furnished flats, not to mention people who may be sofa surfing, sometimes referred to as "the hidden homeless". Without consistency and a stable living environment it is difficult to maintain links with mainstream services.

I felt it was appropriate to present the situation at the diabetes equity of access Managed Clinical Network (MCN) within NHS Greater Glasgow and Clyde. By indicating the increase in diabetes prevalence in this environment it opened up opportunities to gain some help and feedback from the wider healthcare team. It was also beneficial from the point of view that I was given the opportunity to be part of the group.

The issue was added to the agenda of the diabetes equity of access group. They were happy to support any future work relating to this matter. A diabetes specialist nurse (Judith Kennon) and diabetes consultant (Brian Kennon) were keen to be involved in this project, so we set about trying to gather some data to highlight the situation.

Using data in relation to the individuals who had presented at podiatry drop in clinics throughout the city, we started conducting a retrospective audit. This looked at demographics, outpatient attendance/non-attendance, emergency department attendance and outcomes, as well as data centred round hospital admission.

Part of this data indicated that 26% of individuals had type 1, 48% had type 2 and 26% had pancreatic diabetes. The history of alcohol and/or drug misuse was high, and this was found to be the case in 81% of these individuals, with 48% having a history of a mental health condition.

On looking at outpatient appointments, we found that the non-attendance rate at diabetes clinics was 77% and the non-attendance rate was significantly lower at services which incorporated an element of outreach. In terms of attendance at the emergency department, it was found that 46% of these presentations ended up with admission.

Involving social care and the third sector in any ongoing work was and is integral to maximising the likelihood of these individuals engaging with such services. We felt that a good place to start would be awareness sessions, which included presentations from podiatry, diabetes specialist nurse, diabetes consultant and GPs from Hunter Street Homeless and Asylum service. Representatives from each of the following organisations attended: Housing First, Simon Community Scotland, council-run projects throughout the city and Turning Point Scotland.

A significant issue raised in the awareness sessions was computer systems and the capture of data. It became apparent that health and social care are very wide apart in terms of what systems they use and how they identify and capture care data. Link workers were discussed with the group and there appeared to be an appetite for this link to be formalised. This would be a two way process and would involve sign posting and referral pathways from social care to healthcare and vice versa.

Reference was made to current services within the environment that already have a point of contact for social care staff. The suggestion was made about the possibility of a diabetes specialist nurse who was placed within the homeless and vulnerable people environment. This would take the service to these individuals and provide a point of contact for social care staff who have concerns in relation to any service users they are working with. Social care staff seemed keen on this and felt it would be beneficial to this group of people.

We found there was a great appetite from social care and the third sector to be involved in enhancing pathways/referral routes for this vulnerable group of individuals. The need for further training on the subject of diabetes for social care staff was identified as a learning need

and would provide staff with more confidence in dealing with individuals living a chaotic existence with diabetes.

Conversation also identified a need for further training and awareness of social care issues for healthcare staff. Trauma training was identified as an example of where healthcare staff potentially dealing with this group of individuals could be upskilled. It was agreed that two diabetes training sessions for social care workers would be held.

We put together an education session with presentations featuring topics such as: 'Diabetes and Diet', 'Blood glucose monitoring', 'Diabetes and foot disease', 'Hypoglycaemia and Alcohol/drugs and diabetes'.

These education days were very well received and there was a great desire from social care and the third sector for sessions of this nature to be repeated on a regular basis. With an increase in knowledge throughout this sector, it will no doubt have a positive effect on care outcomes, diabetes control and onward referral from social care staff, when they have concerns regarding individuals within their care.

While looking at redesign of services for a specific group of individuals, it is crucial to involve their lived experience regarding these barriers and engagement issues in relation to their management of diabetes. We put together a brainstorming session and invited several experienced experts. Simon Community Scotland were happy to provide vouchers for these experts by experience, for their time and input. This was a success and all attendees were in agreement that current service models are not always conducive to the situations these people encounter.

Simon Community Scotland fully embraced the need for some specific diabetes input and offered to provide a treatment room for a diabetes drop-in clinic. Some consultant time was obtained and at this current stage, there is a diabetes clinic in the homeless environment based in the Simon Community Hub in Glasgow city centre.

Many of these individuals have no cooking facilities, no place to store medications and, due to the transient nature, have difficulty obtaining and storing prescription medicine. It is common to come across individuals living with diabetes in this environment who have not taken any medication in relation to their diabetes for a number of days or even weeks.

Ultimately, the risk of diabetes-related amputation as a result of diabetic foot ulceration is very high in this environment. Individuals present with several other comorbidities and are regularly lost to follow-up for all of these conditions. Individuals presenting with diabetic foot ulceration will generally have a lack of understanding of the condition and will be either unable or unwilling to attend multidisciplinary or any mainstream clinics.

Amputation has a considerable impact on anyone who experiences it. However, within the homeless environment, these individuals are already incredibly vulnerable and amputation increases this vulnerability in the long-term. It also has a detrimental impact on what housing options are available and creates further barriers to accessing suitable healthcare, while also having a significant impact on the individual's mental health.

With all this in mind, we need to continue to raise awareness of these challenges and barriers. We need to continue to look for ways to redesign services to accommodate and support the very specific needs that this group of individuals present with. A holistic approach is crucial and is the only way that outcomes will be improved for this vulnerable group. ■