IMPROVING HYPERTENSION MANAGEMENT IN PEOPLE EXPERIENCING HOMELESSNESS: NURSING INNOVATION THROUGH COMMUNITY OUTREACH

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BACKGROUND

People experiencing homelessness (PEH) have a life expectancy 30 years lower than the general population and suffer higher levels of physical and mental illness (2). Difficulties engaging with this population lead to poor chronic disease management (1), including identifying and treating hypertension. A major barrier to accessing primary care remains the logistical issue of having no fixed abode, as well as a distrust of health services due to stigma and discrimination. Before this innovation, PEH in Leamington Spa had little or no access to systematic blood pressure checks, chronic disease screening, or continuity of care, and many relied on A&E for acute issues.

Twice-monthly community outreach clinics provided an opportunity to identify and appropriately manage hypertension in this hard-to-reach group. Using this innovative approach, a third of our patients were identified as hypertensive and managed accordingly, leading to improved blood pressure control. In addition, identifying underlying trauma through Adverse Childhood Experience (ACE) (1) screening, which measures exposure to childhood abuse, neglect, or household dysfunction and is strongly linked to poorer health outcomes, supported a trauma-informed, quality-driven approach to nursing care. Providing a personalised and trauma-informed service helped to rebuild trust in primary care and enabled reintegration back into local GP surgeries.

RESOURCES

- Staffing: Two TNA's, GP supervisor, PCN Care Coordinator.
- Funding: ICB Health Inequalities Fund, aligned with the NHS Core20PLUS5 (5) cardiovascular disease target.
- Facilities: Helping Hands community centre (trusted, accessible location).
- Equipment: BP monitors, cross-organisational EMIS access.

QUALITY AND ASSURANCE POLICIES

- All BP management deliveredin line with NICE Hypertension Guidelines (3). EMIS used for
- accurate data entry, coding, and continuity across practices. Monthly audits of key
- performance indicators (BP recording, chronic disease screening, ACE completion, follow-up). Safeguarding protocols in place for high ACE
- scores and vulnerable adults. Regular patient and partner feedback integrated into service
- improvement.

SHARING POINTS AND LESSONS LEARNED

- Consistency builds trust: Regular nurse presence increases engagement and adherence.
- Hypertension yield is high: Outreach screening uncovers significant undiagnosed disease.
- Trauma-informed approach is essential.
- Centralised outreach saves time: Streamlines referrals, reduces duplication, and relieves pressure on GP/nurse appointments.
- Scalable model: Already piloted with asylum seekers and women's refuges; adaptable to other vulnerable groups.

PROCESS FOR SECURING RESOURCES

The GP and Leamington PCN led the process of securing resources to establish the outreach clinic by:

- Presenting the case for tackling health inequalities at PCN and ICB meetings.
- Aligning the proposal with the NHS Core20PLUS5 (5) cardiovascular disease priority.
- Successfully applying for the ICB Health Inequalities Fund to support delivery.
- Establishing a shared care agreement across eight GP practices, enabling EMIS access and continuity of care.
- Building multi-agency referral pathways with housing outreach, drug and alcohol services, women's refuge, and mental health teams.

With these resources secured, the TNA's deliver the clinics on the ground, embedding the innovation into practice and driving measurable patient outcomes.

ANTICIPATED AND ACTUAL OUTCOMES

Anticipated:

- Increase detection and management of hypertension in PEH.
- Improve access to primary care and chronic disease screening.
- Reduce inappropriate reliance on A&E and GP appointments.
- Strengthen collaborative working across agencies.
- Identify underlying trauma through ACE (1) screening.

Actual (Jan 2024 – Jul 2025):

- 33 clinics; 205 consultations with 75 patients.
- 90.6% had BP recorded; 33% diagnosed with hypertension.
- 38% of hypertensive patients returned to normal BP after nursing-led follow-up.
- 100% chronic disease screening completed and coded.
- 76.9% of hypertensive patients placed on appropriate management pathways.
- 39% ACE completion; average score 6.7, with 52% ≥8, informing safeguarding and trauma-informed care.
- Reduction in unnecessary A&E attendances reported.
- Partner agencies report improved efficiency through single-point referral.

- References:

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