Health Inequity in the UK: Paper 2 the role of the Practice nurse in addressing health inequity for people who are homeless, from ethnic minority groups or from LGBTQ+ communities

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Introduction

This is the second paper in the series; in the last paper we presented an overview of health inequity and health access in the UK, explored the difference between inequality and inequity and presented key national and international policies working to address health inequity. This paper builds upon this by considering three particular communities: people who are homeless and individuals from LGBTQ+ and Ethnic Minority communities as well as how practice nurses can have a key role in addressing poor health outcomes for individuals within these communities.

Role of Practice Nurses

The Word Health Organisation (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 2006;1). Furthermore, the constitution notes that health is a collective, not a purely individualistic, responsibility and that the highest attainable standard of health is a fundamental human right, irrespective of race, religion, political belief, or socio-economic condition (WHO 2006). Indeed, this assertion of treating people equally is also endorsed in the Nursing Midwifery Council Code (NMC 2018). Practice nurses who work in GP practices as part of the multi-disciplinary team have a key role in the assessment, screening and treatment of people throughout their lives; in addition to proving nursing treatments, they are also involved in the management of long term care (Queens Nursing Institute 2016) and health promotion

through the 'Making Every Contact Count' initiative (Public Health England 2016). Most recently has been the publication of the Core Capabilities Framework for Advanced Clinical Practice (Nurses) Working in General Practice/Primary Care in England (NHS 2020). This framework offers real opportunities for practice nurses to address health inequities experienced by communities through the key competencies (Table 2). However, in order for this to be maximised practice nurses require support and time to enable them to implement community and population based initiatives which are needed to address health inequity and disparity.

Table 1 Key competencies of Advanced Clinical Practice (Nurses) (NHS 2020)

- Critically appraise impact of a range of social, economic, and environmental factors can have on health outcomes
- Analyse data to critically appraise a 'practice population' to help identify needs of the people who are served, to add value and mitigate the impact of health inequalities on individuals and diverse communities
- Explore and act upon day to day interactions to encourage and facilitate changes in behaviour 'Making Every Contact Count'
- Recognise and respond appropriately to the impact of psychosocial factors on the presenting problems or general health such as housing issues, work issues, family/carer issues, lack of support, social isolation and loneliness and consider in the context of local social prescribing services.
- Work collaboratively across agencies and boundaries to improve health outcomes and reduce health inequalities.
- Perform a mental health assessment appropriate to the needs of the person, their presenting problem and manage any risk factors such as suicidal ideation promptly and appropriately
- Lead new practice and service redesign solutions with others in response to feedback, evaluation, data analysis and workforce and service need, working across boundaries and broadening sphere of influence..

We shall now continue by exploring three groups (homeless, LGBTQ+ and ethnic minorities) experience of health inequity in terms of four areas: health status, access to care, quality and experience of care and behavioral risk factors (Kings Fund 2020) and how Practice nurses can assist.

People who are Homelessness

It is important to note that the term homeless is an umbrella term for lots of different groups including: those living in temporary accommodation such as bed and breakfast and hostels; those rough sleeping; and those 'sofa surfing' with friends and families (Heaslip et al 2021a). In terms of health status, people who are homeless have poorer health outcomes than the general population. A woman who is homeless is likely to die 38 years younger than a woman living in permanent accommodation, whilst a homeless man can expect to die 30 years younger than a man who is permanently housed

(Office for National Statistics 2020). In addition to dying younger, people who are homeless are also more likely to live to complex chronic illness including issues with addiction and mental health as well as cardiac and respiratory problems (Heaslip et al. 2021b). In terms of access and experience of care, people who are homeless struggle to register with a General Practitioner (GP) because they are homeless (Gunner et al. 2019). However, even when registered they can experience discrimination and substandard care (Rae and Rees, 2015). In terms of behavioural risk factors and wider determinates of health there are multiple for example, children living in families who are homeless can miss key immunisations as well as being at greater risk of accident and infections due to poor and/or overcrowded housing; young people who are homeless are more at risk of sexually transmitted infections and unwanted pregnancies as they may be under pressure to offer sex for money or shelter (Leng 2017). In terms of mental health, research on 156 homeless adults by Lee et al. (2017) identified that people who were homeless living with anxiety were significantly more likely to consider suicide than those without anxiety, whilst those with a history of drug abuse were also significantly more likely than those without drug abuse to consider suicide ideation. National initiatives of primary care services with people who are homeless (Crane et al. 2018) have identified a range of services that practice nurses can offer those who are homeless (Table 2) as well as longer appointments, leading multidisciplinary team meetings with other services to address those with complex needs. Key to all of this is to create an environment where people who are homeless feel welcomed and listened to.

Table 2 Services that Practice Nurses can offer people who are homeless

- Nurse led health promotion sessions in hostels and homeless day centre provision
- Health assessments
- Screening and management of chronic health conditions,
- Flu vaccinations,
- Sexual health care,
- Needle exchange service,
- Smoking cessation service,
- Access to mental health and addiction support.

People from LGBTQ+ Communities

Considering health status of older LGBTQ+ is challenging as most of the research evidence on LGBTQ+ health is of low quality (Houses of Parliament 2018) which makes it difficult to understand the challenges individuals in this community face. There is however recognition that LGBTQ+ individuals experience poorer physical and mental wellbeing, higher levels of social isolation and loneliness (Subhrajit, 2014). There are higher levels of anxiety, depression, and poor mental health and these have been associated with self-harm, eating disorders and suicide (Bachmann and Gooch 2018). This

poorer mental health is compounded by issues of rejection, homophobia or transphobia and social isolation (Beach, 2019). In terms of older people in LGBTQ+ communities, they are more likely to engage in harmful behaviours like drug use, frequent alcohol consumption, or smoking (Beach 2019) as a coping mechanism to manage their emotions considering these multiple oppressions given the lack of social capital that may exist for their needs.

In terms of health access, McDermott et al. (2021) identified people in LGBTQ+ communities experience significant health inequalities with regards to provision of health care service, health risk factors and health outcomes in comparison to heterosexual people. Survey research with 108,000 participants (NHS 2017) identified that 16% of respondents had a negative experience of healthcare, 38% perceived they had a negative experience because of their gender identity, 51% said they had to wait too long for mental health services and 80% of trans respondents said accessing gender identity clinic was not easy. Bachmann and Gooch (2018)'s study similarly highlighted the presence of elevated levels of prejudice, negative remarks and unfair treatment the LGBTQ+ people receive from healthcare staff.

The Royal College of Nursing (RCN) have produced guidance to support nurses working with people who are LGBTQ+ communities (RCN 2016) and this includes being sensitive and using inclusive language. For example, instead of asking for next of kin ask for a contact person for who information should be shared, challenging discriminatory behaviours of other staff and patients so that there is a safe environment for LGBTQ+ patient or parents of LGBTQ+ children to be open about their relationships.

People from Ethnic Minority Communities

In terms of health status, the Parliamentary Office of Science and Technology (2007) highlighted that ethnic minority communities have worse health than the overall population and there is also evidence that poor mental health (Race Equality Foundation 2019) further acts as a barrier to accessing other health services. There is however a scarcity of data pertaining to specific health experiences of older people from ethnic minority communities (Centre for Ageing Better 2020, 2021) and thus is one area practice nurses may be interested in researching. The Centre for Ageing Better (2020), noted that the proportion of people in England aged 61-70 who are in poor health is much higher for ethnic minority communities with 86% of Bangladeshi people, 69% of Pakistani people, 63% of Indian people, and 67% of Black Caribbean people noting poor health in comparison to 34% for white English people. The recent Covid 19 pandemic further highlighted health disparities for ethnic minority communities

(Public Health England 2020). People from ethnic minority communities are more likely to be key workers and or work in jobs where they are at increased risk of being exposed (The Health Foundation 2020). Within the NHS for example, 40% doctors and 20% nurses nationally (and 50% in London) come from ethnic minority groups (Public Health England 2020). During phase one of the outbreak (Jan - Sep 2020) risk rates of mortality were higher in ethnic minority groups compared to white group including Black African (3.7 times higher for men and 2.6 for women), Bangladeshi (3.0 for males and 1.9 for females), Black Caribbean (2.7 for males and 1.8 for males) and Pakistani (2.2 for males and 2.0 for females) (Office for National Statistics (ONS) 2021). In the second wave (September 2020 onwards) the differences in mortality compared to white British increased for the Bangladeshi community (5.0 for men and 4.1 for women) and both Black Caribbean and Black African backgrounds remained at a higher risk (ONS 2021). It is important to remember that ethnic minority communities are disproportionately affected by socio-economic deprivation which we noted in the previous paper is a key determinant of health status. This is further perpetuated due to racism and intersectional and multiple oppressions. People from ethnic minority communities often experience structural racism and discrimination which strengthens inequalities with regards to employment, housing, and criminal justice system, which may then lead to negative impact on health (Raleigh and Holmes, 2021).

In terms of access to care, whilst the NHS is free upon delivery there is evidence that people from ethnic minority communities report a poorer experience of care delivery across a range of services (Kings Fund 2021). Furthermore, in terms of mental health research by the Race Equality Foundation (2019) noted that Black people were less likely to be referred to talking therapies and more like to receive medication for poor mental health suggesting a medicalisation rather than health promoting role that addresses health inequities. In terms of practice nursing, it is important to note that key ethnic minority groups are at greater risk of specific conditions; for example, Black people are more likely to have hypertension and are at increased risk of experience of Coronary Heart Disease as such, regular blood pressure checks are important (Kings Fund 2021). In addition, obesity levels are also higher in Black groups. The National Institute for Health and Care Excellence (NICE) guidelines (NICE 2013) identified specific guidance which needs to be considered. Lastly, considering risk factors there is a mixed picture in that mixed ethnic groups had the highest prevalence of smoking whilst Asian ethnic groups had a higher prevalence of inactivity whereas Black ethnic groups had a higher prevalence of inactivity and excess weight (Gov UK 2017). Practice nurses can a key role in supporting behavioral change in terms of smoking cessation, weight management and promotion exercise as well as supporting this through social prescribing schemes.

Conclusions

These two papers in the series have identified that whilst the UK is a relatively high income country that provides healthcare free on the basis of clinical need there is evidence that health is not equal amongst different populations in the UK. It is evident there are significant health disparities facing certain communities including those who are homeless, or from ethnic minority or LGBTQ+ communities. It is also evident that individuals and families living in poverty also have poorer health outcomes, and key to addressing this is addressing the wider determinates of health with its associated impact over the life course. Practice nurses are one of the few nurses that work across the life course and as such have a huge contribution to make in addressing poorer health outcomes. In order to achieve this, they need to understand the differences between equality and equity and the importance of tailoring health interventions to meet the needs of their patients. Through the recently established Advanced Clinical Practice (ACP) there are huge possibilities for practice nurses to really look at working with population and community groups rather than just on a one to one basis but time, support and resources are needed to ensure this can occur. Those practice nurses not working in ACP roles can also promote health and wellbeing of communities through their daily interactions and their holistic assessment of patient's needs.

Key Points

1. Practice Nurses have a key role in addressing health inequity of social excluded groups; either as Advanced Clinical Practice Roles or through the Making Every Contact Count initiative.
2. When working with people who are homeless, practice nurses have to consider the wider social determinates of health in managing their care and promoting their health and wellbeing
3. Practice nurses need to ensure that the language used in consultations and in their paperwork is respectful to those from LGBTQ+ communities, replacing next of kin with contact information
4. Practice nurses need to have an understanding of the specific health implications for different ethnic minority groups

CPD Reflective Practice

1) Reflect upon your practice, what initiatives are there in your surgery to promote health inequity?

2) Read the Core Capabilities Framework for Advanced Clinical Practice (Nurses Working in General Practice/Primary Care in England (NHS 2020). Which of the core competencies do you meet in your practice? Identify two other core competencies to work on in the next six months

3) Are you aware of the local homeless services in your region, how can you engage with these to promote the health and wellbeing of those who are homeless?

4) How much of your practice is tailored to meet the needs of those from ethnic minority and LGBTQ+ communities. What have you learnt from this article that you could incorporate into your practice?

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