
**LONDON NETWORK OF NURSES AND
MIDWIVES
HOMELESSNESS GROUP**

**Pan London Homeless Health
Care Commissioning**

LNNM Conference 2015

Recommendations

CHAIRS NOTE

This report has been entirely prepared by the volunteer efforts of nurses and midwives working within the London Network of Nurses and Midwives Homeless Group (LNNM). It has required significant effort and labour. LNNM has no sources of income and is entirely dependent on the goodwill of members and project specific grants to deliver our conference and any publications.

It is our hope that this conference report will contribute to the commissioning of significantly better services for homeless people pan London, by profiling the views and ideas of those currently engaged in relevant service provision. Our network will also endeavour to see that these principles and outcomes are integrated into practice throughout London's healthcare system.

We are very grateful to the London Housing Foundation who funded our annual conference, and Groundswell who co-produced the conference. We are also grateful to many other organisations who provide logistical support and organisational space to hold meetings and discussions.

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EXECUTIVE SUMMARY

This report provides recommendations regarding Pan London Health Commissioning for homeless people drawn from the 2nd LNNM Homeless Health Conference 2015.

Firstly, notes are provided on the Focus Groups that were undertaken in order to inform the pan London commissioning agenda. These groups involved all conference attendances.

Secondly, there is a report of the panel discussion in which key policy makers from NHS England, the CQC, the Department of Health, Lambeth CCG and Westminster City Council were asked some hard questions about both the practical realities of policy delivery and the implementation challenges that health care professionals and allied workers in the homelessness field face. There was much discussion about the interface between housing and healthcare, and the political nuances of service access.

Thirdly, associated views from nurses and midwives within the LNNM Homelessness Group expressed at the time of the conference are summarised.

The LNNM Homelessness Group believes that the overall message coming from the conference participants is that commissioners should endeavour to commission services that:

- **Minimise Unnecessary Gatekeeping** - this refers to streamlining of processes through which services users gain access to healthcare and allied services. **Flexibility of access** was seen to be a key priority.
- **Integrate Care** - where specialist services are available, multiple services and specialisms should be co-located with a unitary access policy and cross speciality working.
- **Provide Assertive outreach** - services should provide assertive outreach to case find and ease access to healthcare where relevant.
- **Involve experts by experience** - Co production of services was recommended to ensure services are accessible and meaningfully delivered in the terms of the group of people they are providing for.
- **Assist mainstreaming** - specialist services should facilitate access to mainstream healthcare and support service users to transition.
- **Collect and Share data for the benefit of patients** – data should be collected in a way that can demonstrate the underlying morbidity and mortality in the group, and thus support needs assessment. It should also be able to be shared for the benefit of patients.

The report also presents a library of potential **Outcome Measures** that were suggested within the Focus Groups, although the production of pan London outcome measures

was felt to be challenging on many levels. Quantative measures are often indirect or introduce their own biases, and a focus on measurement may detract from the provision of care, as has been argued in other healthcare sectors. However some useful suggestions were made, as the value of simple numerical evidence especially in making a case for services and improving quality was widely recognised.

The report also outlines key messages to commissioners regarding the **potential pitfalls**, but also the **perceived opportunities** that were associated with pan London commissioning.

Finally the LNNM Homelessness Group statement at the end of the report expresses the views of the group that developed as a result of producing the conference, and being involved in these important discussions. A key attribute of the statement is an agreement about **current gaps in service** that need to be addressed, and some messages about **how nurses and midwives can be supported to lead the way** in improving inclusion healthcare.

In summary, this report provides a detailed snapshot of the views of around one hundred and forty healthcare practitioners and allies working in the field in London. It is our hope that this will prove extremely useful for service development both for practitioners and commissioners alike.

Maxine Radcliffe, LNNM Homelessness Group Chair

August 2015

INTRODUCTION

The London Network of Nurses and Midwives Homelessness Group (LNNM) is a pan London network that has existed since 2002. There are at least 200 healthcare professionals in the London network, and an increasing number of allies who work in fields such as housing, outreach or peer advocacy.

Aside from the recent conferences, the network holds bi-monthly meetings in London, and hosts a website which is a repository for shared learning resources. The group has previously produced national guidance on homeless hospital discharge, and has developed its own knowledge and skills framework.

One of the outcomes of the first London Network of Nurses and Midwives (LNNM) Homelessness Group conference in April 2014 was representation from LNNM members to the London Health Commission in June 2014. LNNM members presented alongside the Pathway charity, and St Mungos Broadway. Many issues were profiled, but primarily the concerns raised regarded the perceived requirement for a different approach to homeless health care commissioning - in order to meet the needs of homeless clients with multiple complex needs, who are transient, and accessing multiple services. Three case studies that were presented to the Commission by the LNNM group are included in Appendix 1.

In response to this, the need to improve homeless health services was outlined by recommendation 31 of the Better Health for London report, which states:

'Health and care commissioners should develop a pan-London, multi-agency approach to health care for the homeless and rough sleepers, with dedicated integrated care teams and commissioned across the capital by a single lead commissioner.'

As a consequence the Healthy London Partnership – a collaboration between NHS England and all London CCGs, is now jointly leading a programme to transform London's homeless health services. An operational board was established to steer the programme (the Health for Homeless People Programme Board) and two LNNM group members currently sit on the Board. The work programme has moved fast, and Lambeth (CCG and Local Authority) and Central London CCG have recently been appointed as joint Lead Commissioners.

The second LNNM Homelessness Group conference was seen as an opportunity for service providers to input into the development of the programme. The Conference theme was 'Austerity and Access'. This highly successful conference was attended by a wide range of health care professionals and allied colleagues including homeless peer advocates working mainly in London. Conference attendee views were established via focus groups, a panel discussion, and additionally through the capture of some more informal networking discussions.

The recommendations in this report are therefore drawn from a pool of around one hundred and forty healthcare practitioners working in London in the field of

homelessness and allied services including peer advocacy, as well as homeless clients. This report has also gone out for consultation throughout our peer network.

FOCUS GROUPS - METHODOLOGY

Methods and Impact

The following sections of the document are an attempt at synthesis of the themes emerging from the focus groups. It should be noted that the majority of this has been done by network members whom have some research training, but have not used one explicit qualitative methodology. We have attempted to aggregate things based on order of frequency and emphasis based on the notes taken during the groups. Where possible some illustrative quotes have been provided. It is our belief that this report constitutes a fair summary of participants' views and given the nature of the number of participants and range of clinical expertise that the report should be a strong steer for commissioners.

Operational Delivery

The four focus groups each contained approximately thirty people and lasted an hour and involved all conference attendees. The structure of questions for the Focus Groups were discussed in advance and agreed with members of the Health for Homeless people Programme Board. Participants were deliberately mixed across the groups to get a spread of London geography and clinical expertise as far as was possible.

The Focus Groups were facilitated by LNNM members. Each group was split into four smaller groups (7-8 in each group), and each smaller group asked to consider the following statement, and answer the questions below:

One of the aims of the pan-London Homeless Health Services programme is to set up a lead commissioner model, where one CCG leads on behalf of the rest of London.

This is a significant challenge.

1. We want to know what your group thinks are the **key 5 core service attributes** that a lead commissioner should be looking for in all homeless health services – no matter where they are, or what their core remit is. *(10mins to discuss, 10 mins for feedback)*
2. When you have decided on this we would like you to take **2 of these core service attributes and suggest 2 possible outcome measures** (1 for each) that might be used to measure these. *(10mins to discuss, 10 mins for feedback)*
3. Finally we want to hear any **concerns that your group has about the concept of pan-London commissioning** that may have arisen from your discussion. Ideally we would like to hear 1 concern per group. *(5mins to discuss, 10 mins for feedback)*

Focus Group Facilitators

Maxine Radcliffe, David Robertson, Samantha Dorney-Smith, Paul Coleman, Rosa Ungpakorn, Malachy O Hagan, Jane Cook, Ela Orciari (all are senior nurses working in homeless services pan London).

Summary

The following pages give detailed notes outlining the responses to the questions, and a summary of the discussions that took place. However the headline **commissioning principles** that came through in the discussions were that services should seek to:

- **Minimise Unnecessary Gatekeeping** – It was widely accepted that homeless people experience many barriers to accessing healthcare, and in order to mitigate this services should provide access to initial assessment for all - local connection issues and immigration issues should not come into this. Inclusive access policies e.g. drop in clinics should be encouraged. Disability, language and literacy issues should never be barriers. Services should consider increasing hours of access outside Mon-Fri 9-5.
- **Integrate Care** - Services should ideally integrate care for physical, addictions and mental health, and wherever possible provide a one-stop shop to housing, immigration services etc. A quote from a service user was significant 'I felt unmanageable. I was sent from pillar to post.'
- **Provide Assertive outreach** - Services should provide an assertive outreach model to case find and provide drop-in clinics, as well as actively following up those otherwise lost to follow up.
- **Involve experts by experience** - Services should involve peers wherever possible as there is good 'on-the-ground' evidence that health outcomes and engagement are significantly improved in both the immediate and long term. Peer advocacy/experts by experience should be integral to service design, so that as many barriers to access as possible are mitigated. It was expected that where this is implemented it will have positive health outcomes and result in better engagement.
- **Assist mainstreaming** - Permanent GP registration should be standard wherever a patient is registered, so that patients so can access follow up and secondary or tertiary care if needed. This should also enable better management of chronic long term conditions. There should be an emphasis on transitioning people into mainstream services as a move to recovery. Mainstream practices should be held to account if they are not following recommended registration procedures.
- **Collect and Share data for the benefit of patients** – data should be collected in a way that can demonstrate the underlying morbidity and mortality in the group, and thus support needs assessment. It should also be able to be shared for the benefit of patients.

CORE SERVICE ATTRIBUTES

The core service attributes that were felt to be **essential** (in order of the approximate order frequency in which they were discussed):

1. Services should provide access to initial assessment for all - local connection issues or immigration issues should not come into this.
2. Services should be flexible, and think about increasing hours of access if possible. Services should be able to meet the needs of those with disabilities, and literacy/ language barriers should be well catered for.
3. Services should provide assertive outreach according to local need.
4. Services should ensure clients are permanently registered with GPs, and aim to mainstream people as much as possible. There should be an emphasis on transitioning people into mainstream services wherever possible, as a move towards recovery.
5. Services should seek to work in partnership, and ultimately to integrate physical, addictions and mental health services. Wherever possible a one-stop shop approach to all relevant services involving e.g. housing, immigration services, benefits, welfare to work, dental and podiatry etc should be encouraged. If not possible, services should have up to date directories of other services they can signpost to in their local areas, and should have good working relationships with these services.
6. Services should seek to minimise referrals to multiple sites wherever possible, and seek to obtain realistic appointments for clients.
7. Services should be empowering for service users, involve peers in their design wherever possible, and ideally have a peer advocacy element.
8. Services should improve physical and mental health in a measurable way.
9. Services should share data with other services in a way that benefits service users, and supports effective case management and safeguarding.
10. Services should actively signpost patients to services to get them work ready e.g. ESOL classes, IT classes, employment advice, welfare to work advice where this is relevant.
11. Service should seek to retain staff, primarily by providing adequate training and protected time for informal networking support and more formal supervision services e.g. physical health, mental health and addictions services for homeless people were cited as particular issues

CORE SERVICE ATTRIBUTES - DISCUSSION

'I felt un-manageable. I was sent from pillar to post' – Service User

There was a general sense that enabling health care access was the most important attribute that a service could have. It was frequently suggested that as a priority any simple operational barriers in existing specialist services should be broken down as soon as possible. Everyone agreed that initial assessments should never be refused, even if signposting on was likely. There was a view that all services should move towards walk-in services with extended hours where possible. Good access to interpreting services should be provided at all times, and literacy should not be a barrier. Where outreach services are being provided in locations without disability access, this should be highlighted and dealt with ASAP. One stop shops were widely agreed as the ideal solution where this was possible, encompassing e.g. physical health, mental health, addictions, housing, dental, podiatry, and optician services, and benefits and employment support. However in other areas where one stop shops were felt to be unrealistic, active partnership between services was felt to be key. Access to faster social care assessment was also viewed as desirable.

'We need a one-stop shop which would encompass key areas: health, housing, social care, other support' – Joe (Central London CCG)

Many participants highlighted that assertive outreach was important, but it was suggested that this might look different depending on the core service. For example this might encompass regular outreach visits to a key homeless hostel or day centre, or could be focused on outreach to specific individuals on request. However the underlying principle was that outreach should always be able to be provided to meet the needs of very vulnerable clients if necessary.

Integrated service provision was view to be vital, and there was discussion regarding how to ensure continuity of care on discharge. There was a particular concern about the current need for service users to engage across multiple agencies, and also the ability of services themselves to develop a coherent care plan across services, whilst ensuring appropriate patient confidentiality and consent. It was also felt that 'referring on' could in some cases be detrimental to the relationship between the provider and the service user. Case management solutions that work across service boundaries were recommended, and the development of pan-London care pathways.

'The relationship is fundamental, and if that goes they won't come back'
– Tristy Robinson

The importance of sharing of data so that e.g. safeguarding alerts can be shared contemporaneously came up frequently. However also highlighted was the need to stop clients having to recount their stories numerous times, the need to avoid staff doing duplicate assessments, and the need to support case management and care pathway approaches – thus emphasising the need for a shared clinical system, or at least compatible systems. Standardised data collection was recommended to allow benchmarking and inform commissioning decisions on planning / service improvements. There were frequent debates around information governance (particularly if there is considerable integration with non NHS services), and it was recognised that there was a need to do further work in this area.

Specialist services were not seen as the only services relevant to homeless people, as there was a general view that homeless people should be accessing mainstream services, and be moving into mainstream GP practices when they are able. However the lack of ability of all mainstream services to deal with any form of ‘difference’ was much highlighted (e.g. services not being able to deal with clients who change address frequently, or those who find it hard to wait in a waiting room, or those who have literacy and language problems). It was felt that wider education of mainstream service staff regarding the needs of homeless people was needed (e.g. a 5-10 minute awareness raising film explaining how a homeless person might feel when trying to access mainstream services).

Temporary GP registration was seen as bad practice for this group, although it is now not common practice within specialist services. It was felt that GP practices should be encouraged to help people to move towards permanent registration in all cases, by signposting them to services which can help patients to get identification, if they are unable to do this themselves. It was identified that chronic disease management should be given an extra focus, although it should be acknowledged to be more complex, and require greater time investment than in mainstream services. Moreover all homeless people should be referred on into secondary or specialist services on the basis of clinical need, not based on the likelihood of attendance or adherence, and that homeless people should receive extra support to attend / adhere to treatment.

‘It’s about encouraging services to up their game and raise their standards’
– Stan Burridge

It was strongly expressed that services should involve peers wherever possible (e.g. by focus groups, and by involving peers in service development discussions and recruitment etc), but should also work towards having peers as employees in a peer advocacy role. It was suggested that this was likely to lead to better engagement and more positive outcomes for more chaotic clients. Research / evaluation in this area was recommended. Overall the need for services to be empowering for service users was agreed, and as such people felt that signposting patients to appropriate training and education was a part of the health role.

'If you invest in the individual it will be more expensive...but the outcomes will be better' – Stan Burridge

Finally it was discussed that specialist training courses for staff were limited (both due to lack of availability of suitable courses, and due to funding restraints on smaller services), and that adequate supervision was necessary, but not always available. There was discussion about the need to work to retain staff, as the current high turnover in some areas has negative impact on relationships with clients. A key route to this would be by improving access to CPD, and supervision, but also by ensuring access to informal networking support like e.g. the LNNM group. Psychologically informed working environments were recommended.

'[homeless organisations] need training in person-centred active listening skills...as a way to establish and maintain relationships, and also regular supervision...to equip the staff with the means to develop their shared understanding.' – John Connolly

FOCUS GROUPS - OUTCOME MEASURES

The outcome measures most commonly suggested were:

- Measures of overall accessibility of services
- Increase in GP registration / enabling access to mainstream services
- Increase in number of clients with a multi-agency care plan
- Increase in engagement in care (e.g. via a reduction in outpatient DNAs)
- Patient satisfaction
- Increase in number of clients receiving peer advocacy support and/or level of peer involvement in the service
- Public health related outcomes / chronic disease related outcomes (e.g. health check measures, vaccinations etc)
- Decrease in unnecessary A&E attendance
- Decrease in unsafe discharges
- Extent to which a service supported it's staff
- Patient self-reported health outcomes (PROMs)
- Housing outcome measures

OUTCOME MEASURES - DISCUSSION

This element of the discussion was perceived as the most challenging by many of the focus groups. The difficulties establishing meaningful, quantifiable outcomes measures were commonly discussed. The services represented at the conference specialised in several different aspects of healthcare and looked after different patient groups, making it hard to agree on quantifiable measures that would be meaningful for all. It was also felt that targets for individual patients should be very individual, focusing on specific needs and progress. There was discussion regarding how targets for clients might vary widely amongst individuals e.g. for some people gaining a job might be a priority, where for others it might just simply be surviving.

'There must be some incorporation of the human element, they [the service users] have been on a journey' - Cath

One suggestion to tackle this problem was the development of a new Pan London Homeless Assessment Tool. It was felt that this could take account of e.g. service access and key public health indicators, but could also include more social indicators for

example access to training or employment, and the obtainment of housing, as well as allowing individualised goals to be agreed across services.

‘[We must appreciate the] different levels of outcomes: the personal outcomes and our care outcomes’ – John Connolly

‘We must be braver in thinking about outcomes... co-producing outcomes’
– Tristy Robinson

There was again discussion regarding the need to develop a shared dataset in order for services to be able to report on patient morbidity and mortality, and levels of vulnerability in the population served.

‘Sadly, a measure of a positive outcome is whether they are still alive at the end of the quarter...’ - Stan Burridge

It was noted that it would be difficult to benchmark services without being able to fully understand the nature of the population served, and that there was a need to ensure that simple attributes like housing status, immigration status etc needed to be routinely collected. For example, there was discussion about ‘hidden homelessness’, and how some services would be unable to report on the number of sofa surfers or homeless hostel dwellers they served due to inadequate coding.

It was also felt that a future target for services would be to be able to report on early interventions provided to prevent future homelessness (e.g. patients discharge with floating support services in place) and/or reduce impact of homelessness. The importance of measuring the potential long-term hidden costs of homelessness, both on individuals and on the economy, was emphasised. For example reductions in criminal justice contact could be measured.

Some suggestions were made about specific outcome measures with a health context, and these are outlined in the following pages.

SUGGESTED OUTCOME MEASURES

Flexibility / open access

- Services could be asked to describe the measures they have in place to meet the needs of various groups e.g. clients with literacy problems, clients with language difficulties, clients with disabilities
- The % of contacts with non-English speaking patients that used interpreting services could be measured
- The number of assertive outreach contacts / outreach clinics could be measured
- The % referrals to a service that are rejected could be measured (services could be asked to keep a log of referral rejections with reasons)

Enabling access to GPs / mainstream NHS services

- Services could be asked to report on the % of patients who have permanent GP registration 1 month after 1st contact with service
- Services could be asked to report on the % referrals made to secondary care / specialists (maybe in particular areas of concern e.g. Hepatitis C or mental health services)
- Services could be asked to report on % secondary care / specialist booked appointments that are attended
- Services could be asked to keep a log of onward referrals rejected (in order to monitor trends in secondary / specialist service access)
- Services could be asked to keep a log of discharges with discharge destinations (in order to establish the numbers of clients 'mainstreamed')

Integrated services & one-stop-shop provision

- Services could be asked to report on the % of clients with a multi-agency care plan (preferably following MDT discussion)
- Services could be asked to report on multi-professional/ agency working within services
- Services could be asked to demonstrate up-to-date directories / referral pathways to relevant organisations
- Services could be asked to be able to demonstrate joint working with other relevant services e.g. providing evidence through minutes of MDT meetings, information sharing agreements / protocols, joint record keeping systems etc

Patient engagement in own care / Patient satisfaction

- A tool could be sourced to measure the % of patients who felt actively involved in own care
- DNAs could be measured (both for follow-up appointments to the service, and any for any onward referrals)
- Use of the Friends and Family test could be considered (perhaps an edited version – would you recommend this service to other people who found themselves homeless)
- Specific questions e.g. ‘Do you know what to do in a crisis?’ ‘Do you know how to make a complaint?’ could be used to measure service performance
- Level of overall patient satisfaction with their care could be measured.

There was much discussion regarding how patient satisfaction could be measured e.g. via patient questionnaires and patient participation groups, although obstacles to these e.g. the levels of literacy and the variety of languages spoken by this population were noted. Some services used incentives for involvement, but this is obviously problematic. For clients with mobile phones, independent follow-up of patients after encounters with a service to request feedback was suggested, or independent persons sitting outside clinics to get feedback at the time (perhaps a couple of times a year). There was discussion regarding whether staff could come to perform this function for each other’s services.

Peer involvement in services

- Services could be asked to demonstrate peer involvement e.g. in board / management / decision making structures and recruitment
- % of patients referred to a peer advocate could be measured (for services with this option available)
- Services could be asked to report DNA reduction (within services / secondary care) in patients who are referred to a peer advocate

Public Health Outcomes

Suggested outcome markers were:

- % of clients receiving relevant vaccinations (or referred for these) e.g. Hep A / B, flu, pneumococcal
- % of clients receiving BBV testing / STI testing (or referred for these) taking into account appropriate protocols for when to re-test
- % of clients receiving cancer screening e.g. cervical screening
- % of clients receiving TB screening (either verbal testing, or via chest x ray)
- Mortality rate measures??? (only if overall caseload mortality could be measured alongside)

- % of client deaths discussed to establish joint learning

Reduction in unnecessary A&E attendance

There was discussion regarding how this should not be used to dissuade clients from accessing emergency services appropriately however potential outcomes suggested were:

- No of frequent attenders known to the service (how services would get this information and report on it would need to be discussed)
- % of frequent attenders with a multi-agency care plan
- % of frequent attenders referred to a peer advocate
- % of frequent attenders with a crisis plan in place

Providing a positive and supportive working environment for staff

- Services could be asked to report on structured CPD & training available to staff
- % staff satisfaction could be measured (via staff surveys)
- % staff attending regular clinical supervision sessions could be measured

Housing outcome measures

- % of rough sleepers moving into accommodation

It was discussed that although improving housing status was not a traditional core target of homeless health services, resolving homelessness was a key step in the move towards recovery, and an important mediator in getting ongoing access to health care services. As such 'improvement in housing status' could easily be a core outcome. However in order for this to be reportable and measurable it was noted that housing status and associated housing stability would need to be measured in a consistent way.

It was noted that some recent work that was done for the Westminster Homeless Health team around outcomes which might be useful to commissioners. This work will be made available when this report is published.

FOCUS GROUPS - CONCERNS ABOUT PAN-LONDON COMMISSIONING

The main concerns regarding pan-London commissioning were:

- Concerns about the interface between commissioners and providers (pre-existing)
- Concern that a central commissioner might lead to a loss in responsiveness to local needs
- Concerns regarding the monitoring of process - who will ensure this the process is actually improving things. Will key concerns of staff be dealt with through this process? e.g. issues regarding clients being unable to register with GPs, concerns regarding what to do with sick clients with no eligibility etc
- There was a concern about data sharing consent / protocols within integrated services e.g. those with peers
- There was a concern about the One Stop shop idea, and whether staff training would be available to ensure this could be delivered.
- There was a concern regarding services currently being funded on a year to year basis (because recovery in this group is around long term engagement) and whether pan London commissioning could address this

However the discussion revealed that participants could also easily identify the opportunities presented by pan London commissioning, and as such discussion below focuses both on the potential pitfalls, but also on the perceived opportunities presented by pan London commissioning.

CONCERNS ABOUT PAN-LONDON COMMISSIONING – PITFALLS AND OPPORTUNITIES

Interface between commissioners and providers

Participants commonly suggested that there was urgent need to overcome the underlying, pre-existing issue of disconnection between commissioning and service provision. Many services reported not currently knowing who their commissioners were, or how to enter into dialogue with them. This was felt to be a historical change (staff reported previously knowing who their commissioner were) that needed reversing.

It was also felt that pan-London commissioning body stood a strong risk of not being engaged with services equally even if a dialogue was started – and that smaller services

could easily continue to be disenfranchised. Given that many of the smaller service have the most difficult issues to address, it was felt this was an important concern.

However overall it was important to note that participants were generally very keen to engage with commissioners.

Central commissioning may lead to loss in responsiveness to diverse local needs

There was a concern that a pan-London commissioning framework applied to homeless health services might not be responsive to local needs. There was a concern that smaller services might try to attempt to deliver in line with the larger services, and therefore deliver something that was not needed, or simply fail through lack of resource. Similarly there was a concern that specific gaps might be missed.

‘Commissioners are not involved or engaged enough in the actual services... where there is a need or a gap’ – Emily

There was discussion around the possibility that the centralised commissioning carried with it a danger of an actual dilution of expertise in commissioning – i.e. it is unlikely that one commissioner could be an expert in all of London’s homeless health needs e.g. the difference between Westminster, Croydon and Ealing were discussed.

There was a consensus that a pan London commissioning body should be aware of the differing issues and priorities in separate localities, and be able to enable local services to respond to local needs in partnership with other services. It was suggested that a pan London commissioning body should lead on developing locality assessments, and that this would provide a basis for active engagement with the individual providers. An initial pan London homeless health needs assessment was suggested.

There was a suggestion that in order to respond to the ‘different areas - different needs’ issue, whilst maintain the value of specialist commissioning, it would be useful to split pan-London commissioning into an inner and outer London forum.

Monitoring of the quality improvement processes

Participants identified that the pan-London commissioning idea was a real opportunity to improve quality in service provision and reduce inequalities. However there were questions raised regarding who will be responsible for monitoring the pan-London commissioning process (and the resulting healthcare provision), in terms of actual service quality improvement. Examples of potential issues that staff currently want to see resolved e.g. problems with GP registration, issues with eligibility for No Recourse

to Public Funds patients, problems with social care access, enabling adequate data capture - there were questions regarding how progress would be reported.

There were also concerns regarding whether the commissioning process would allow frontline staff concerns to be raised and dealt with. One proposed solution was that there could be commissioner - provider forums to enable feedback and share learning. It was felt that service users should also be present on these panels.

There was also a concern raised about the danger of increased bureaucracy, and wasted clinician and administrative time if new processes are implemented – it was felt that any new processes due for implementation should be widely consulted on to ensure practical application, and that existing innovations should be built on wherever possible e.g. existing Pathway standards.

Data sharing and implementation of integrated services' protocols

There appeared to be a consensus that e.g. an established data sharing protocol across homeless services would be of huge benefit to service users and service providers – focused initially on alerts, safeguarding concerns, and 'immediate action plans'. However, there were concerns raised around data sharing consent protocols and the broader issue of monitoring these processes.

The new commissioning arrangements were looked on as an opportunity to look at this issue pan London in order to avoid duplication of the considerable amounts of time that have already been spent discussing these issues with Information Governance departments.

Data sharing with voluntary sector services including peer advocacy services (how to do this safely), and system interoperability (is there a joined up approach) were identified as issues that a pan London commissioning body needed to address as a priority.

'One Stop Shop' service models - the need for additional staff training

While the inclusive, holistic nature of a 'One Stop Shop' model of service was seen as desirable – there was a concern that this should not lead to 'One Size Fits All' approach. There was a feeling that ambitions should be realistic and deliverable, and that core priorities should be established - particularly in the context of already overstretched services.

In general it was felt that if homeless health care staff were to be jointly focused on health care and social recovery interventions then multi-skilled staff would be needed. Although there was a general appetite for development and training, there was a concern about how realistic this would be in the current landscape of lesser funding.

There was also a concern about the dilution of specialist skills, and whether this would lead to lowest common denominator services - forgetting that homelessness health itself is a highly specialist area of practice.

‘There is less funding across the board, resulting in fewer specialties being involved in homeless health and a risk of losing the finer detail’ – Tristy Robinson

Funding concerns

Many practitioners were concerned that pan London commissioning could lead to more reorganisation of services, job losses, and more short term funding envelopes for ‘pilot projects’. There was a general concern that current trends in short term funding were not good for staff retention or project success, and that pilots should ideally take place over 18 months to 3 years at the least. There were also concerns about some existing funding streams might be withdrawn, and there would be a lack of transparency around this.

However there was recognition that if duplication could be reduced e.g. through better data sharing, efficiency savings might result.

Commissioning boundaries

Finally there was a concern about the complexity of service delivery and whether the Lead Commissioner would really be able to deal with addressing complex commissioning boundaries that currently exist – as homeless health care commissioning spans health, social care and the Local Authority. The need to involve all commissioners from all these areas was identified.

PANEL DEBATE - 'AUSTERITY AND ACCESS'

The panel debate took place after the Focus Groups and focused on the conference theme, and attempted to further draw out issues of concern for service providers.

On the panel were Dr Adrian McLachlan (Lambeth CCG Chair / Chair, Homeless Health Services Transformation Board), Dr Ray Earwicker (Senior Policy Manager, Health Inequalities Unit, DH), Michele Golden (Head of GP Practice Inspections – London, CQC), Jenny Travassos (Rough Sleeper Commissioner, Westminster) and Caroline Alexander (Chief Nurse for London, NHS England). The debate was kindly facilitated by Stephen Robertson, Chief Executive of the Big Issue Foundation. Questions were invited prior to the session, and the most popular questions (voted on by all attendees at registration) were the questions asked in the debate.

The debate was seen as real opportunity to engage with policy makers, and it was notable that several service users got involved in the debate. Attendees from NHS England and the Office of CCGs said they found the debate very informative regarding the current concerns of service providers.

The full suite of questions that was made available for voting (suggested by panel members) is available at the end of this report (Appendix 3), but the ones that were chosen concerned:

- Issues with mainstream GP registration
- Issues with No Recourse to Public Funds clients (mainly EEA Nationals) with addictions, who are not agreeing to return home, but have no to access addictions treatment and are deteriorating on the streets
- Issues with some clients not being able to access outreach nursing services due to local connection issues
- Concerns about clients with high level safeguarding issues, that homeless teams are managing without support from safeguarding teams and/or social services
- Concerns re a lack of training opportunities for nurses in the area of inclusion health

The chosen questions are outlined as follows along with the key related points that arose, it is worth noting that the responses from the panel members are outlined in depth but there was considerable audience participation which it has not been feasible to document extensively here. However the audio is available from <https://soundcloud.com/lnmhomeless/panel-discussion-austerity-and-access-lnm-2015>

PANEL DEBATE - NOTES

Question 1: We all know there are many mainstream GP practices that turn away homeless people, on the surface of it because they have no ID to prove they live in the area. Do you think this is right, and if not, what can be done about this?

Michele Golden made it clear that the Care Quality Commission (CQC), as a regulatory body, expects GP practices to register homeless people. This includes instances when a homeless person is legitimately unable to provide documentation such as passport or/and proof of address. Persons with no fixed abode are entitled to register with GP practice using a temporary address, address of a friend, the centre they are attending or, indeed, address of the GP practice they are intending to register with.

Adrian McLachlan emphasised that that GP practices are intended to be the universal service providing the first level of care, and they should be doing this. He stated that there is no requirement to apply ordinary residence test before allowing a homeless person to access primary care. It was also pointed out that, from this year – the patient does not even have to be in the practice area.

Dr Phil Timms (audience) brought up an important point about the need to accurately record housing status on clinical records in order to fully understand the numbers of homeless people registering with health services.

Question 2: There is a concern that many people with addictions problems who do not have recourse to public funds, are not eligible for treatment, but are not being deported - so they are deteriorating on the streets. What can be done about this?

Jenny Travassos admitted that there is not an easy solution, and communicated very well with audience in this regard. She emphasised that reconnection is still an option so that persons with no recourse to public funds in the UK can access addiction services in their home country instead, and noted that Reconnections services directly link clients with detox, rehab and supported accommodation services in their own countries. Removal was discussed - clients first need to be shown by immigration officers that they are not exercising their Treaty rights, and it was noted that joint working with the Home Office threw up complex issues, but was necessary.

Adrian McLachlan said that persons with no recourse are still eligible for addiction treatment in their General Practice. It might be useful to test the definition of 'necessary treatment' in relation to addiction services in extreme cases.

Regarding the 'necessary treatment' issue, Michele Golden said that the Care Quality Commission inspects hospitals' mental health services which include drug and addiction provisions – and that the CQC acknowledges that if non-UK nationals are in severe health crisis due to addiction issues, that they need their immediate healthcare

delivered in an appropriate service. The CQC would expect to see evidence of robust decision making in these cases.

Ray Earwicker said that the inequalities issue needed further analysis, and that he would like to hear more about this, and would be happy to attend an LNNM meeting to discuss this further. He noted that a pan-London strategy should include robust economic analysis to help build business cases for doing things differently, i.e. focusing on prevention and early treatment. Such business cases would only rely on economic argument, but are also quite clearly supported by the fundamental human right argument.

Question 3: In Westminster some clients without a local connection are now not able to access day centre services, and as a result they cannot see the outreach nurses working in the day centres. Should local connection issues be allowed to affect access to health care?

Jenny Travassos informed that Westminster has 36% of all UK rough sleepers - approximately 250-300 persons on the streets every night. The restricted access to local authority commissioned day centres applies to people with no local connection, and those not willing to engage with the housing plan - but usually takes place after initial assessment / signposting. Again it was described to be a difficult decision, and any lack of health access an unintended consequence.

Jenny noted the need for central government commitment to empower and enable local authorities to work differently in order to make access to housing better than it is currently.

Adrian McLachlan pointed out that there are generally ways of accessing healthcare other than day centres (and this is definitely true in Westminster), and while it is good to bring healthcare on outreach - we should be promoting wider universal access to primary care, such as GP practices wherever possible.

Michele Golden said primary healthcare professionals should be encouraged to go on outreach where relevant, including to known rough sleeping sites.

This question prompted a lot of passionate dialogue from the audience, and this linked in with the previous question. There was a real feeling that disenfranchising health access in any way would end up creating public health problems and increase morbidity and mortality - and that health care provision should not be conditional e.g. on someone engaging with housing plan.

Question 4: The threshold for a response from safeguarding teams appears to be getting higher, leaving homeless teams holding responsibility for very complex patients who appear to us to be highly vulnerable. Is there a forum to which this concern could be taken?

Caroline Alexander identified health and social care pan-London safeguarding networks to which homeless health professionals should connect, and said this could be taken up in a future meeting. She also identified that the new Care Act gives opportunities to revisit, and potentially resolve, some of the issues surrounding the concept of safeguarding of this patient group. The LNNM group noted that their next meeting concerned the Care Act.

Jenny Travassos encouraged service providers to contact and involve local authority commissioners in complex cases, and advised ensuring that case conferences were well attended with relevant professionals being consulted.

Michele Golden acknowledged that there was a need for residential care facilities that cater specifically for the complex needs of the homeless, and that this was on the agenda.

Question 5: There is an absence of professional development opportunities, leadership courses, and appropriate supervision opportunities for many specialist nurses working in homelessness. How can this be addressed?

Caroline Alexander encouraged health care professionals to access the NHS Leadership Academy's local and national courses, as well as related mentoring and coaching programmes. She also emphasised that the local education boards are now focusing on education in the areas of: mental health, long-term conditions and substance use and as specialist practitioners we should be utilizing these training opportunities. NMC revalidation process is another opportunity to build on existing post-registration education and practice (PREP). Caroline said she was happy to discuss this with LNNM members in a future meeting.

Jane Cook (audience) noted that the Inclusion Health Programme commissioned Queen's Nursing Institute to produce an education health training guide for health professionals – and that this was due to be released later this year.

Key outcomes from the debate:

Guidance on GP registration which makes it absolutely clear that GP practices should be registering homeless patients without any requirement to provide ID was signposted to, and has now been widely distributed via the LNNM, Faculty of Homeless and Inclusion Health, and via the Homeless Health Services transformation board.

Dr Ray Earwicker has agreed to attend an LNNM meeting later this year to follow-up on concerns regarding rough sleeping clients with no recourse to public funds who are suffering significant health deterioration.

The LNNM group will also be meeting Caroline Alexander (NHSE) later this year regarding safeguarding and training concerns.

Panel members and representatives of the Health for Homeless People Programme Board were made aware of the concerns of conference attendees.

PANEL MEMBERS

Facilitator: Stephen Robertson, CEO, Big Issue Foundation

Dr Adrian McLachlan, Lambeth CCG Chair, is one of the key clinicians being consulted for the Homeless Health Services Transformation programme. This programme aims to deliver the recommendations of the London Health Commission report around homeless health.

Michele Golden, is the current Head of General Practice Inspections for the South. Michele's role involves developing an approach methodology for GP practice inspections, and ensuring all practices are inspected in a way that makes a real difference. She originally trained as a nurse, and was previously a lecturer in palliative care.

Dr Ray Earwicker, is a Senior Policy Manager at the Health Inequalities Unit at the Department of Health, and is attending at a time when the Visitor and Migrant NHS Cost Recovery Programme is being rolled out. In the past he was the Secretary to the Independent Inquiry on Health Inequalities (the Acheson report).

Jenny Travassos is a Commissioner for Rough Sleeper Services in Westminster. Commissioners in Westminster have to make hard decisions about who can and cannot access rough sleeper services, and the inherent challenges mirror the challenges being faced pan London at a time when 53% of the rough sleeping population are not UK nationals, and many do not have a local connection to any London borough.

Caroline Alexander, Chief Nurse for London, NHS England is a champion for compassionate leadership and care, and a long term friend of homeless nurses, having supported the LNNM homelessness group for many years

LNNM HOMELESSNESS GROUP STATEMENT –

THOUGHTS FROM NURSES AND MIDWIVES ON

IMPROVING HOMELESS HEALTH CARE DELIVERY

PAN- LONDON

The following is an attempt to capture the thoughts of nurses that were identified by the LNNM group in networking discussions, and when running the conference.

- a) Nurses working with homeless people have a key role in promoting equity, justice, and human rights, and are there to search out health needs, influence and advocate, and essentially be a voice for the disenfranchised to central Government.
- b) Nurses working with homeless people have a key role to play in meeting the health needs of homeless people pan-London, because they have:
- expertise, experience and skills in meeting multiple, complex needs
 - advanced physical, mental and addictions health assessment skills
 - advanced engagement skills with those who are deemed 'hard to reach'
 - networking skills, and experience of working in multi-professional / multi agency teams including with peers
 - knowledge of the wider issues surrounding health and homelessness
 - considerable advocacy skills
 - a willingness and ability to share knowledge and training
 - audit and service evaluation skills
 - entrepreneurial and often business management skills
 - the ability to deal with change and be flexible
 - leadership skills
- c) Nurses working with homeless people pan-London are already leading on issues highlighted in the 5 year Forward Plan, Public Health Framework and Making every Contact Count such as:
- Developing more accessible primary care models
 - Providing person centred complex case management
 - Developing and working within multidisciplinary teams
 - Promoting integration
 - Developing care pathways
 - Working to prevent disease, and identify chronic health conditions early
 - Providing care for physical health, mental health and substance misuse issues concurrently
 - Reducing use of accident and emergency and promote safe discharge from hospitals

As such it is hoped that nurses can be consulted and involved in developing and taking forward and proposed changes / innovations to homeless health services pan London.

A summary of the specific changes that were thought to be needed:

- ❖ An approach to commissioning that is based on a robust pan London homeless health needs assessment
- ❖ Standardised records and data collection methods pan London which can be accessed by all practitioners and also ideally by clients
- ❖ The continued development of multidisciplinary, multi-agency team including the integration of peer advocates
- ❖ An agreed person centred case management approach with personalised self-management plans
- ❖ A recognition that nurses working in the area of complex case management need to carry low caseloads in order to be effective. Caseloads of 10 – 15 maximum are generally felt to be realistic, although for very entrenched clients this may need to drop below 10.
- ❖ The develop of health promotion resources specifically for homeless people
- ❖ Improved clinical spaces that are spacious and designed to deliver high quality care
- ❖ A robust system to collect and collate client feedback in order to shape service delivery
- ❖ A requirement for homeless people to be the co-designers of resources and services (with appropriate training and support)
- ❖ More integration of existing services e.g. via frequent attender forums, or complex case meeting discussions
- ❖ Better models of support for homeless people designed and commissioned by health, housing and social care in partnership
- ❖ Better training and support for clinical specialist nurses working with homeless people. This should include access to master and leadership classes and should importantly be accessible to nurses working in both statutory and voluntary sector services
- ❖ Development of a clear career pathway for nurses working in inclusion health
- ❖ Funding for an administrator for the LNNM Homelessness group so the network can continue it's good work

With regard to developing an approach to commissioning that is based on a robust pan London homeless health needs assessment, there was considerable discussion regarding current a **gaps in service** that need examining and these are outlined below.

Gaps in service:

- ❖ End of life care (St Mungos have an excellent service, but there are difficulties in many areas)
- ❖ Low level counselling for homeless clients with substance misuse issues (Westminster and St Mungos have the only current services)
- ❖ Specialist services for homeless people with personality disorder (some exist e.g. in Lambeth, but many more are needed)
- ❖ Specialist services for homeless people with brain injury
- ❖ Specialist services for e.g. failed asylum seekers and migrants who have been unable to register with GPs (who have a known high prevalence of public health related issues) - Project London and the Pavilion practice are current provisions
- ❖ Responsive treatment services for clients with Hep C
- ❖ Specialist health services for women potentially including sexual health and midwifery outreach services for homeless women
- ❖ Residential substance misuse treatment options for EEA Nationals not returning home
- ❖ Medical respite (some limited models exist, but this needs developing / formalising)
- ❖ The need for more 'care type environments' for chronically alcohol dependent clients and clients with cognitive / mobility issues (again, only limited provision exists). This will involve liaison between Social Care and Housing.
- ❖ Homeless hospital discharge services are not provided in all hospitals, although this is now accepted as good practice
- ❖ Specialist services for chaotic individuals in the 16-25 age group

The LNNM Homelessness group would like to work with other partners to deliver the changes recommended above, and help to develop services to address the current services gaps.

WHAT NEXT?

The LNNM Homelessness Group plans to discuss the detail of this paper with the Health for Homeless People Programme Board, the chosen Lead Commissioners (Lambeth CCG and Local Authority and Central London CCG), Caroline Alexander (Chief Nurse, NHS England), and with anyone else to whom it seems relevant.

The London Housing Foundation has already agreed funding for next year's conference, and we would like to discuss how we can make further use of this forum to assist in the improvement of London's Homeless Health Services.

APPENDIX 1 – ACKNOWLEDGEMENTS

Samantha Dorney-Smith - Overall Editor

Maxine Radcliffe – Editing, Chairs Note, Executive Summary, input into all sections

Rosa Ungpakorn – Outcomes section

Ela Orciari – Concerns section / Panel Debate

Jane Cook – LNNM Statement section

Barbara O Connor – note taking / write up of Focus Group

Bradley Sanders – note taking / write up of Focus Group

Harriet Gass – note taking / write up of Focus Group

Alexandra Hughes – note taking / write up of Focus Group

APPENDIX 1 – LONDON HEALTH COMMISSION - LNNM CASE STUDIES FOR EVIDENCE

1. SC – the case for integrated IT

SC has had a pattern of homelessness and frequent attendance that probably goes back to 2002. She has been registered in hospitals under **at least 10 different names**, although generally the same date of birth. She suffers from alcoholism, hypertension, fits and asthma, and has a left sided weakness after a stroke.

Her attendances are being collated for the 5 years 2009 – 2013. So far we have tracked **508 A&E attendances and 59 admissions** across 8 hospitals. Complete data is still missing from 3 of these hospitals (particularly admissions data), but she is known to have been at least 13 hospitals during this period. In St. Thomas' data she has arrived at A&E **via LAS 72% of the time**. If you only cost the actual A&E attendances, LAS calls and admissions that we know about this comes to **£222,208 over the 5 years**, however if you include missing data from other hospitals is likely this is nearer £300,000, and may even be double this sum. This lady may well have been 'living in hospital', and she is not the only person displaying this pattern of behaviour – there are many.

The reason this pattern continued is because there is no easy way for professionals to communicate within hospitals, let alone across hospitals, other health services, and with allied agencies. The full extent of SC's pattern was suspected by many, but nobody had the time required to resolve the situation without a very high degree of time and e-mail input (which was eventually operationalised).

SC's case was raised at a very high level in Brent, and they agreed to fund an appropriate nursing home placement without ever having formally assessed her for this. SC is now in a care home in Brent, and has settled in well.

2. JA – GPs are refusing to register homeless clients

JA is a 73 year Nigerian man who was legal resident of UK from 1962 - 1976, and then went back to Nigeria. JA re-entered the country in 1999, and has remained here as an illegal migrant ever since. He has filed two legal claims for 'leave to remain' both of which have failed. The UKBA however, has no plans immediate plans to remove him (contact has been made with the UKBA caseowner). He is required to 'report' 6 monthly. JA says he stays in churches, ministries and on buses, so there are no bedded down CHAIN contacts for him. There are currently no accommodation options available to him.

JA is an insulin dependent diabetic. He was refused GP registration by 4 different practices, and another expressed reservations. The refusals have been on the basis of his homelessness, not his immigration status.

JA lost his previous GP after telling them he being evicted from the garage-like accommodation where he had been staying, and was now NFA in another area. Several weeks later he was admitted to Kings in ketoacidosis.

On discharge from hospital, the practice was contacted to see if they would re-register him, but they refused, saying they were unable to register NFA clients. The nearest homeless practice to the area he says he stays in (Merton) was then contacted, but they said they would need proof that he was NFA in Croydon (i.e. he would need to have been seen street sleeping in Croydon) to register him. He was then escorted him to a large practice in Lewisham (because he has outpatient appointments that he attends at Lewisham hospital) by a nurse, and his situation was explained face-to-face. He was again refused. During this time he was re-admitted for 5 days to Lewisham hospital.

JA was then seen at the Walk-In Centre in Croydon and given an interim prescription. However they then told him he would need to register with a homeless practice to get future prescriptions. He then took himself to a homeless practice in Westminster. The practice gave him a sandwich and cup of tea, and made some enquiries, and referred him on to the specialist asylum seeker and refugee GP service at the Pavilion practice in Brixton. He did not fit their criteria, but they agreed to book an appointment for him. He did not turn up. During this time attended Kings A&E seeking medication.

He has now been registered at a practice in Merton.

3. BW – proving homelessness and ‘local connection’ issues

BW was in A&E 9 times, and admitted 3 times in a 6 month period for a deteriorating neurological condition. On two occasions he was directed to Housing Options by himself on discharge. Although he had family (including grown-up children) in the borough he was applying to, and wanted to stay there, he had split from his wife in that borough several years previously. Since then he had been sleeping at work in Wembley, until having to leave work due to sickness, although he had no proof of this. **He was turned down for housing on both occasions, apparently due to a lack of proof of homelessness, and an unclear local connection, although he was not given a formal decision letter in either case.**

On the third occasion he was escorted to Housing Options by an experienced Housing Advocacy worker, and was (somewhat reluctantly) housed in temporary accommodation by the same borough. He has returned to hospital since, but now has a care package in place in the temporary accommodation, and his hospital attendances have stopped. There is no doubt that he needed appropriate housing to stop the revolving door.

This simple case demonstrates the value of having experienced housing workers based in hospitals, but does suggest housing and health would benefit from working more collaboratively together pan London.

APPENDIX 2 – QUESTIONS FOR THE PANEL

1. As a nurse in a hospital I have recently been in the position of telling our overseas team that a patient was in the hospital, only to then have to fight them to prove she was entitled to on-going treatment. I do not feel I should be being put in this position. Do you have any thoughts on this?
2. We all know that homeless health services are not always cost effective in the short term. Engaging our clients in services can be more costly, and our services are always seem vulnerable as a result. How can our services ensure they don't get cut after the election?
3. We all know there are many mainstream GP practices that turn away homeless people, on the surface of it because they have no ID to prove they live in the area. Do you think this is right, and if not, what can be done about this?
4. In Westminster some clients without a local connection are now not able to access day centre services, and as a result they cannot see the outreach nurses working in the day centres. Should local connection issues be allowed to affect access to health care?
5. There is a concern that many people with addictions problems who do not have recourse to public funds, are not eligible for treatment, but are not being deported - so they are deteriorating on the streets. What can be done about this?
6. The threshold for a response from safeguarding teams appears to be getting higher, leaving homeless teams holding responsibility for very complex patients who appear to us to be highly vulnerable. Is there a forum to which this concern could be taken?
7. The number of homeless families increased 32% last year, and there has been an increase in out-of-borough placements, breaking existing links for these families. What can be done about this?
8. People with personality disorders are still stigmatised across the board, with many mainstream services not understanding what they can do to support these clients. In addition, there is still a lack of appropriate treatment available, largely because this is resource intensive. What can be done to address this in the short and long term?
9. There is a concern that gypsies and travellers are not being appropriately provided for - because if there are no outreach services providing services to these groups, there is no one documenting the numbers of people that are there. Whose responsibility is it to consider this issue?
10. With recent hostel closures there is an increasing lack of provision e.g. for couples, and clients with dogs. There is also no established process for sitting dogs when clients need to go into hospital. How can we ensure that services remain responsive to individual need in these times of austerity?
11. There is an absence of professional development opportunities, leadership courses, and appropriate supervision opportunities for many specialist nurses working in homelessness. How can this be addressed?