This report from the 2017 LNNM Conference summarizes key themes discussed in focus groups at the conference. Information sharing challenges, prison discharge procedures and geographical safeguarding processes were identified as key areas requiring improvements.

LONDON NETWORK OF NURSES AND MIDWIVES HOMELESSNESS GROUP (LNNM)

Executive Summary

The 2017 conference was the largest London Network of Nurses and Midwives Homelessness Group conference ever. The conference was well attended and greatly enjoyed. 236 participants from multi professional backgrounds as well as people with lived experience of homelessness were divided into 10 focus groups to discuss integration challenges within homeless healthcare.

Information sharing was seen as a central issue underpinning many other challenges. The failure to share information appropriately and effectively has an adverse impact on prison discharge, transition between secondary & primary health care & safeguarding for homeless people. Some groups felt that increased information governance support would be needed to facilitate improvements in this area. Conversely strong concerns were expressed about the negative impact of information sharing between health systems and home office enforcement teams. It was felt that this was leading to an increase in vulnerable, sometimes infectious patients avoiding care.

Multi-agency multi-disciplinary meetings to discuss individual cases, and borough / network wide resource management were identified as important tools for case management and resolution and should be routinely employed. These are best supported by effective service level agreements around information sharing and by generating inter and intra agency trust. This can be hard to foster initially but once in place offers great benefits. It was also felt that MDTs could benefit from including people with lived experience of homelessness wherever possible.

Geographically based care systems, such as the safeguarding teams in London, do not work well for transient homeless people who often do not fit into their borough-based referral criteria. The impact of this needs to be assessed.

"A pregnant woman disclosed a very recent sexual assault in my outreach clinic, it happened in the borough where the clinic took place but she was temporarily housed in another borough. I spent five hours over four days bouncing between the two local authority safeguarding teams trying to get one of them to engage with the case"

Prison discharge is currently poorly managed creating significant problems as many prisoners become homeless on discharge. The health of this group could be greatly improved by better communication between prisons and the wider health, housing and social care systems. Effective prison discharge pathways have potential to resolve health issues and reduce re-offending. As prison healthcare is centrally commissioned by NHS England, potential exists for some commissioner led systems change.

Homelessness and housing status is inconsistently recorded, across health settings and other government systems in London. This should be addressed at a Pan London level to provide more meaningful data in future.

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INTRODUCTION

This report by members of the London Network of Nurse and Midwives Homelessness Group (LNNM) summarizes the key themes and concerns that emerged at the Conference which was titled Integrating for Inclusion on May 2017.

The report draws together the group's attempt to strategize at a conference wide level, in order to promote service improvement and professional learning.

The LNNM is a voluntary network of health care professionals working in homelessness and health inclusion that has been in existence since 1999. It has recently evolved from being a purely nurse, midwife and health visitor focused network to include allied health professionals, support workers and peer advocates. The LNNM has greatly benefited from partnership with Groundswell in the production and organization of our conferences. We welcome people with lived experience of homelessness.

Conference 2017 was held on May 12th 2017 and attended by over 250 people from a range of professional backgrounds across health, social care and housing. A large number of attendees were nurses but there were also significant numbers of doctors, midwives, health visitors, allied professionals, and workers from key voluntary sector organizations alongside policy makers and people with lived experience of homelessness. Most of the attendees were from London services but some came from as far afield as Manchester and Dublin.

This number of attendees was again an increase on the previous year and a further range of workshops and sessions were offered.

Support/Infrastructure

We were lucky to have the support of the Hillsong Church who were very flexible venue hosts. The event was again catered for by the Munch Marylebone Women's catering collective who provide training and employment opportunities for homeless women. This was their largest catered event to date and a great success.

'Integrating for Inclusion'

This conference title was chosen by the organizing committee because of our sense that many of our members operate under what seem to be ever more adverse circumstances with a rising demand for complex boundary spanning roles, and ever decreasing time to deliver healthcare – but with the stated high-level 'integration agenda' failing to relieve these challenges at service delivery level.

We were also mindful of the **5 year forward view,** and the strong policy drive to promote service integration from NHS leadership bodies and wanted to ask people working in the sector if they were seeing the benefit of this on the ground.

In general, the annual conference provides a golden opportunity for a wide network of interested people to come together and discuss pressing issues and potential solutions. It is a unique opportunity to gather a diverse range of views and experiences that can inform commissioning and service delivery as well as wider policy. With this in mind conference wide focus groups are held every year, the questions set can be found in Appendix 1

Methodology

The LNNM Homelessness group has worked hard to establish a tradition of cross-professional discussion. Many participants in past conferences have described these sessions as one of the most valuable attributes of the conference to them - as it is rare for people to have this opportunity together to discuss issues in such an open way.

In order to generate something measurable the focus group sessions were formally structured. Qualitative data was obtained by audio recording the groups and nominated participants taking notes. Transcripts of the recordings and notes from them have been utilized to generate themes in an inductive manner broadly based on grounded theory[1].

This report summarizes the views and perceptions of issues in homeless healthcare and thus a qualitative approach is entirely appropriate.

236 conference delegates divided into ten discussion groups. This was done using random number allocation based on ticket purchase. Members of the LNNM Conference organizing team facilitated the focus groups with two facilitators per focus group, and additional note takers.

All of the focus group recordings were professionally transcribed and the report author (an experienced homelessness nurse and one of the conference organizers) reviewed the transcripts for the key themes. Due to limited capacity, it was not possible to generate detailed codes. The thematic analysis has been cross checked by LNNM colleagues who, like the author, are well

[1] Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory* Thousand Oaks, CA: SAGE PublicationsCharmaz, K. (2006). *Constructing grounded theory: a practical guide through qualitative analysis.* London: SAGE Publications

grounded within the data, being themselves conference organizers and professionals working within homelessness. As such it is a reliable presentation of the views of a large sample of people involved in homeless healthcare and thus provides powerful insights.

3 broad questions around the theme of integration were asked, the exact format of these can be found in Appendix 1. Essentially though, participants were asked for input on three aspects of care integration as follows;

1) What are the gaps in service integration that you experience?
2) What could be done to improve this?
3) How could improvements be measured?

Ethics

At the start of each focus group participants were made aware that the discussions would be recorded for the purposes of this report and anonymity of comments made would be maintained. Each participant agreed to this as part of the initial ground rule setting during the group conduction, participation was voluntary.

Advantages and limitations of the methodology

There are a number of limitations that are noteworthy. Focus groups can be prone to domination by one or several individuals, permitting only one opinion to be heard. Using focus groups to gather data involves group dynamics that can obscure more controversial or minority perspectives: there can be a group tendency to reproduce normative discourse on a topic. Moreover, the way in which the groups were run in terms of a tight time schedule very much lent towards the collaboration and production of joint perspectives or collective consensus rather than individual's views.

Conversely it is difficult to see how this research could otherwise have been carried out - as to interview or survey every attendee on each topic would have been logistically unfeasible without funding, and the collective voices that emerge are the valuable themes the LNNM conference was interested in.

There is of course inherent participant bias in that the questions were all framed by the LNNM conference organising group, and the focus groups were facilitated by members of that group. The moderators of each focus group may also have affected the contributions of participants. The author of the report is the former Chair of the group and facilitated a focus group at the conference.

However, whilst recognising these limitations the author would contend that they do not detract from the overall value of the report as one of the largest syntheses of views of workers in homeless healthcare.

DISINTEGRATION: THE FAULT LINES BETWEEN SERVICES

Lack of effective information sharing tools & policies

Multiple contributors described the failure of handovers of care or the simple failure to share important information in a way that really highlights the complexity of homelessness. Many felt that the lack of a common language to describe homeless people's situations compromised vital interagency information sharing throughout the sector. A hostel manager told us that *"It's like you need to speak a different language to every service and know their priorities or key service indicators to get anywhere. There might be between 8 to ten different services involved in one person's case"*

Communication within the NHS

Breakdowns in communication at the point of handover of care were a key theme identified as an issue throughout all the focus groups. The primary and secondary care interfaces were the most cited example of this across all the focus group discussions. There was a stated disbelief particularly amongst people with lived experience of homelessness about the extent to which clinical systems are not joined up and the extent to which communication fails. It was noted that hospital staff and primary care staff often cannot see the same information even when they are supposed to be working together, which feels like a failure and compromises continuity of care.

Specialist GP "Primary care and secondary care are the challenge. We just had an example … of a respiratory patient who had been in 25 different hospitals in London. Then a Consultant took a special interest during one of his ITU admissions to liaise with us, and to actually get quite a good outcome

for the person ….In London we have all these different secondary care services and our patients tend to float around between them. So there is a difficulty getting the information back to us so we can be a central repository of what is going on . And then to try and coordinate where that person is and get a better relationship with the hospital. But this difficult with all these big hospitals with a high turnover of staff and so on."

An outreach worker described her experience of this when working with clients with mental health needs *"For mental health clients who need urgent care, not necessarily as bad as sectioning, but they do need help - it's like hitting your head on the wall you go round and round in circles. It's frustrating and disheartening. It is difficult to feel like you are making a difference. In every different hospital, GP have different note taking systems. The clients go from one hospital to the next, and care details are not shared."*

Information sharing between the NHS and the Home Office

Conversely there was widespread concern about data sharing agreements between the NHS and Home Office across the focus groups and none spoke in favour of this. One nurse described their perception of the impact *"some particularly vulnerable patients may be reluctant to come forward for treatment from the NHS because they fear -and quite rightly – that may result in them being grassed up to the home office and their personal details being shared."*

One of the focus groups spent a significant period of time on this with all 18 participants unanimously agreeing that the LNNM should actively campaign for this information sharing between the NHS and the Home Office to stop or be repealed. There was great strength of feeling on this topic and anxiety about the effect it was having on vulnerable homeless people.

Lack of co-ordination and collaboration between services

It was frequently discussed that despite multi-agency, multi-disciplinary team meetings being utilized as a case management tool by many services, there is still a lack of joined up working in many areas.

Differing priorities

There was a feeling that any one time there are many different services with competing paradigms that a homeless person can be interacting with simultaneously. The differing ways of labeling of clients within services was one way of showing the competing paradigms that are evident within the groups - a person may be referred to as a 'guest' or a 'service user' or a 'patient' or a 'client' depending on the context. This allows services to interpret need and develop responses in different ways. Individual services outlined a wide range of different priorities ranging from enforcement to healthcare and more than one contributor spoke about their frustration with this.

Not my jobism – the 'inappropriate referral'

Multiple participants referred to the challenges of facing services that are gatekeeping or which appear to be excluding people from access to services for a variety of reasons that do not seem appropriate - resulting in very negative outcomes for the homeless person they were working with. Examples related e.g. to clients with care needs, dual diagnosis, personality disorder or clients with an ambiguous local connection. Professionals are often having to go to great lengths to get people access to services which

takes a significant toll on them. Many described constantly having to 'sell the worst-case scenario' in order to get any response.

Specialist Nurse "I am taking some time out of clinical practice…but it was because I got to the stage where I just thought we were at war. At war with social services. We were at war with housing. We were at war with the GP practices. Because everybody is just having to close down and protect their own budgets. And protect their own caseloads and stuff like that. And you literally having to sell the patient to social services so hard. They put so many barriers, like you are on the phone for 20 minutes, really trying to break you down."

Too many cooks?

The scale, nuance and complexity of just the homeless health service in London was noted. As one contributor said; "*to get a health policy signed off for homeless people for the whole of London which is only one city of 10 million people, there are roughly 936 separate organizations that would need to agree the policy".* Whilst this may not be absolutely true, the frustrations inherent in developing London wide joint working seemed palpable.

Lack of access to services across borough boundaries despite evidenced need

Geographical challenges and 'local connection'

This was cited as a key challenge to any integration or continuity of care by all the focus groups - there is wide variability between all the different boroughs in terms of service availability and pathways for care whilst the clients are transient and frequently move across borough boundaries. Navigating this even for professionals with years of experience working in the sector was seen as very challenging and time consuming.

London clinician "One particular barrier is the local connection, the borough thing, … which is particularly visible in London. Where you waste so much energy trying to establish a local connection for people – when they don't have a connection. And of course, following on from that there is a huge variation in the services which can be available to you depending on which side of the Tottenham Court Road you sleep on for example. Which is crazy"

It was noted in all groups that this was not just about housing eligibility, but also about access to health care too. Many contributors across different focus groups discussed fragmentation of services and relationships as people moved over borough boundaries.

Inflexibility of Local Authority services

Housing departments were seen across all the focus groups discussing them as having extremely rigid boundaries that often were about reducing demand on the housing department rather than providing an appropriate service (even when clear compelling needs were evidenced). For example: when a

client is entitled to benefits including Housing Benefit and has no formal local connection but has been evidenced by health services to be present in the area for a long time and obviously needs support, some Local Authorities are still unwilling to accept this as meeting their criteria for establishing local connection.

Additionally some Local Authorities often wait until the last possible moment to house people. One London midwife said *"it's actually really hard even if they are in the system. I go to some young people's clinics. There are hostels in which I've got 18 years olds pregnant with their first child who are not allowed to stay in the hostel after they have given birth, but who the local authority are not going to find them move on accommodation until they give birth. So literally they have to present with a one-day old baby"*

Even when housing duty is accepted placements are often out of borough, and this creates issues in terms of continuity of care and access to services. Another specialist midwife said *"we talked a bit about people who live on the streets, but I work in the community, with young parents. We try to work with them for about 2 ½ years, and a lot of my clients they are kind of homeless, moving round hostels, temporary accommodation. But they want to be settled. And maybe that is different from some other groups. They want to be settled in an area so they can start to get on with their lives. And the problem I see is because of the housing crisis in London the local authority aren't so able to place them within the borough. So you know, I work in Lewisham, a lot of our clients recently have been placed in Ilford. And that then completely breaks up services that are trying to work with people in the long term .."*

The dangers of boundary issues: Safeguarding

Safeguarding across area boundaries was a key issue of concern. Many participants referred to the challenges they faced in safeguarding cases where issues were bounced around between boroughs (often inappropriately). This frequently took hours of clinical time in attempting to manage safely.

A specialist Nurse Practitioner said *"A pregnant woman disclosed a very recent sexual assault in my outreach clinic, it happened in the borough where the clinic took place, but she was temporarily housed in another borough. I spent five hours over four days bouncing between the two local authority safeguarding teams trying to get one of them to engage with the case"*

A London Ambulance Service clinician said "*We are the only Pan-london provider and so we see everything across the whole system. And nothing is joined up. One of my biggest challenges I think in terms of our safeguarding referrals for people that we are very concerned about who are rough sleeping for lots of different reasons. We never get any feedback. So we put the referrals in, referrals in, referrals in. And it could be with mums with children, people who have just been evicted, people with mental health conditions etc. They don't need conveyance to an emergency department, but they do need help, but we just don't get any feedback. So I don't know what happens. And I am trying to deal with 32 boroughs ….it's particularly difficult for homelessness because people move across boroughs, so by the time we chase up... I think this group of clients is lost."*

Lack of knowledge amongst staff in mainstream NHS

Clinical services across the NHS were described in many focus groups as still displaying a lack of understanding, knowledge or capacity to appreciate the problems a homeless person might face.

A junior doctor in secondary care described this *"Another huge problem, I think you were touching on earlier saying about the hoops and hurdles everyone has to jump though and over… these clients don't fit into the neat little boxes we put our mainstream people in and from having worked in the hospital, I mean… we just want to clear that bed, don't we? We don't care about discharging someone at 3 o'clock on a Friday night when they've absolutely nowhere to go, no services, no GP they can access. We don't think about maybe we could keep them in until Monday. That we could safely discharge them, and them have time to get down to housing. I think a huge problem certainly coming from a doctor's point of view, is just a lack of education. It's not in our medical education, it's not even touched on."*

Encouraging Self Discharge as a gatekeeping strategy

There was a perception that in some cases there was active strategy within NHS services of encouraging homeless patients to self-discharge. One outreach worker said *"they don't like homeless people or people with drug or alcohol problems, so they encourage them to sign themselves out because then they don't have to deal with their problems".*

The challenge of Self Discharge

Some focus groups discussed self-discharge by homeless people from hospital and the problems this can subsequently create. Often when a patient self-

discharges a discharge summary is not automatically generated by the clinical team overseeing their care meaning that all of the information from the admission is not communicated outside the hospital. The person who self-discharges often doesn't understand this and may be left without a mechanism for passing on information about their admission & any treatment received or outstanding. It was felt that it would be helpful if mainstream services understood this and continued to issue discharge letters when vulnerable clients self-discharge. It was also felt mainstream services needed to understand the wider impact of advocating for self-discharge amongst vulnerable groups.

Lack of adequate prison discharge services

Another area raising serious concerns was the interface between the prison system and health & housing services. It was discussed that a large number of prisoners become homeless when they leave prison and concurrently have unresolved health problems - a very significant component of which are seen to be substance misuse and related physical health problems.

The idea of people being discharged from prison into homelessness with health problems produced very strong feelings in one focus group who discussed this issue in depth and felt it was adversely affecting client outcomes. The lack of information given to homeless health teams by prison health teams was also discussed.

Specialist Nurse Practitioner "There is a lack of communication for newly released people from prison to primary care. Very limited information is provided from prison services to GP. Chasing information is time consuming and the information provided depends on the prison and who answers the phone"

In general, however, the idea of delivering health care in prison was viewed very positively – the prison population being a captive audience for health care interventions. Prison was described by one participant as 'a golden opportunity to improve health outcomes for some of the hardest to reach'.

As such it was felt that there was definite scope for improvement.

Lack of understanding in determining 'eligibility'

Another key theme across all the focus groups was the challenge people face in meeting sometimes shifting eligibility criteria. Immigration policy and NHS charging enforcement was cited in every focus group as both a barrier to accessing many types of care and a hindrance in terms of providing a joined-up service. Some voluntary sector organizations have now also started to deny access on the basis of eligibility, however it is often true that establishing current eligibility for certain individuals across different services can be very complicated and subject to change.

Participants noted that there are not even consistent messages across NHS secondary care settings as different acute hospitals have interpreted recent legislation differently. For example in some central London acute Trusts women may be asked for proof of identity and residency before accessing antenatal care, whereas in other Trusts this is not requested. Assessing eligibility presents a very heavy burden for practitioners which is exacerbated if they have a caseload of unwell people with no recourse to public funds (NRPF). A Nurse (Pathway team Central London Hospital) described the challenge of the 'move on' for NRPF clients.

"No-one is interested and it's a very common problem. I can spend hours and hours trying to come up with an option for someone who is very ill and it's very

difficult. Often I don't find a good solution and that person ends up on the street and then readmitted very quickly".

It was felt that eligibility to NHS services was frequently misunderstood and with many clients still facing barriers to GP registration there needs to be greater clarity on secondary care access rights & entitlements.

PERCIEVED SOLUTIONS

It is noteworthy that all the focus groups spent the majority of their time discussing the challenges of integration and problems they had experienced. However, some concrete suggestions and examples were offered to resolve these. Methods of implementation, measurements of effectiveness or how they might be described in a convincing business cases were discussed in a minority of focus groups and are also included in this section.

Improvements in Information Sharing

As discussed in the previous section every focus group cited this as an issue, and its resolution was seen as central to improvement of integration.

Diverse methods of achieving better data sharing were discussed, such as appending assessments to the existing CHAIN[2] database in London, and maximizing the functionality of current systems – like the EMIS Web information sharing agreement being developed by Pathway for specialist homeless health services currently using this platform..

Examples of information sharing agreements already in place were given e.g. the Westminster mental health outreach team (the Joint Homelessness Team) which has service level agreements with relevant housing providers; the Westminster Integrated Care Network which is a cross borough initiative and the Royal London and KHP Pathway teams. It was noted that all of these had required considerable time & effort to agree and implement.

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[2] CHAIN is a a multi-agency database recording information about rough sleepers and the wider street population in London commissioned and funded by the Greater London Authority (GLA) and managed by St Mungo's, it does not routinely contain health data.

It was suggested in four of the ten focus groups (the others did not discuss solutions to this issue) that service level agreements between housing, health and other third sector providers were needed. It was felt that some level of Pan-London information governance support was needed to examine the complex issues generated within the sector – particularly where clients move across boundaries regularly using multiple services and the need for information sharing is pressing.

Creating an entirely new information sharing architecture was seen as costly and likely to fail – but it was felt that improvements to existing systems were urgently required and that more information governance support should be made available to the sector as a priority.

Agreed Levels of Information Sharing and Consent

There was also detailed discussion in some of the focus groups about the complexity of this issue as there are some types of some information (such as for example sexual health history or mental health) that has previously not been as viewed as appropriate for sharing - however it was also recognized that in some cases clients want this information to be shared. Also, there was concern about outcomes for people who did not agree to data sharing as it was felt they were typically those it was most important for as they were often experiencing underlying challenging pathologies such as personality disorders. An example was given by a receptionist in a specialist homeless general practice of a patient at that had accumulated 53 unique NHS numbers.

Suggestions were made regarding how there could be differing levels of information shared including utilizing existing Role Based Access settings in some systems.

Consent was viewed as vital to effective information sharing however enabling people to understand it fully and consent in an informed manner was viewed as sometimes challenging in this sector. Again, it was felt that this whole area needs specialist support.

More Multi-Disciplinary Multi-Agency meetings

Multi-Disciplinary Team (MDT) meetings were discussed as a solution to lack of collaboration and co-ordination, and also in part as a training opportunity for mainstream staff. Generally these were referred to as MDT meetings since this is an easy description, although it was clear from the discussions that people meant multi–agency as well as multi-disciplinary meetings. The four focus groups that discussed them, all referred to them as essential foci for effective information sharing, networking and care planning, both at an individual patient and local service delivery level.

The composition of the MDT was a key factor with many participants describing those that were effective as having a wide range of inputs, (not exclusively clinical) and including e.g. housing, benefits, support workers and experts by experience. One peer advocate described the importance of their input in the following way *"It's important to ensure that in that MDT there is some lived experience. So it's an MDT as not just a doctor or nurse, an OT, a social worker, its people who .. Yeah. It's a lived experience as well so that its informed. So people take – people are prepared to take alternative approaches and maybe understand, situate themselves more in the persons shoes."*

Specialist Nurse "The Pathway team at the Royal London's MDT meeting has made such a difference in highlighting client needs, getting more comprehensive history, undertaking proper assessments, and thinking outside the box to come up with pathways of care. MDT meetings are open to

everyone." (meaning all services - it was also discussed that the information sharing agreements & patient confidentiality needed to be adhered to).

Essentially it was thought that all services including mainstream NHS should be encouraged to attend and enabled to contribute in multi-agency multi-disciplinary meetings as a way forward for improved case management.

Payment following the patient

This was discussed as method of generalized service improvement in one group and also as counterpoint to local connection exclusion criteria. It was controversial and generated debate - but some participants felt that if the patients had a personalized health budget or similar way of 'choosing' a service that works well for them this would force all services to improve as they would have to compete for funding. This was suggested so that services did not have to exclude on the basis of local connection and instead included homeless people wanting to attend as this would be their mechanism for generating funding..

Service payments for completed health screening or treatment for people experiencing homelessness were also proposed as other potential innovations to improve care for patients.

Better Prison Discharge Pathways

It was felt that whilst many prison healthcare services are now provided privately by non-NHS providers there was significant scope for improvement in both health care delivery and information sharing. This would require a relatively small investment for a much larger return yielding long term cost savings across the health, welfare & criminal justice sectors

If information sharing between prison systems and NHS services could be improved then it was felt a very large number of adverse outcomes would be prevented as there is often a gap between these services mainly when people are discharged from prison without adequate onward care arranged. One participant suggested that since the commissioning of these services sits centrally within one department NHS England it should be relatively achievable to get significant contractual levers or incentives to push prison health services into sharing information more effectively with healthcare services working with offenders both pre and post incarceration. Measurement of outcomes such as number of offenders actively engaged with the substance misuse service 6 months post discharge were suggested as one example indicator for contractual reference.

It was also discussed that with health and homelessness being so intrinsically linked that prison discharge processes should be re-considered and perhaps be seen as a problem to be resolved in a manner similar to the recent drive towards making improvements in homeless hospital discharge..

Accurate recording of housing status

Many participants pointed out that this is done inconsistently across all health and many other statutory services and as such makes it impossible to reference consistent, accurate data regarding the number of people experiencing homelessness or their health outcomes.

Suggestions were made that working out how health systems in London could do this and supporting implementation of the emergent mechanism should be a key priority of the pan London Homeless Health Program.

RECOMMENDATIONS

INFORMATION SHARING

- Support and resourcing is needed within the homelessness sector to develop information sharing policies which effectively guide working with clients experiencing multiple complex needs who move across borough boundaries.
- Ideally there should be one Pan-London Information Sharing Framework agreed across health, housing and social care services (including commissioned voluntary sector services)
- In the interim support should be provided to maximize the functionality of existing information sharing systems to improve cross boundary working with immediate effect
  NHS Digital should **cease** information sharing with the Home Office whilst the impact of this policy is fully assessed.

MULTI-AGENCY MEETINGS

- Multi-agency, multidisciplinary meetings should be encouraged within homeless specialist services and invites extended to mainstream service staff in order to improve care and provide learning opportunities.

PAN-LONDON SAFEGUARDING

- Safeguarding policies need to be reviewed and consideration given to the current challenges created by borough boundaries

STAFF TRAINING

- Training opportunities should be offered to staff within mainstream services to enable them to meet the needs of patients experiencing homelessness.

PRISON DISCHARGE

- Prison discharge services should be developed providing onward referral and accurate information to appropriate health services alongside support to prevent homelessness on release.

ASSESSING THE IMPACT OF ELIGIBILITY ISSUES ON STAFF

- Research should be undertaken into the significant hidden costs of demoralization and burnout faced by staff working with unworkable eligibility and boundary issues bringing them into conflict with their professional ethics. There is concern that poor staff retention outweighs any costs 'saved' by not treating these patients.

CONCLUSIONS

There was an overall evident sentiment of exhaustion and frustration amongst participants and of teams of people battling with a Kafkaesque system that is being tied in an ever-increasing series of knots using ever decreasing resources and budgets. It was abundantly evident is that there is great passion to deliver quality healthcare to homeless people in London, but that great tenacity is required to do so.

The image of a clinician at war with all of the surrounding services struggling with an overheating telephone to get even one possible option for the person sitting in front of them came up again and again. Additionally there was a feeling that with every small victory came the feeling of the inevitable revolving door approaching – a feeling that many people will probably be subsequently 'discharged' from a service and appear again in slightly worse condition in front of another colleague in the very near future, probably with even fewer options. Sadly this was echoed by multiple contributors from a wide variety of backgrounds. Whilst repeat presentations are a central feature of working with homeless people, there was a strong sense that this was considerably exacerbated by current government health, immigration and benefits policies.

Most people working in homeless healthcare are very frustrated with the way information sharing between agencies is working, or rather, failing to work and saw this as a key issue. Contributors gave many examples of how this is resulting in service inefficiencies, detrimental effects on patient care, increased economic costs and direct human costs in health terms for homeless individuals.

It is clear there is great appetite for more integrated working with multi agency collaboration. However, there is also great anxiety about the implications of this when different agencies have different thresholds for data governance and information sharing particularly in the light of recent revelations about the Home Office access to NHS data.

Other issues raised could also be linked to information sharing challenges. There were concerns echoed widely about the safeguarding processes in use and how homeless people were recognized within this, especially since raising an alert appears to be entirely tied to a geographically based system of boroughs creating chasms for information to fall into and opportunities for responsibilities to be passed over. Another significant area where people felt better information sharing would improve outcomes was prison discharge which people felt could be addressed with relative ease generating significant impact. Almost universally it was felt multi-agency, multi-disciplinary meetings were a core part of effective communication and service delivery in this sector and needed to be supported.

The LNNM group would welcome discussion on any or all of the above issues, and hopes the report will result in constructive changes in the future. We would be particularly interested in any opportunity to engage with colleagues in Housing and Prisons to discuss ways of working towards improvements.

Report authored by:

Maxine Radcliffe, outgoing Chair, LNNM, February 2018

Appendix 1

Focus Group Questions

1. **Identify areas where poor integration of services adversely impacts homeless people at the moment. (15mins)**
   Share examples of where lack of integration causes problems, and where people currently fall through the safety net. Thinking about areas where lack of integration is a problem – where is this most evident and problematic?

2. **Focus on an area of specific interest for the group where you believe there is a lack of integration. Consider what could be done to improve things, and how you might go about achieving this.** (15mins)*Why have you chosen this area? Who could need to work together? What would need to be done to achieve this? What work would be involved to get to where you would like to be? Could it mean sharing spaces, workers, clients, information? What could this look like in practical real terms? What barriers might be anticipated? What could be done to overcome them?*

3. **How could the care improvements generated by this integration project be measured, and how would you argue for funding and to whom? (15mins)***How would better integration actually improve things for service users? How could you measure the changes in client outcomes that come about directly as a result of the integration? What would be the risks & benefits for service providers? What would be the cost implications– which organizations would need to invest and which ones could save? Who would pay?*