Symposium Report

The Voice of the Frontline During Covid-19

On September 30th 2020, in the dip between the first and second waves of Covid-19 in the UK, the London Network for Nurses and Midwives Homelessness Group ran our first online symposium. This was part of a programme that replaced the annual conference we usually hold, which had been made impossible by the pandemic.

We bought together 98 people, a mix of inclusion health professionals and people with lived experience, and asked them about their experiences during the pandemic and what we could learn.

Chair's message

Jane Cook is a General Nurse and Public Health Specialist who has worked with excluded groups in a range of settings. Jane is the Health and Homelessness Adviser with the Rough Sleepers Initiative (Ministry of Housing, Communities and Local Government) and is co-founder of the Queen's Nursing Institute Homeless Health Programme.

'This symposium focused on the work that had been delivered in London in response to Covid-19 and homelessness, not only by nurses, but by a wide range of colleagues and organisations, from when lockdown occurred in London beginning in March. This mobilisation, which was unprecedented, was undertaken to protect people who were sleeping rough and those in night shelters, moving 5,000 people in London into self-contained rooms in hotels. This had an impact on the health of individuals as they were provided with accommodation and both emotional and practical support, which led to health improvement. People had the time, space and support to make choices, plan and to access services, often on-site.

Partnership working was key in getting systems in place that delivered integrated models of care so as to meet presenting needs. Key partnerships were developed at both strategic and front-line levels with leadership provided by the Healthy London Partnership and the Greater London Authority. Healthy London Partnership and key partners developed the Clinical Homeless Sector Plan which not only addressed presenting need but also started to look at what was required in the future in order to address the health needs of people who were homeless. The response from specialist nurses and health teams working with people who are homeless, both single homeless people and families who are homeless was phenomenal. The response was rapid, practical and of a high quality in this emergency. Courage, commitment and compassion was evident on a daily basis.

Covid-19 highlighted the inequalities in our society and there is much to be learnt from this mobilisation in how to meet the health, housing and care needs of people experiencing homelessness in an integrated way. Ongoing work is needed to address issues such equity and equality in accessing primary care, in having services at transition points such as hospital discharge, in addressing frailty and disability, in joint commissioning and joint budgets. Not only is work in London boroughs key but also engagement with Integrated Care Networks to ensure health inequalities are tackled and there is inclusion in both commissioning and local delivery.'

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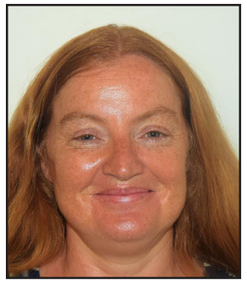
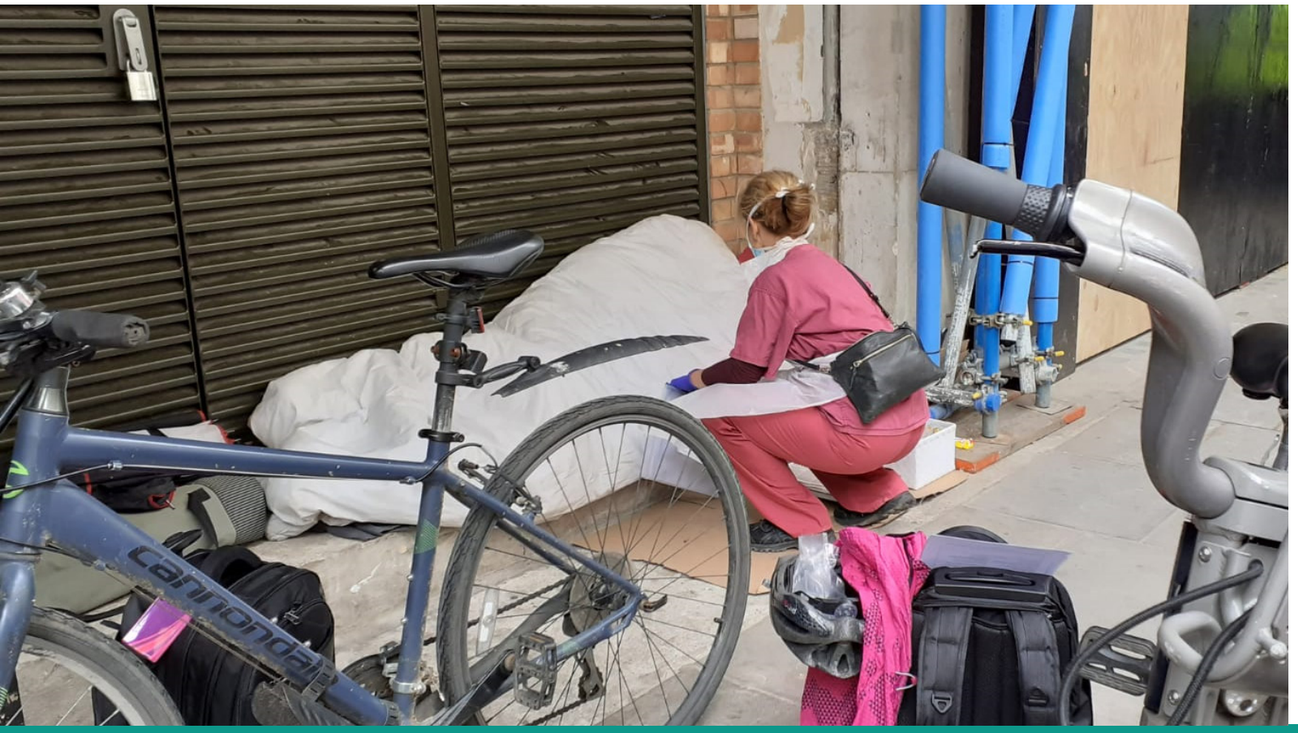


'The Covid-19 health response to homeless populations in London', a summary of the Secretary's presentation.

Sam Dorney-Smith is an RN and Specialist Practitioner. She has been working in inclusion health since 2004. She previously managed the Guy's and St Thomas' Trust Health Inclusion Team, and set up Pathway inpatient services for homeless people across a number of London trusts. Sam now works as a Nursing Fellow for Pathway, is the programme lead for the QNI Homeless Health Programme, and also works for Doctors of the World as an Outreach Nurse. Sam recently spent 3 months working on the 'Everyone In' Covid-19 programme in London

'The pan London health response commenced on the 16th March. The response was largely specialist inclusion health nurse and GP led in the initial phases. NHS and voluntary sector providers organised themselves to deliver a response, which was then later coordinated by the London Covid-19 Homeless Health Response Cell. LNNM communication was a key part of connecting people during the early days of the response. The response followed the Test-Triage-Cohort-Care plan put forward by LNNM member and senior nurse Dr Al Story, in partnership with Dr Andrew Hayward. Many nurses and midwives contributed to guidance provided on the 'Homeless Health during Covid-19 webpage' (LINK) provided by the Response Cell for all providers, and this information is still available at the time of publication of this report.



Interventions delivered by the nursing workforce in partnership with other health professionals and support workers during the 'Everyone In' hotel response to rough sleepers have included:

- **Face to face and remote triage and cohorting -** by volunteers from organisations including Greenlight, Doctors of the World, Pathway, the London School of Tropical Medicine and Tropical Medicine, and also specialist primary care providers like Great Chapel Street, and the Westminster Homeless Health Service in partnership with the University College London (UCL) Find and Treat Service. Much on this happened on the street in the early stages, some by phone.
- **Initial assessments** – often still undertaken by volunteers, using the partnership above.
- **Ongoing support** – has mostly been provided by commissioned primary care, though some new teams have been created for this such as the ELFT primary care outreach team.
- **Testing** – at hotels, hostels and on the street via the UCL Find and Treat service.
- **Addictions support** – via the newly commissioned HHDAS (Homeless Hotels Drug and Alcohol Support Service).
- **Mental health support** – via RAMHP (Rough Sleeping and Mental Health Programme) teams and EASL (Enabling Assessment Service London) where other support was not available.
- **Covid Care** – this hotel has supported Covid-19 positive individuals who did not need hospitalisation. The hotel was staffed been jointly by Find and Treat and Médecins sans Frontiers nurses and Doctors.

The result of this incredible partnership (combined with the hotel provision itself, and voluntary sector support) contributed to that fact that there were only 6 known Covid-19 deaths in the homeless population up until 26 June 2020 (Office of National Statistics). It is estimated that the Test-Triage-Cohort-Care approach and partnership may have avoided around 266 deaths across England and thus about 80 deaths in London alone.

Nurses have also been involved as volunteers undertaking the UCL led CHRISP (Covid-19 Homeless Rapid Integrated Screening Protocol) survey, which has led to some key insights including the fact that 25% of clients were not registered with a GP when they entered the hotel, and a further 25% were not engaging with their GP. It is also vital to acknowledge the input of specialist Health Visitors working with Homeless Families who have done incredible work during the pandemic, and have been lobbying hard for better circumstances for their clients. Several LNNM members were involved in the production of the article 'Health Visiting with Homeless Families During the Covid-19 Pandemic'.

Our word cloud

On the day of the symposium, we opened a collaborative word cloud and asked people to sum up their recent experiences in three words. The outcome is below and speaks for itself. It is heartening, and unsurprising, to see people at the centre.

Our panel discussion

Panel Chairs summary

Kate Bowgett is Groundswell's Director of Advocacy and manages their Homeless Health Peer Advocacy services across London. Her background is in volunteer management, and she has worked for the Terence Higgins Trust, Volunteering England and as a Volunteer Management Advisor for small charities and museums. She is particularly interested in how organisations can meaningfully involve people who are often excluded from volunteering.

Kate explains: 'We selected our panel to include people whose work had been key to the Covid homeless health response in different ways. We asked them to reflect on the changes that they had made to the way they delivered services, what had gone well, and what adaptations they would keep in the event of future lockdowns, or even integrate into their mainstream delivery.'

A brief summary of our panellist's reports follows.

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Max Radcliffe is a trustee of the LNNM and a previous chair. She is the Director of Nursing for the Covid Vulnerable People Response Unit in Ireland, and provides health support for homeless people who are shielding. She also manages a team supporting Dublin wide hospital and prison discharges for people who are homeless. She is currently working on her PHD at University College Dublin around gendered experiences of homeless health.

Max describes that during Covid-19 she has been involved in:

• Rapid innovation, including developing a scoring system for shielding.

• Managing a large influx into services, such as the initial admission of over 450 people to shielding.

• Complex multidisciplinary working such as a regular Shielding Service led meetings.

• Ongoing complex assessments, such as completion of 220 'CHRISP' documents.

• Meeting diverse challenges involving a breadth of patient demographics with varied health beliefs.

Dr Debbie Robson is PhD Senior Research Fellow and a Mental Health Nurse. She has co-developed and evaluated tobacco dependence treatment pathways, policies and training. Among other collaborations, Debbie is part of the NIHR South London Applied Research Care (ARC) where she leads a programme of research about tobacco dependence and treatment across King's Health Partners.

During Covid-19 Debbie volunteered with the newly established London Drug & Alcohol Service (HDAS) to provide tobacco harm reduction to residents in London's emergency hotels, aiming to minimise:

- Covid-19 transmission from risky smoking behaviours such as sharing cigarettes
- Nicotine withdrawal symptoms if confined to a bedroom
- Former smokers relapsing back to smoking
- Fire risk in hotels

Many hotel residents said this was the first time they had been offered the opportunity to quit or reduce smoking. As they felt more relaxed and safer, they were able to address their dependence on smoking and other risky behaviours. They were grateful they had easy access to simple to use and good quality nicotine alternatives. Feedback from hotel staff about the project was positive.

Rikke Albert is a Nurse Consultant and is the Service Lead for the Rough Sleeping Adult Mental Health Team in East London Foundation NHS Trust. Rikke has worked with the team in East London and third sector organisations to provide mental health care during the Covid crisis.

Rikke describes that during Covid-19:

• Access to housing (even if hotels) has made it easier to get the wider mental health system to engage around care. People who are street homeless often struggled with accessing care as they didn't have an address to be seen at or a place for appointments to be sent to.

• As people have a place to stay from a crisis mental health perspective it is one factor less which influences the mental health.

• The support organisations have done a very good job in generally supporting people to have more stability around their daily living skills and basic care needs. This has had an impact on the mental health for the better.

Kendra Schneller is a Nurse Practitioner working with the Health Inclusion Team at Guy's and St Thomas' NHS Foundation Trust. Kendra has won awards for her community nursing practice and her mentorship and has published articles relating to her work. Kendra is currently a member of the NHS Assembly and is a Queen's Nurse. Kendra is the Vice Chair for the LNNM.

Kendra describes that during Covid-19 there has been:

• The need to adapt to the change of environment, fo example running clinics in a hotel.

• An increased number of meetings to attend.

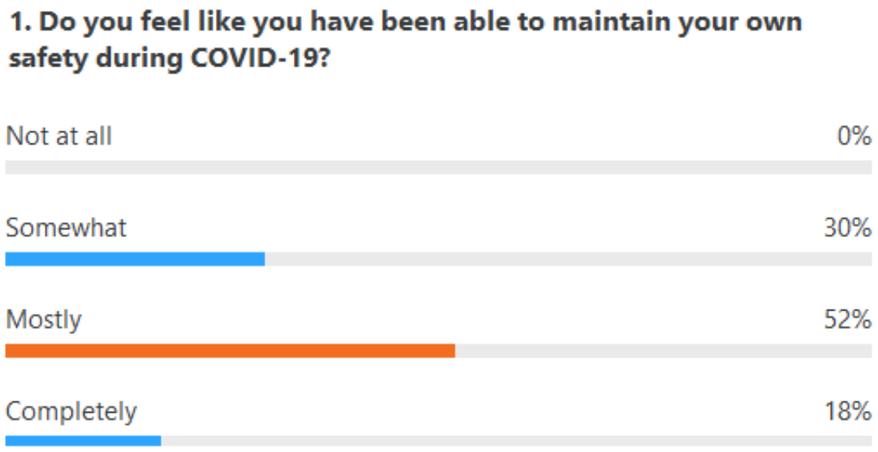
• An increase in the number of clients being seen with a variety of complex needs such as more elderly clients requiring social input.

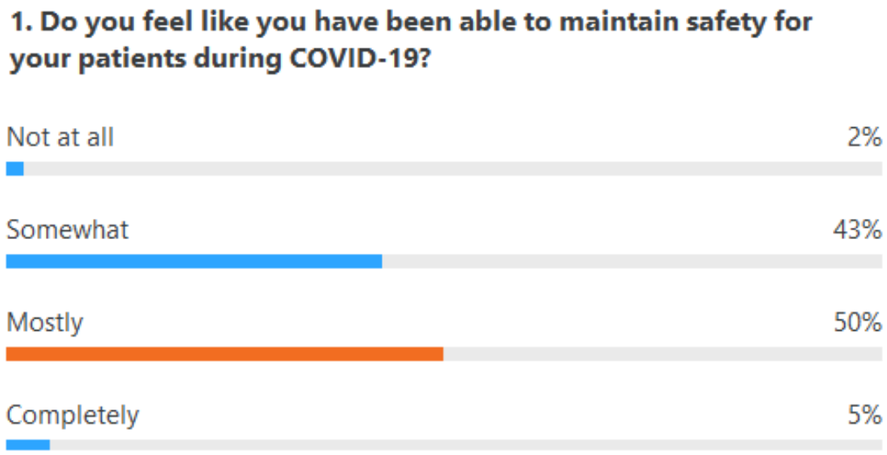
• The need to work with non NHS staff such as hotel staff and to support them to understand the needs of the clients staying in the hotels.

• Opportunities for staff to gain new skills such negotiating for technology for clients.

Our polls

At the end of the first half of the symposium, we anonymously polled our attendees, asking whether they felt they had been able to keep their patients and themselves safe during Covid-19 so far. These are the results.





Though it is arguable that safety can never be perfect, and perhaps unsurprising that a sudden change in how clinicians were able to operate in the context of a highly contagious novel virus presented safety challenges, we still need to ask why there was such a range of experiences for our colleagues and our clients, and what we can do to make things safer.

Our discussion groups

We invited our attendees to participate in breakout groups, divided roughly by speciality, to discuss their experiences during Covid-19.

We asked them to discuss:

- Changes to services they had experienced during Covid-19
- Which of these they felt had been positive and which had been negative
- Which changes they would keep and which we should mitigate against

Despite each group containing a diverse range of clinicians, other inclusion health staff and people with lived experience, and being separated by speciality, there was broad agreement across the groups on a number of important points.

The method of summary was review of recordings of the discussion groups, with thematic consistencies identified by a clinician with experience in qualitative research. Clearly this is limited in its use as definitive data and we do not represent it as otherwise, but believe it gives a good snapshot of attendees experiences during the pandemic so far.

Recordings and transcripts are not publicly available as it was felt that this would compromise peoples capacity to be open and honest.

Narrative summary of discussion groups

Digital healthcare and access to care

In this area there was significant concern about digital exclusion. People without phones and email addresses were discussed, as was the failure of some GP services to register people without digital access, and the poor management of some online systems. A lot of people need extra support with digital healthcare, and it was felt that ‘digital by default’ would cause some people, who already struggle with accessing care, significant new problems, though some people do prefer digital consulations.

We also heard that not being in the same room as people hindered comprehensive assessment.

The importance of choice was felt to be an essential consideration with digital healthcare.

The group also reflected on the strong case for keeping people housed in relation to optimising their care and opportunities.

Addictions

The addictions group discussed huge shifts in service provision. As addiction services are generally primarily face to face and based on regular ongoing casework, the change to digital was huge for this sector. The rollout of rapid opiate substitute prescribing processes, with many of the usual barriers removed, was reported as a hugely positive shift for both clinicians and patients.

Again we heard that a minority of clients preferred remote contact, but overall therapeutic relationships were felt to be compromised and thorough assessment not possible when working remotely with clients. Staff also found remote meetings and multi-agency work very complex at times.

The connection and centralisation of services, especially in the context of clients being safely housed, was reported to be a positive experience for clients and staff, allowing better collaboration. The scope of work made possible by the temporary increase of resources such as smoking cessation aids and mobile phones was also noted. However, there was still a level of fragmentation of funding, so not all hotels had the same level of provision for people with substance misuse needs.

Secure housing was described as having a positive effect on the mental health of clients with substance misuse needs, allowing them to prioritise their physical and mental health in ways they had not previously been able to.

Mental Health

The Mental Health group identified housing people who were previosuly street homeless as a good opportunity to inreach and provide mental health support to people who were otherwise hard to meet. It was noted that alongside mental health support, the initiation of substance misuse treatment was very good. In line with other groups, feelings around moving online for services including counselling was mixed. Though less helpful for some people, remote support was good for people who have struggled to engage face to face. It also meant that safety was easier to maintain with high risk patients.

The significant impact of Covid on staff wellbeing was noted, as was burnout due to the intensity of work required. Mutual support and reflective sessions helped to mitigate this to an extent. The importance of developing a stronger pan London homeless mental health network was discussed, as many mental health workers are relatively isolated. Prompted by reflective sessions, planning for this has started.

Compassion as a core ingredient to the positive impact of mental health work came up, as did the importance of common values, and the way that these can be eroded during times of stress and failing processes, as was seen during the pandemic, was discussed.

Migrants and people with no recourse to public funds (NRPF)

As ever, attendees described a difficult time for migrants and people with NRPF. Though it was easier to get people into accommodation, and to link them up with some services, there was a pervasive sense of uncertainty about what would happen after hotel provision ended and concern about whether people would be lost to follow up. It was also reported that some services that people were already connected to became harder to access due to Covid restrictions.

People with NRPF were discussed as particularly vulnerable to digital exclusion. There was also discussion of people being moved around compulsorily away from their support networks, and people falling between jurisdictions in a way which led to nobody taking overall responsibility for their care. This was compounded by poor information sharing across systems which did not speak well to each other.

It was reported that there was a feeling that there is will to maintain tackling inequalities in a multidisciplinary way from ‘higher up’, but that there are concerns that this does not always lead to action on the ground.

As with other groups, it was felt that the shift in dynamics due to Covid allowed better joined up multi-agency work. Improved access to legal advice was also noted.

Primary Care

This group discussed the impressive speed at which services were able to adapt to new conditions. It was suggested that despite its challenges Covid-19 had ‘shaken up’ passivity in nursing, and that this was a good thing which should be maintained.

The support needed to engage with primary care for some patients was highlighted, with the role of volunteers being important, especially those with pre-existing relationships to patients.

There were significant challenges to providing primary care during Covid restrictions, including around having access to appropriate settings such as uncarpeted clinic rooms in hotels, and needing to prioritise teaching patients to self-care meaning that opportunities to assess thoroughly were missed.

It was felt that nurses being given flexibility and autonomy to adapt to new conditions was a positive thing.

Group members also described ongoing issues with GP registration, including GPs continuing to not register people without documentation, against official advice.

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Street outreach

Again, we heard about services adapting rapidly to new requirements, and about improved multidisciplinary working from this group.

There were reports of increased isolation for people who were still living on the streets, and that some were fearful of attending clinics and hospitals due to Covid-19.

It was discussed that people who were housed in the hotels felt their self worth was improved. They reported better opportunities to do things they had not felt able to prioritise before, such as registering with GPs.

As with other discussion groups, we heard that patients were picked up who had not been engaged with services at all before. People engaged with drug services for the first time, especially as the supply of street drugs had been disrupted and services were more immediately available where people were sleeping.

We also heard concerns about people being lost to follow up after being moved between authorities, and again about lack of face to face assessment due to risk. There were reports of both staff and patients fearing what would happen after hotel provision ended.

Women's health and families

In this group we heard about service innovation through necessity, one example of this being the provision of contraception on wards where this had not been done previously. There were again also reports of better multi agency work.

It was reported that services were able to engage people who had not engaged before, and measures were put in place for more thorough assessment when people were seen to make the most of increasingly limited time and contact. More care occurred in hospitals in this area of clinical work, due to community contact becoming more difficult.

Where contact did happen remotely, again we heard about missed opportunities for full assessment, and in this case not being able to undertake psychological screening as effectively without face to face contact was also mentioned.

Summary of themes from discussion groups

Remote healthcare and access

Positive	Negative
Some people prefer it as they find phone or online appointments make them less anxious	Gets in the way of therapeutic relationships and building trust
It allows some people to be reached more easily more of the time	Lost opportunities for visual assessment, for example noticing a wound or a smell
People feel good about being given resources including phones	Some people struggle to operate phones and technology in general
Allows rapid processes to be facilitated, for example quick prescribing	Some virtual portals, for example some GP registrations, are poorly set up and managed

Overall, what emerged across the groups was a consensus about the importance of maintaining choice around access, which it was felt is not always offered effectively generally, but particularly during Covid-19. There was an understanding that restrictions during Covid had made offering comprehensive choice around engagement particularly challenging and at times not possible.

It was reported that some people would benefit from more ‘telehealth’ offerings, but a total shift to remote connectivity would completely exclude some people, exacerbate existing inequalities and mean that important opportunities for relationship building and health monitoring were missed. Again, this was linked to the importance of choice.

There was discussion around the challenges of registration at GP surgeries in a number of groups, which is a well documented issue for people of no fixed abode or without documentation, despite Public Health England guidance being clear that surgeries should not require proof of address or identification to register new patients.

'The temporary demise of drop in and outreach primary care services is of huge concern. Engaging clients is the core of what we do - we have historically relied on face-to-face models of care to build trust, and help people to understand they have health problems that need addressing. We rely on seeing people to know what is really going on with them - their jaundice, their anaemia, their malnourishment, their limp and so on.'

Multidisciplinary working

Positive	Negative
Having multiple services accessible in one place meant that patients could access support for a range of needs more easily	Concern that systems are being set up that will not be sustainable or will have to be dismantled if the status quo is re-established
Organisations are more able to work together when the focus comes off competition, which disincentivises sharing information and resources.	Pressure on third sector organisations due to reduction in volunteer pool
Opportunities for staff to learn new skills in collaboration with new partners	Concern that people are not able to meet funding goals in a novel context

There was a clear consensus across groups that multidisciplinary working was more flexible and functioning particularly well during Covid-19.

There was a shared concern around what will happen next, especially around having to move back to previous models. There was also concern that due to the current situation some third sector organisations were not able to fulfil their contractual obligations as they had needed to change how they function, and that this could prove to be a challenge to explain when next bidding for contracts or continuation of funding.

'Multidisciplinary working during Covid-19 has pushed us outside our comfort zone in a good way! During this time, we have demonstrated the value of working together quickly, efficiently and flexibly. It's incredible how well people have worked together under this pressure'

Housing

People being housed through the 'Everyone In' strategies was broadly reported as positive on a number of fronts, and professionals reflected that people who were housed who had previously been street homeless suddenly had headspace and time to prioritise their physical and mental health.

It was also stressed that having services available in a single place, where people were also living, took the stress out of accessing services for clients.

It was said that people were more open and engaged about their needs when housed in the hotels, including around sexual health and immigration status and the support wneeded around this. There was good uptake of innovations like smoking cessation models based on the use of e-cigarettes.

'We need an ongoing conversation about the positive effects of housing, and the social, psychological, health related and economic benefits that investment in getting people off the streets will have, immediately, and down the line.'

Summary

The sudden shift in context for health professionals, and our patients, has presented both challenges and opportunities.

We believe it is essential that when thinking about what a 'new normal' will involve that we are learning from our experiences during Covid-19 and not simply reinstating processes or assumptions about finances, teamworking, or clinical approaches and housing that may not be in the interests of the people that we support, and may be easier to change than we might have come to assume.

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We are recommending that policy makers, commissioners and providers should:

1. Ensure that services are person centred, holistic and accessible for those who experience exclusion, with a multi-disciplinary approach to meet complex and multiple needs.

2. Attempt to reduce the barriers to sector wide multi agency working and cooperation created by competition and fragmented, transient funding models.

3. Ensure planning and commissioning involves both voluntary and statutory agencies so as to develop a whole system integrated response that meets the needs of people experiencing exclusion.

4. Consult people with lived experience of homelessness to co-design of services and resources, and give feedback.

5. Provide training to all pre and post registration staff on inclusion health to improve access, service delivery and standards.

6. Develop pathways that improve access to and discharge from services that will provide a seamless service and continuity of care.

7. Tackle digital exclusion ensuring people experiencing exclusion have access to digital appliances as required as well as the necessary training and support.

8. Ensure that there are data sharing agreements in place for both individuals and services that will ensure person centred and inclusive services.

9. Recognise the importance of the LNNM in co-ordinating action in an emergency situation, and supported the LNNM to undertake this role in the future.

10. Undertake research s into the impact of the increase of online primary care provision and the demise of drop in services.

11. Undertake research into the changes in the delivery of addictions services during Covid 19 and what the impact of this has been on inclusion health groups.

12. Learn lessons learned around smoking cessation and provide guidance for the promotion of better smoking cessation support.

13. Should improve MDT working by examining how data sharing between organisations working in partnership can be improved.

Finally, the LNNM and the inclusion health community as a whole should be lobbying on the importance of housing in delivering better mental and physical health outcomes.

London Network of Nurses and Midwives

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