

# How Safe is the Safety Net?

## LNNM Conference 2016 Report



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

### Table of Contents

EXECUTIVE SUMMARY.....	3
INTRODUCTION.....	4
FEEDBACK FROM DISCUSSION GROUPS.....	6
KEY GROUPS VULNERABLE TO SLIPPING THROUGH THE SAFETY NET.....	6
PEOPLE BORN OUTSIDE THE UK.....	6
PEOPLE WITH MENTAL HEALTH PROBLEMS.....	7
PEOPLE INVOLVED IN / AFFECTED BY JUSTICE SYSTEM.....	8
HOMELESS PEOPLE UNABLE TO ACCESS HEALTHCARE.....	8
HOMELESS PEOPLE AT THE END OF LIFE.....	9
MOTHERS POST REMOVAL OF CHILDREN.....	9
PEOPLE WITH LEARNING DISABILITIES / LEARNING DIFFICULTIES.....	9
HOMELESS FAMILIES.....	10
OTHER VULNERABLE GROUPS ALSO MENTIONED DURING DISCUSSION.....	10
SUGGESTIONS FOR IMPROVEMENT & MEASURES OF POSITIVE IMPACT.....	10
SUGGESTIONS TO IMPROVE HEALTHCARE FOR PEOPLE BORN OUTSIDE THE UK.....	10
SUGGESTIONS TO IMPROVE HEALTHCARE FOR PEOPLE WITH MENTAL HEALTH PROBLEMS (IN PARTICULAR COMPLEX PERSONALITY ISSUES).....	11
SUGGESTIONS TO IMPROVE HEALTHCARE FOR PEOPLE WITH ADDICTIONS.....	12
SUGGESTIONS TO IMPROVE CARE FOR SEX WORKERS.....	12
SUGGESTIONS TO IMPROVE HEALTHCARE FOR HOMELESS PEOPLE WITH ACCESS PROBLEMS.....	13
SUGGESTIONS TO IMPROVE PALLIATIVE CARE FOR HOMELESS PEOPLE.....	13
SUGGESTIONS TO IMPROVE HEALTHCARE FOR MOTHERS POST REMOVAL OF CHILD.....	14
SUGGESTIONS TO IMPROVE CARE FOR HOMELESS FAMILIES:.....	14
‘GAPS IN THE SAFETY NET’ – SUMMARY OF DISCUSSION GROUP THOUGHTS ON WIDER SYSTEM SOLUTIONS.....	15
PERSONALISED GOALS AS MEASURES OF POSITIVE IMPACT.....	15
IMPROVED DATA.....	15
INTEGRATED CARE.....	16
IMPORTANCE OF PEER ADVOCACY.....	16
PANEL DISCUSSION.....	17
PANEL MEMBERS.....	17
QUESTION 1:.....	17
QUESTION 2:.....	18
QUESTION 3:.....	19
QUESTION 4:.....	20

QUESTION 5: .....	21
QUESTION 6: .....	21
<b>CONCLUSION .....</b>	<b>23</b>
ACCESS TO SERVICES IS WORSENING FOR HOMELESS PEOPLE IN LONDON. ....	23
LACK OF INFORMATION SHARING .....	23
SKILLED ADVOCACY AND SUPPORT CHANGES THE OUTCOMES SIGNIFICANTLY FOR HOMELESS PEOPLE IN TERMS OF ACCESSING HEALTHCARE AND HOUSING AND SOCIAL CARE AND SHOULD BE VALUED. ....	23
PARTNERSHIP WORKING BETWEEN SERVICES IS VERY DIFFICULT .....	23
A) WHERE THE AGENDA OF EACH INVOLVED SERVICE IS DIFFERENT: .....	23
B) WHERE SERVICES ARE CONTRACTED OUT: .....	24
EXPERTS BY EXPERIENCE OR PEER ADVOCATES ARE KEY TO THE SUCCESS OF HOMELESS HEALTH SERVICES.....	24
<b>CHAIRS NOTES: NEXT STEPS .....</b>	<b>25</b>
APPENDIX 1: CONFERENCE TIMETABLE.....	26
APPENDIX 2: QUESTIONS FOR THE PANEL (QUESTIONS HIGHLIGHTED IN RED WERE THOSE THAT WERE CHOSEN FOR DEBATE ON THE DAY) .....	27
<b>ACKNOWLEDGEMENTS.....</b>	<b>28</b>

## Executive Summary

Conference 2016 was well attended, and feedback from attendees about the event was overwhelmingly positive. However many attendees reported serious concerns about the perceived erosion of what we have described as ‘the safety net’, and felt bleak about the future of their services, and how their clients would or could be supported in the future.

A number of clear themes emerged.

Many professionals reported and discussed the many **non-orthodox solutions and improvisations they have to make every day in order to deliver a level of acceptable care**. There was a clear sense that too often the only meaningful resources available required a high level of energy expenditure to access them, or indeed expert legal input, at a high human, social and economic cost to health services especially.

Moreover the **emotional labour** required by professionals working in services on a day to day basis continues to **escalate to levels that are unsustainable, and often have adverse consequences on other areas of their life**.

**Access to services is reducing/worsening significantly.** GP registration remains extremely difficult for the majority of homeless people. *Project London suggest 39% of referrals they make to mainstream GP’s fail at reception. Numerous other examples were shared at conference.*

**Information sharing remains difficult and needs to be improved.**

**Partnership working between services is very difficult.** There are very significant health consequences from this, *notable examples being that of the very often difficult communication channels existing between the Home Office and health services. Cases were reported that were ‘near-death’ misses as a direct result of clashing policies.*

**The governance of health and social care services is too fragmented.** There are many competing agenda’s that have a frustrating impact on an individual’s ability to gain access to services and their experiences of them. *This is also true for professionals trying to work in a multi-agency multi-professional way with complex cases. The lack of a working joined-up structure for issue reporting between different health and social care interfaces, contributes significantly to clinical risks and risks to homeless people across a number of areas especially that of safeguarding vulnerability.*

**Experts by experience or peer advocates are key to the success of homeless health services.** *There is a good evidence base for the impact of their work and this was recognized both by panel members and conference attendees in discussion. More should be done to both fund and develop this work both within homelessness and mainstream health and social care services*

## Introduction

This report by members of the London Network of Nurse and Midwives Homelessness Group (LNNM) attempts to summarise the key themes and concerns that emerged at the Conference in May 2016 which was titled *How Safe is the Safety Net?*, and provides recommendations for pan-London commissioning. The report underlines the group's attempts to strategize at a conference wide level, in order to promote service improvement and professional learning.

The LNNM is an unfunded network of professionals working in homelessness and people with lived experience of homelessness that has been in existence since 1999, and has recently evolved from being a purely nurse and midwife network to include allied health and housing professionals. We have also welcomed people with lived experience of homelessness, and have recently benefited from partnership with Groundswell in the production and organisation of our conferences.

Firstly, notes are provided on the discussion groups that were undertaken at the conference. These groups involved all conference attendees. The report includes outcome measures where they were suggested by the discussion groups to support development ideas.

Secondly, there is a report of the panel discussion. The Panel Members were Garry Money, *Associate Director, London Homeless Health Programme*, Hong Tan, *Head of Health in the Justice System (London Region)*, Susan Munroe, *CEO, Freedom from Torture*, Dr Claire Shortall, *Refugee Health Lead, Doctors of the World*, Ronald Kelly, *Solicitor, Southwark Law Centre*. These experts 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.

Finally, the key themes from conference are summarized for the purpose of informing policy development. All workshop presentations provided to the conference organizing committee are available from our website for review, as are the audio recordings of some keynote speeches and the panel discussion.

## **Event Summary**

Conference 2016 was held on the 20<sup>th</sup> of May, and was 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 and policy makes, as well as people with lived experience of homelessness.

This number was double that of the previous year, so a change of venue was required. A full attendee list is available on request.

Similar to previous years the day comprised key note speeches, workshops on specific topics, and opportunities for thinking about our policy wish-list/key concerns in facilitated discussion groups. There was a panel question and answer session that generated lively debate, and live music from the Streetwise Opera which was breathtaking.

## **Support/Infrastructure**

We were lucky to have the support of the Territorial Army who were very flexible venue hosts. The event was catered for by the Munch Marylebone Women's catering collective.

## Feedback from Discussion Groups

198 conference delegates were divided into four discussion groups by the planning committee. The make-up of these groups was planned in advance to ensure a varied cross-section of professions, services and areas of work. Members of LNNM Conference Team facilitated the focus groups. Three questions were presented to the four large groups (see below), who were asked to split into smaller groups to share their thoughts, and then to feedback to everyone. Notes were taken to form the basis of this summary. Further contributions via email after the event were accepted although these were a small number.

### Key groups vulnerable to slipping through the safety net

#### Question 1:

***“We want you to spend a few minutes discussing examples of clients you have worked with who you think have ‘slipped through the safety net’. Do your teams work with many of these clients? Can you identify any key groups who are vulnerable, or any particular themes?”***

Analysis of all four focus groups’ discussions has identified key groups more vulnerable to slipping through the safety net, than perhaps others. By definition a homeless person is vulnerable. The focus of discussion was the demographic groups within the homeless population that have additional factors that make them more vulnerable to system failure, and the themes linking these groups.

#### **People born outside the UK**

- Clients with No Recourse to Public Funds (NRPF)
- Asylum seekers
- Undocumented migrants
- Trafficked people

One of the main themes that emerged from this discussion was the vulnerability of patients who are born outside of the UK, and do not have citizenship. This included people who have been undocumented migrants, EU citizens with no recourse to public funds, and people who had been trafficked, but also asylum seekers and refugees. These groups were felt to be at increased risk of homelessness and to have fewer options for accommodation. It was also felt that they faced many obstacles to accessing adequate healthcare, and were therefore seen to have poorer or deteriorating health.

Obstacles to accessing and receiving equity of healthcare included a lack of awareness of their rights, poor understanding of how the NHS system works, and language barriers. The Home Office policy of creating a “hostile environment” for failed asylum seekers and undocumented migrants – denying essential services while failing to take swift action to deport people – was felt to be a major factor in deterioration of health in some cases. Particular concerns were expressed regarding the mental health of current and failed asylum seekers, many of whom have experienced trauma and/or bereavement.

Many delegates were apprehensive about planned changes to NHS charging policy for non-UK born patients. There were reports of London hospitals actively pursuing payment after patients had been discharged, in particular following maternity care. It was felt that most patients would be unable to pay these large bills, and this would lead to debt-related anxiety, possible negative impacts on future immigration decisions, and increasing numbers of people failing to access essential healthcare, including midwifery & obstetric services.

### **People with mental health problems**

The high threshold of care to access some mental health services, due to cuts to mental health budgets, was a major concern for delegates.

It was widely felt that people with mental health problems classed as “low-level”, and not “severe and enduring” or without psychotic features, were denied access to adequate support. A very high percentage of homeless people report mental health problems, and these issues often have a significant impact on their physical health and opportunities to find and maintain accommodation.

People with complex psychological trauma issues (personality disorders) were felt to be especially at risk of deterioration in their health and wellbeing. A tendency to use many different services was discussed, with a lack of joined up working between services leading to inconsistency in care, and sometimes repeated assessments without a service being offered. Frustrations were expressed that meaningful solutions to physical health or housing problems were not possible to achieve without specialised mental health support. The wider context of failures in the care system and child mental health services was also highlighted as a contributory factor for complex personality problems in the longer term.

People with a dual diagnosis of mental illness and substance misuse were also identified as vulnerable. The separation of addiction and mental health services was felt to be unhelpful, causing people to become stuck in a cycle where their mental health cannot be addressed while they are intoxicated, and their addiction cannot be treated without mental health support.

Inequity in peer advocacy funding was also discussed in a mental health context - peer advocates funding has traditionally focused on physical health appointments and excluded appointments for mental health or addiction services.

## **People involved in / affected by justice system**

People released from prison were felt to be at high risk of repeated homelessness, with many releases occurring straight to the street, without any plan for accommodation. This was reported to cause high levels of re-offending and the immediate re-initiation of alcohol or drug use following detox in prison.

Punitive systems employed by London Councils, with a focus on enforcement as a solution to homelessness – e.g. issuing ASBOs, and refusing to engage with people rough sleeping in certain areas – were felt to be misjudged, and to lead to the criminalisation of vulnerable people. Restrictive door policies of local authority funded day centres, based on local connection, were also discussed as an obstacle to homeless people accessing outreach health services on their premises.

Similarly the criminalisation of sex workers was felt to increase risks to personal safety, and to prevent access to healthcare. Perceived police failures to take violence against sex workers seriously in some cases, and a criminal focus on sex workers themselves, was felt to be increasing reluctance to report assaults. Healthcare services that previously provide outreach to brothels in central London cannot now be accessed by some sex workers, who have been ‘dispersed’ to the suburbs.

## **Homeless people unable to access healthcare**

Increasing difficulties accessing healthcare and poorer health were reported amongst people in temporary accommodation or sofa surfing (who are often very transient across London), and other people judged not to be in priority need for housing, or without a local connection.

Two main issues with accessing healthcare were identified:

### 1. Unable to register with GPs

Despite NHS England guidance that GPs should register homeless patients, using the surgery address, this was widely reported as still not happening in practice, even when peer advocates accompanied people to support registration. Lack of proof of address and ID remains a major obstacle to GP registration.

### 2. Difficulty getting appointments

Even if GP registration is possible, difficulties navigating the rigid appointment systems remain. Many GP surgeries refuse to book appointments unless patients call during a narrow time slot in the morning. Consultation times are often too short to discuss more complex health problems, or address more than one issue. Homeless people do not have access to a phone, or may have other priorities (e.g. accessing food or shower facilities) that conflict with healthcare appointments, and their referral appointment letters are often sent to old addresses, leading to high Did Not Attend (DNA) rates. Inflexible DNA-discharge from treatment policies (where hospitals cancel referrals after a number of DNAs) mean that

health problems go untreated, as patients and professionals are often unwilling to go through the processes again.

It was discussed that homelessness is not routinely or consistently recorded at all health contacts. There are many different terms or read codes used on medical notes, and many hidden homeless patients who may give a false or 'care of' address are never asked about their living situation. Accurate data is therefore very difficult to collect and statistics of homeless people using the NHS are likely to be too low.

### **Homeless people at the end of life**

Quality end of life care is not always available to homeless people, as palliative care services are mainly focused on the housed population. The lower average age of death among homeless people (often related to alcohol or drug addiction) was felt to be a factor in this, leading to a failure to identify people as palliative, and therefore to arrange early support. Complex family and next of kin structures for homeless people were also identified as a challenge to ensuring end of life wishes are met. A high level of anxiety surrounding death was also reported among hostel staff and other residents.

### **Mothers post removal of children**

Homeless women whose children are removed by social services were identified as particularly vulnerable. Some women have had multiple children removed, due to on-going substance misuse, a mental health problem, a learning disability or a combination of these. The intensity of support during pregnancy, from specialist nurses, midwives and social services, with a positive focus on promotion of the mother's wellbeing, was felt to be in stark contrast to the lack of support after the birth and removal of the child. The emotional impact of the child's removal and the need to prevent repeated pregnancies with the same outcome are not being adequately addressed currently.

### **People with learning disabilities / learning difficulties**

- Adults with no official diagnosis of learning difficulties
- People with autism / Asperger's syndrome
- Un-diagnosed or under-diagnosed Adult Attention Deficit Disorder
- Adults with undiagnosed learning difficulties or even simply literacy challenges

Service thresholds employed by social services were deemed to be too high, creating a situation where vulnerable people are "not vulnerable enough" to receive support. Many professionals reported systemic care failure issues around adults with signs of a learning disability, but no official diagnosis or lack of evidence around the diagnosis being used to 'gate keep' services with very little flexibility or common sense taken in approach. Many cases were reported where this rigidity led to hospital readmission, failed discharges and multiple adverse health consequences. In some cases historic assessments such as school

statements of learning needs have been lost, or are not part of care records. If available in some cases this may have changed entitlement to care decisions.

It was also noted that it is difficult to refer to social services if there is no actual 'evidence' of threat or extreme vulnerability (i.e. in many cases serious professional concerns have not been deemed to warrant a response without 'evidence').

### **Homeless Families**

There are over 50,000 homeless families in London now, with many placed out of borough or outside the capital through dispersement schemes. Many professionals describe Bed and Breakfast situations rapidly approaching slum like conditions– overcrowded, dirty, invested. Families are often embarrassed and 'ground down' by the experience

### **Other vulnerable groups also mentioned during discussion**

- Young men
- Young people fleeing gangs
- Women in refuges
- LGBT people, especially if older or elderly

### **Suggestions for improvement & measures of positive impact**

#### **Questions 2 & 3:**

***Choosing one of the key vulnerable groups you have discussed, could your group make any innovative suggestions about what could or should be done to stop some of these situations occurring?***

***Referring back to your suggestions from 2, could your group suggest how the positive impact of your suggestions could be measured?***

Suggestions for improvement made by all four Discussion groups, and possible methods of measuring their positive impact, are discussed below.

### **Suggestions to improve healthcare for people born outside the UK**

Key suggestions to prevent people born outside the UK slipping through the safety net focused on three main elements - culturally appropriate services, informing and empowering patients, and better hospital discharge for people with NRPF (it was felt that hospital admissions were a key opportunity to improve the lot of these patients).

To achieve culturally appropriate services efforts should be made to employ native speakers of appropriate languages. Interpreting services should routinely be available at GP and health service receptions, as well as during consultations. Training and briefings should also be provided for interpreters, improving their understanding of complex needs, health and social care terminology, and the management of these patients' – and probably their own - emotional distress. A pan London network of interpreters who have accessed this training could be established. English classes with a health focus could be provided in a variety of settings, emphasizing key phrases for health.

To inform and empower patients, healthcare clinics should ideally be located within a One Stop Shop, incorporating access to legal advisors specialising in immigration, housing issues and healthcare rights. Better legal support would enable people to appeal more NRPF and asylum decisions.

Better outcomes for people with NRPF could be achieved by establishing homeless discharge teams in all London hospitals, where all available solutions could be considered before discharge. To avoid discharge to the street, the provision of emergency bed spaces and respite projects in the community for very unwell clients with NRPF is also important (from a humanitarian perspective, and to avoid blocking beds). Alerting systems ensuring all local homeless health teams are informed of vulnerable discharges would improve continuity of care.

It was also felt that greater public awareness of the challenges facing people born outside the UK was essential, to personalize people's stories and offer an alternative to the negative portrayals common in the mainstream media.

### **Measures that could be employed:**

- % services with native speakers employed
- % consultations using interpreters for non-English speaking patients
- % of clients without recourse that have received legal advice
- Reduction in A&E visits
- Reduction in discharge to the streets
- Reduction in unplanned hospital admissions and readmissions

### **Suggestions to improve healthcare for people with mental health problems (in particular complex personality issues)**

If changes to mental health service referral criteria are not achievable, then more specialised services need to be provided for people with complex personality problems. This should include outreach psychological services, offering specialised therapy with a proactive focus on making every contact with a person count. Referral processes, should be flexible and care provided on an open-ended basis to allow people to re-engage if necessary.

Better communication between services across London was also suggested as an important factor in providing joined up care that crosses borough boundaries and avoids repetition. Joint work between mental health services, physical health services, addiction services and housing services was also felt to be essential in order to address the holistic impact of complex personality problems.

Funding for peer advocacy for mental health appointments would provide extra support for patients and increase levels of engagement with services.

#### **Measures that could be employed:**

- % of clients declaring a mental health problem accessing mental health services
- % Reduction in specific service DNAs due to peer support
- Increased wellbeing scores including measures of clients achieving employment, volunteering
- Reduction in the number of clients reporting feeling depressed

#### **Suggestions to improve healthcare for people with addictions**

Addiction services should offer person-centred care, allowing time to build relationships and a non-judgemental, respectful approach. The importance of on-going support was emphasised with suggestions for open-ended therapy (no restriction on the number of sessions), and better follow up after rehabilitation to help maintain abstinence.

Joined up working was also discussed in relation to people with addictions. Provision of drug and alcohol services and mental health services within a One Stop Shop was suggested as an ideal solution. Peer advocacy should also be embedded within addiction services.

#### **Measures that could be employed:**

- % of personalised client goals met
- Increased wellbeing scores
- Length of time drug or alcohol free

#### **Suggestions to improve care for sex workers**

The creation of safe spaces for sex workers - with a non-judgemental approach to lifestyle choices, including continued sex work – would allow healthcare needs to be met. The focus of services should be safety and prevention of violence, in addition to the promotion of better sexual health. Joint working with addiction services would provide better access, and individualised packages of care and support would improve patient experience.

### **Measures that could be employed:**

- % of personalised client goals met
- Improvement in self-worth measures
- No of people engaged in drug and alcohol treatment

### **Suggestions to improve healthcare for homeless people with access problems**

To facilitate GP registration, information should be provided to homeless patients detailing their rights. Training for receptionists should be provided to increase awareness of registration rules and improve empathy. Universal registration forms, which could be sent into GP practices, would allow homeless teams to easily assist with registration.

In addition to the pro-active suggestions mentioned, it was also felt that GPs who deny registration access to homeless people should be reported to Healthwatch and enforcement measures should be put in place to ensure they comply with NHS England guidance, which it was felt does not happen very often now.

Flexible appointment policies for homeless patients would decrease the occurrence of repeated DNAs. These policies should include allowing homeless people to book appointments in advance at suitable times, and the facility to arrange double consultations. Suggestions to implement these policies included cards for people to present to receptionists or reminders on their medical records. All professionals should routinely screen for barriers to future appointment attendance when they discuss referrals or book appointments, and solutions should be put in place to overcome these e.g. peer advocate referrals, arranging communication of appointment details via text, through homeless health services or day centres.

### **Measures that could be employed:**

- Reduction in % of A&E attendances with no GP registered
- Audit of Healthwatch responses to complaints about GP registration
- Audit of GP receptionist knowledge regarding registration rules
- Reduction in DNAs at GP practices
- Reduction in DNAs in secondary care
- Improved measures of patient experience & improved patient feedback

### **Suggestions to improve palliative care for homeless people**

To ensure early identification of palliative homeless patients training should be provided to increase awareness among health professionals, hostel and housing workers and homeless people, including details of how to refer to palliative care

teams and what support will be available. Training could also reduce staff anxiety and enable open conversations about death and improved emotional support. Better links between homeless health services and palliative care teams in the same area would also facilitate joint working.

Palliative care services need to be flexible, with an outreach element. An awareness of possible complex family situations and a focus on providing individualised end of life plans would also be important.

One innovative suggestion was the establishment of specialist end of life care hostels. The value of this idea was debated among the delegates, who considered whether improved access to specialised palliative care might be outweighed by individual wishes to die in familiar surroundings.

#### **Measures that could be employed:**

- No of health / housing service workers receiving specialist palliative care training
- Audit of staff awareness of referral criteria and process to local palliative care services
- Increase in numbers of referrals to palliative care from homeless services
- Increase in number of homeless people receiving palliative care.

#### **Suggestions to improve healthcare for mothers post removal of child**

The care of mothers post removal of a child should be taken over by specialist teams providing bereavement and trauma support, as well as contraception interventions, and wider interventions to support recovery.

A London wide research programme was also suggested, looking at the needs and outcomes of homeless mothers after children are removed and including an economic analysis of the long-term impact if no support is provided.

#### **Measures that could be employed:**

- Reduction in subsequent unplanned pregnancies
- Increase in contraception uptake & smear testing / STI treatment
- Reduction in children taken into care

#### **Suggestions to improve care for homeless families:**

It was felt there needed to be improved cooperation between health and social care. Ideally a pathway should exist for homeless families with at least one named health care worker that would have a clear role and be able to cross borough boundaries & ensure joint working between other professionals and the

families themselves. It was recommended that expertise within community groups should be drawn on – particularly around culturally appropriate discussions and translations e.g. different understanding of mental health.

### **Measures that could be employed:**

- Lower DNA rates for primary and secondary care appointments
- Increased rates of child health checks / vaccinations etc being completed on time
- Reduced rates of child mental health
- Reduced rates of adult mental health
- Improved patient experience and feedback.
- Reduction in families lost to follow-up

### **'Gaps in the Safety Net' – Summary of discussion group thoughts on wider system solutions**

It was widely evident that the key concern of LNNM Homelessness Group members that inspired the title of the 2016 Conference (namely a concern that a background of austerity and continued cuts to public services was increasing the risk of vulnerable people slipping through the safety net) was confirmed through the related experiences of front line workers, peer advocates and experts by experience.

Ideas on wider system solutions included:

#### **Personalised goals as measures of positive impact**

The creation of individualised care plans with negotiated personalised goals set by the client in relation to their treatment was felt to be both a positive method of engagement and in self report terms a potentially useful outcome measure. Work focused purely on healthcare professional identified clinical agenda's is likely to be significantly less productive.

It was noted that health outcomes in homeless services were notoriously difficult to measure: small incremental changes that may be very significant to a patient, may not be sufficient to meet health service targets. Self-report measures of wellbeing or motivation were recommended.

#### **Improved data**

Improvement in data collection was a key point from the group discussions. Although every group had multiple examples of patients / clients who were slipping through the safety net, it was apparent that there is a lack of collated data evidencing this.

*LNNM recommends that a central repository to collect stories and spot trends is established e.g. a Homeless Healthwatch for London. Improved data collection would enable research into the long term impacts on society.*

### **Integrated care**

Throughout the discussions the need for better communication and joined up working was repeatedly raised. Improved links were recommended between homeless health services and social care, housing and the Home Office (both prisons and immigration services); primary and secondary care services; mental health, physical health and addiction services; and the multiple agencies looking after families.

A major role of LNNM has been to improve integration and inclusivity, bringing together expertise and experience from across London, from different professions and experts by experience. LNNM recommends that we continue to work towards integration of services, with the aim of trying to close the gaps in the safety net.

### **Importance of Peer Advocacy**

The importance of lived experience was highlighted by both the discussion groups, and the panel session. Peer advocacy was seen as a fundamental strand of all health inclusion services, and funding should be expanded to cover mental health and addictions appointments. Mainstream services should also utilize experts by experience where possible.

## Panel Discussion

The panel discussion was run as a 'Question Time' style session with conference wide audience participation. Questions were submitted by LNNM conference attendees via email or verbally prior to conference, and then voted on to be the panel discussion questions of the day, using a manual voting system that was placed on the wall on the morning of the conference.

What follows is a brief synopsis of the key points made by each panel member in response to the questions asked. This is not obviously exhaustive as each question provoked lengthy dialogue between panel members and the audience, and a full audio of the panel discussion can be accessed online if desired: <https://soundcloud.com/lnnmhomeless/lnnm-2016-panel-discussion>

### Panel members

- Garry Money, Associate Director, London Homeless Health Programme, **GM**
- Hong Tan, Head of Health in the Justice System (London Region) **HT**
- Susan Munroe, CEO, Freedom from Torture **SM**
- Dr Claire Shortall, Refugee Health Lead, Doctors of the World **CS**
- Ronald Kelly, Solicitor, Southwark Law Centre **RK**

### Question 1:

**This year NHS England issued guidance for practices on GP registration policy, saying that practices should not insist on ID for our client groups. However our experience is that this is still happening. Does the panel agree that this is still happening, and what should be done about this?**

Question posed by Melu Mekonnen, a Groundswell peer.

**CS:** Despite the guidance we are seeing very high rates of GP refusal. This has been a major focus of Project London where we provide advocacy to support onward referral to GPs. It is very challenging that even with this advocacy 39% of our onward referrals for GP registration are refused, usually due to lack of identification documents being available - despite the guidelines that this isn't needed for registration.

**GM:** Absolutely recognize that this is a key issue that needs tackling. The London Homeless Health Program (LHHP) intends to provide much stronger guidance to the 1500 general practices across London.

**SM:** We need to think beyond just GP registration, and think about what post-registration support homeless people are getting for example access to interpreters, peer advocacy etc.

**HT:** The GP is critical as the first port of call to access the whole of the health and social care system. 70% to 80% of prisoners are not registered, or are removed from GP lists whilst they are in prison, and this is an acknowledged problem. We (NHS England, Health in the Justice System) have just commissioned a pilot in to support prisoners with registration on discharge.

**RK:** As a solicitor I find that generally if a phone call fails, I threaten to take them to court (Laughter and applause from audience followed this slightly tongue in cheek response!). There needs to be some kind of penalty to practices - fines might be effective here in improving practice rather than soft guidance.

## Question 2:

**We know of many homeless clients who are known to the Home Office and have no current legal status, yet they have not been detained, and are also deteriorating from a health point of view. In health we are desperately waiting for them to go over the 'care needs threshold', so we can get them some support. How can health care professionals influence the Home Office to enter into a discussion about a humanitarian approach to the management of these individuals?**

Question Posed by Dr Caroline Shulman, Kings Pathway team

**CS:** A similar example of this that I am often faced with, is when families have no recourse to public funds (NRPF). They are often assessed under Section 17 of the Children's Act as having a child in need, but social care will not provide housing, so the child doesn't get support. The families move to wherever they can afford to live, and are forced into extreme poverty which worsens the child's situation.

**SM:** The wider economic and humanitarian costs of this must be debated. There is a lack of integration and partnership between health and social care in raising the profile of this issue. There is now a toxic discourse around immigration. The Home Office have a duty of care but don't communicate with health care services – this needs to be taken up at high level.

**GM:** Most NHS management teams, have no relationships with the Home office. There is a beneficial dialogue to be had, as healthcare professionals do not want to enforce immigration policy and are stuck with very difficult choices. The London Homeless Health Programme is attempting to build links now. London as a whole has some clout, as it is a healthcare system with a very large budget

which provides some leverage. The GLA also need to be in the debate as social care budget holders.

**RK:** With regard to children it is also important to note that Local Authorities (LA) are being told that Section 17 is not expected to provide support to the family members of the children if they are all irregular migrants. I also recognize similar conflicts of interest e.g. a) where hospitals want to discharge a patient, but not to the streets, but thus support assertive reconnection policies when people do not want to be reconnected. b) where women are not accessing maternity services because they feel scared that charges from this will affect a decision regarding their immigration case. They know they can't afford to pay any potential charges, so don't access care. It is possible that Europe can hold the UK to account for this. Most EU countries exempt pregnant women and children from charges to healthcare, and there are very significant adverse effects and risks attached to this kind of charging.

### Question 3:

**Ensuring a flow of information between services that benefits and protects our most vulnerable clients, and manages public health risk still remains out of reach despite a general consensus that data sharing should take place in these cases. E.g. there is currently no national alerting system for transient homeless pregnant women / vulnerable migrants. Does the panel agree this is an issue, and if so, how can we ensure that further work takes place in this area?**

Question posed by Nicky Tanner, Lead Nurse Homeless Health Team, Westminster

**HT:** This is key issue e.g. when we recently reviewed the map of the Haven Rape Crisis Centres we found that attendees were experiencing repeated requests for the same information, with significant adverse consequences. We have since redesigned the system. Information sharing is vital as well as the information governance to support this and we.

**GM:** This is focus of some of the LHHP work. It is recognized this is an issue which concerns practitioners, and is ongoing. We agree that it is very important and needs addressing, and are thinking about how best to support change.

**RK:** Data sharing is vital, but critical analysis and interrogation of data provided needs to take place. The quality of the information provided by actors such as the Home Office can be a big problem, as records often have gaps or mistakes within them.

#### Question 4:

**One of the conference case studies concerns a prisoner with dermatology, mental health, and addictions problems who was discharged from remand homeless. After failing to obtain housing himself, he said he wanted to re-offend to avoid homelessness. However he ended up in hospital, where a Pathway housing worker helped him to get housing. What could be done to improve prison discharge processes in terms of health and housing?**

Question posed by David Axten Guys and St Thomas' Pathway team.

**HT:** Community rehabilitation companies are key players to engage in working towards solutions on this. There is currently a pilot project involving the Mayor's office, NHS England, the Home Office and a Community Rehabilitation Company with a focus on providing enhanced offers to prisoners which will hopefully improve things. It will be important to get data from this project - no one should leave prison without housing.

**GM:** The revolving door described at Accident and Emergency is due to multiplicity of other issues beyond exclusively health services, for example social care issues. It is important to note that in this case the Pathway team was more successful than the individual alone in obtaining housing – advocacy was needed to prove eligibility here. However Local Authority cuts have been very significant especially around what were previously 'Supporting People' budgets, so it is difficult for them too. The new Mayor has just been elected on housing platform – hopefully this will have positive outcomes.

**RK:** This is all due to gatekeeping. Local Authority's won't do anything currently unless they are forced to, but this is a position they have been forced into politically.

**David Axten, Pathway:** This is our experience. Even when clients are in clear priority need and attend a housing office, without support they are not likely to get very far.

**CS:** The threshold for access to mental health services is also now so high that you must be in crisis to access them. It is almost impossible to access things without having advocacy now, and knowing the exact words to say. This is difficult for service users who may have a language barrier or other communication issues.

**SM:** A significant proportion of the prison population have experienced brain injury, and therefore like familiar environments with structure where they feel safe and this may also be a factor which needs consideration.

### Question 5:

**At birth social services often offer support to children, but not the mother, presenting an unenviable choice for migrant women with no status. This tends to drive these women underground, threatening the future of both the mother and the child. What does panel think about this issue, and should more support be offered?**

**CS:** Although I am aware of this being ‘threatened’, I don’t know of any cases where children have been taken into care on this basis. Does anyone have an example of where this has happened?

**Audience response:** No cases known of actual child removal from parents but many cases where it was threatened. Typically in Section 17 support cases.

**CS:** Social Services need to be held accountable. Families need to be given advocacy support. Advocacy really changes what is actually said to clients. It is important that frontline workers are aware of this, and offer advocacy as well as any resources they provide.

### Question 6:

**Should peer advocacy be a core service for all health and homeless inclusion services and if so how should it be funded?**

Question posed by Dennis Rodgers, Groundswell.

There was a consensus across the entire panel that peer advocacy was fundamental to health and homeless services. Further it was suggested that this involvement should be broadened to more mainstream services.

**GM:** Peer advocacy means many different things to different organisations across London. This is an issue for commissioners who are not experts. Agencies have begun to gather good evidence base for peer advocacy, but this needs to be explained cleared to commissioners.

**HT:** We need to understand the power of lived experience a lot more, and leverage service users to have more influence in service design.

**SM:** This should be much wider than inclusion health, as the impact evidence is very powerful. However getting funding is very challenging as measurement of the impact is difficult in quantitative terms.

**Stan Burridge Pathway:** People with lived experience be involved in commissioning too. They be on the board to provide ‘boots on the ground perspective’

**HT:** This is actually already happening in the Health in the Justice System – people with a lived experience are referred to as ‘commissioning technicians’.

**GM:** Two members of LHHP program board have lived experience, also we are talking to Healthwatch. In Kingston and in Waltham Forest Healthwatch have done interesting work involving people with a lived experience.

**Sonja, Groundswell:** Further training and support for peer advocates is important. Shouldn’t there be more than just training to NVQ3 level 3 for peer advocates (Referring to an earlier description of St Giles project which trained people up to NVQ 3 level, which is quite common). Shouldn’t there be a specific funding stream for this? I am a Groundswell peer now studying at university. It’s hard, but we need to support more people with lived experience to do this.

Much applause and unanimous agreement from the panel that this should happen, and that there should be more explicit pathways for this.

## Conclusion

### **Access to services is worsening for homeless people in London.**

GP registration remains extremely difficult for the majority of homeless people. Project London suggest that 39% of referrals they make to mainstream GP's fail at reception. No specific data was presented regarding secondary care, but there were several case reports, which frequently included issues with social care and mental health care. Some very concerning reports also emerged regarding the impact of charging legislation, and a resultant lack of take-up of maternity and family care in certain groups.

**Lack of information sharing remains a challenge**, and was frequently cited as reducing the efficacy and quality of care that can be provided. Information sharing challenges contribute to the duplication of effort across health and social care systems, as well as elevating risks especially around safeguarding and frequent attenders. More effort needs to be put towards finding easy, safe routes for information sharing.

**Skilled advocacy and support changes the outcomes significantly for homeless people in terms of accessing healthcare and housing and social care and should be valued.** In line with the above it was felt that many health and social care processes appear to be designed purely to gate keep access, rather than actually meet need. This is leading to the 'more vulnerable' clients not accessing any services. Advocacy is becoming an essential role for homeless healthcare practitioners, and needs to be valued and made explicit as a core homeless health service activity.

**Partnership working between services is very difficult** and there are very significant health consequences from this. The governance of health and partnership services (e.g. social care) is too fragmented and exacerbates this. It was also noted that quality systems can be particularly opaque and unhelpful where commissioning structures involve Local Authorities (LA) Clinical Commissioning Groups, as well as other players such as NHS England or other government services - as each may have a different reporting structure and responsibility can be passed around.

Two particularly challenging situations were familiar:

- a) **Where the agenda of each involved service is different:**  
e.g. notably there is an observed friction between the Home Office goal of a hostile environment for migrants, and the health service obligation to treat based on clinical need. This is leading to unacceptably high levels of clinical risk. Examples were cited of women sharing maternity bookings, and identities to access healthcare, or simply delivering babies entirely outside the maternity system.

**b) Where services are contracted out:** and the contract is inadequately managed by commissioners (all cases discussed were non NHS providers). This is leading to providers renegeing on existing collaboration agreements, excessively gatekeeping, or simply failing to deliver an adequate standard of service. Many examples of this were provided.

It was felt that efforts need to be made to align the agendas of government departments to ensure they are not forcing front-line practitioners into impossible situations, and generating in-humane circumstances for patients.

**Experts by experience or peer advocates are key to the success of homeless health services.** More should be done to both fund and develop this work both within homelessness and mainstream health and social care services.

## **Chairs notes: Next Steps**

The LNNM will continue to advocate both for those working in the field of homeless health, and for homeless people. We are an unfunded network that exists entirely through the voluntary efforts of our members and we have achieved a great deal, this year's conference being a big part of that. We hope to continue this.

It is our intention to discuss the content of this report, and its implications with key policymakers, particularly the Mayor's Office, London Homeless Health Program, and other key actors such as specific local authorities and CCG's with a view to driving some change where possible, particularly around tangible things that we feel should be deliverable such as improved reporting mechanisms for quality issues, and improving information sharing.

It is likely there will be another conference in 2017. The feedback from 2016 was overwhelmingly powerful and positive. The day was a great reminder of the inventiveness and creativity of all the people working with passion in this sector.

**Maxine Radcliffe**

**LNNM Chair December 2016**

## Appendix 1: Conference Timetable

08.30 - 9.00	Registration / networking. Coffee / Tea and biscuits.
9.00 – 9.15	Opening address: Update and progress since last year. Maxine Radcliffe, Chair of the LNNM Homelessness Group
9.15 – 09.40	Key note speech and questions: Jill Demilew, Consultant Midwife, Kings
09.40 - 10.00	Life on the front line: Gerry Dickson, Caseworker, Groundswell
10.00 – 11.00	Break Out Workshops 1 <ol style="list-style-type: none"> <li>1. The Club Drug Clinic - Dr Owen Bowden Jones, Consultant Psychiatrist and Lead Clinician for Club Drug Clinic, CNWL (65)</li> <li>2. Midwifery 101 – Corrine Clarkson, Specialist Midwife; Morag Forbes, Family Nurse; Sue Byrne, Supervisor of Midwives; Emily Nygaard, Safeguarding Midwife – various NHS Trusts (45)</li> <li>3. Partnership to combat trafficking – Karen Anstiss, Manager, Caritas Bakhita House; Detective Sergeant Phil Rashidi, Metropolitan Police Human Trafficking Unit (40)</li> <li>4. Female Entrenched Rough Sleeper Project – Dagnija O’ Connell, CPN, Joint Homelessness Team (25)</li> <li>5. Learning from the Family clinic at Project London – Dr Clare Shortall, Volunteer Doctor / Family Clinic Lead; Jenny Booth, Volunteer Nurse; Bettina Wanninkhof, Volunteer Midwife, Doctors of the World (15)</li> <li>6. Meeting the challenge of treating homeless people – John Conolly, Lead Counsellor, Westminster Homeless Health Team, CLCH (10)</li> </ol>
11.00 – 11.15	Coffee / Tea, Biscuits.
11.15 – 11.40	Progress on pan London Homeless Health Commissioning and questions: Dr Adrian McLachlan, Chair, London Homeless Health Programme / Chair, Lambeth CCG
11.45 – 12.45	Professionals Focus groups – ‘How Safe is the Safety Net?’
12.45 - 13.30	Lunch and poster viewing
13.30 – 15.00	Panel discussion – chaired by Stephen Robertson, CEO, Big Issue Foundation <ul style="list-style-type: none"> <li>• Garry Money, Assistant Director, London Homeless Health Programme</li> <li>• Hong Tan, Head of Health in the Justice System (London Region)</li> <li>• Susan Munroe, CEO Freedom from Torture</li> <li>• Dr Clare Shortall, Volunteer Doctor / Family Clinic Lead, Project London</li> <li>• Ronald Kelly, Lawyer, Southwark Law Centre</li> </ul>
15.00 – 15.15	Streetwise Opera
15.15 – 15.30	Coffee / Tea, Biscuits.
15.30 – 16.30	Break Out Workshops 2 <ol style="list-style-type: none"> <li>1. Meeting the Health Needs of the Asylum Seeking Population – Dr Shazia Munir, Specialist GP Refugee Health; Clinical Nurse Specialists Kirit Sehmbi and Caitlin McCullen, Health Inclusion Team, GSTT (65)</li> <li>2. Sexual health and precarity – Deborah Clark, Matron, Sexual Health Outreach, GSTT; Jane Ayres, Manager, Praed Street Sex Workers Drop In, Westminster (45)</li> <li>3. Maternity Rights for the most vulnerable in an age of austerity – Ros Bragg, Director, Maternity Action (40)</li> <li>4. Parents and Communities Together – Imogen Moore, Manager; Grace Romero, Parent Organiser; Dayo Adude, Early Intervention Health Visitor (25)</li> <li>5. Working with Gangs - Dorcas Gwata, Clinical Nurse Specialist, Integrated Gangs Unit, CLCH (15)</li> </ol>
16.30 – 16.50	Closing speech and questions: Professor Ursula Gallagher, Deputy Chief Inspector of General Practice and Integrated Care (London)
16.50 – 17.00	Final thoughts: Stan Burrige, EBE Project Lead, Pathway
17.00 – 17.15	Results of the poster competition, quiz, and thanks: Maxine Radcliffe Drinks Reception

## Appendix 2: Questions for the panel (questions highlighted in red were those that were chosen for debate on the day)

1. One of the conference case studies concerns a prisoner with dermatology, mental health, and addictions problems who was discharged from remand homeless. After failing to obtain housing himself, he said he wanted to re-offend to avoid homelessness. However he ended up in hospital, where a Pathway housing worker helped him to get housing. What could be done to improve prison discharge processes in terms of health and housing?
2. We know of many homeless clients who are known to the Home Office and have no current legal status, yet they have not been detained, and are also deteriorating from a health point of view. In health we are desperately waiting for them to go over the 'care needs threshold', so we can get them some support. How can health care professionals influence the Home Office to enter into a discussion about a humanitarian approach to the management of these individuals?
3. Vicarious trauma is a known issue for professionals working in this sector. What does the panel think professionals working in this sector should be doing to mitigate against this?
4. This year NHS England issued guidance for practices on GP registration policy, saying that practices should not insist on ID for our client groups. However our experience is that this is still happening. Does the panel agree that this is still happening, and what should be done about this?
5. What concerns does the panel have about the Immigration Act, and will it make our work any more difficult than it already is?
6. At birth social services often offer support to children, but not the mother, presenting an unenviable choice for migrant women with no status. This tends to drive these women underground, threatening the future of both the mother and the child. What does panel think about this issue, and should more support be offered?
7. Ensuring a flow of information between services that benefits and protects our most vulnerable clients, and manages public health risk still remains out of reach despite a general consensus that data sharing should take place in these cases. E.g. there is currently no national alerting system for transient homeless pregnant women / vulnerable migrants. Does the panel agree this is an issue, and if so, how can we ensure that further work takes place in this area?
8. Should peer advocacy be a core element of all homeless and inclusion health services, and if so, why, and how should this be funded and the success be measured?
9. The number of homeless families increased 45% last year to a 12 year high. There has also been an increase in out-of-borough placements, with at least a third of homeless families now being placed outside London (2/3 in the case of Kensington and Chelsea). What does the panel think are the impacts of families being placed out of borough, and should this practice be challenged?
10. What should be in a 5 year plan for homeless health care for London?

## **Acknowledgements**

This report was generated by the collation of feedback from the conference and edited by Rosa Ungpakorn, Sam Dorney-Smith, Yasmin Appleby, Amy Hall, Corinne Clarkson, Kate Bowgett and Maxine Radcliffe.

It would not have been possible without the many additional people who made conference possible. You are too numerous to list. Thank you.