

## **Homelessness and integrated care: an application of integrated care knowledge to understanding services for wicked issues**

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### **Abstract**

**Purpose** – People experiencing homelessness often have complex needs requiring a range of support. These may include health problems (physical illness, mental health and/or substance misuse) as well as social, financial and housing needs. Addressing these issues requires a high degree of coordination among services. It is, thus, an example of a wicked policy issue. We examine the challenge of integrating care in this context using evidence from an evaluation of English hospital discharge services for people experiencing homelessness.

**Design/methodology/approach** – The paper undertakes secondary analysis of qualitative data from a mixed methods evaluation of hospital discharge schemes and uses an established framework for understanding integrated care, the Rainbow Model of Integrated Care (RMIC), to help examine the complexities of integration in this area.

**Findings** – Supporting people experiencing homelessness to have a good discharge from hospital was confirmed as a wicked policy issue. The RMIC provided a strong framework for exploring the concept of integration, demonstrating how intertwined the elements of the framework are and, hence, that solutions need to be holistically organised across the RMIC. Limitations to integration were also highlighted, such as shortages of suitable accommodation and the impacts of policies in aligned areas of the welfare state.

**Research limitations** – The data for this secondary analysis were not specifically focused on integration which meant the themes in the RMIC could not be explored directly nor in as much depth. However, important issues raised in the data directly related to integration of support and the RMIC emerged as a helpful organising framework for understanding integration in this wicked policy context.

**Practical implications** – Integration is happening in services directly concerned with the discharge from hospital of people experiencing homelessness. Key challenges to this integration are reported in terms of the RMIC, which would be a helpful framework for planning better integrated care for this area of practice.

**Social implications** – Addressing homelessness requires careful planning of integration of services at specific pathway points, such as hospital discharge, but also integration across

wider systems. A complex set of challenges are discussed to help with planning the better integration desired and the RMIC was seen as a helpful framework for thinking about key issues and their interactions.

**Originality/value** – This paper examines an application of integrated care knowledge to a key complex, or wicked policy issue.

**Keywords** integration, homelessness, multiple exclusion, Rainbow Model of Integrated Care, wicked policy issue, VUCA environment

**Paper type** conceptual paper and evaluation

# Homelessness and integrated care: an application of integrated care knowledge to understanding services for wicked issues

## Introduction

Homelessness covers a range of circumstances from 'sofa surfing', through temporary and insecure accommodation arrangements, to living on the streets (Crisis 2017). It is increasing in England (National Audit Office 2017). Many people experiencing homelessness have different, often complex, patterns of needs, making it difficult to organise systems of support for them. The complex environment of support across housing, health, social care and other services can lead to fragmented support when more integration around an individual's complex needs is required. Despite evidence that integrated support can make a difference for people who are homeless, gaps remain in services and our evidence (Miller & Appleton 2015; Albanese, Hurcombe & Mathie 2016).

In this paper we apply a framework of integrated care knowledge to the pressing need to ensure better coordinated care for people experiencing homelessness. We draw on evidence from a national evaluation in England of hospital discharge services for people experiencing homelessness (Cornes et al. in press). We begin by examining the phenomenon of homelessness as an example of the concept of a wicked policy issue and the challenges this presents to integrating care.

## Homelessness as a wicked policy issue

Wicked problems in social policy are characterised as presenting difficulty with defining and locating the actual nature and source of the problem(s), and consequently having no simple solution, with complex and complicated responsibilities for delivery of the support arrangements (Rittel and Webber 1973; Ferlie et al 2011). It is in no sense a pejorative term implying anything about individuals.

The concept of wicked problems has been noted to be used across many areas of society and related scholarly work, to the point where there is contention about its exact definition and utility for research, policy and practice (Termeer, Dewulf & Biesbroek 2019; Turnbull & Hoppe 2019). Turnbull & Hoppe (2019) in particular, are critical of the original categorisation of problems as wicked/tame as being too simplistic, preferring, for example, a continuum of (un)structured problems. Nevertheless, the body of literature and knowledge on wicked problems is substantial and a helpful framing of this study on integrated initiatives in the area of homelessness.

Some continuing areas of uncertainty regarding wicked problems are the potential for creating paralysis amongst practitioners and policy makers when they closely scrutinise the concept in relation to specific issues, and the need for more detailed understanding of how responses to specific wicked problems succeed/fail when governance crosses organisational and professional boundaries and a more integrated response is required (Termeer, Dewulf & Biesbroek 2019). This paper contributes to developing the evidence in these areas by considering integrated approaches to support people experiencing homelessness at the point of discharge from hospitals.

Organising support for people experiencing homelessness is, we argue, a wicked problem. It contains high degrees of conflict over the nature of the problem/solutions, complexity at many levels, and uncertainty as to the best interventions, the three broad criteria representing promising means of defining wicked problems (Termeer, Dewulf & Biesbroek 2019). In addition to their need for accommodation, many people experiencing homelessness also have physical, mental and/or substance misuse problems. Each need can be difficult to address, but in their interactions, they present complex situations where solutions do not always sit easily within the remit of individual services or government departments. Neglect of needs is a significant problem, with, for example, around a third of deaths amongst this population arising from treatable health conditions such as cardiovascular disease (Aldridge et al 2019).

Integration of care is central to improving care and outcomes for people experiencing homelessness (Cornes et al. 2018). Improvement will involve integration within sectors and across these boundaries. For example, integration may be needed within the housing sector (e.g. local authority housing departments, providers of social and private housing, and housebuilders), as well as with specialist homeless services. Within health services, there may be a need for better integration of, for example, primary, acute and mental health care, as well as horizontally with housing/homeless services. Closer integration across this complex landscape will be highly challenging, and the point of discharge from hospital is one area where it is needed.

Tansley & Gray (2009) discuss how people experiencing homelessness were subjects of inappropriate discharge planning when in hospital, often resulting in a revolving door of readmissions that were potentially avoidable with adverse impact on the costs of care (readmissions and often longer stays) and people's health and lives (e.g. loss of the accommodation they did have). Premature and risky discharge with poor after care plans is common for people experiencing homelessness, with about 70% of such discharges being to the street rather than an environment conducive to recuperation (St Mungo's and Homeless Link (2012).

Recognising this failing in provision of care, in 2013 the then Department of Health in England launched a Homeless Hospital Discharge Fund to stimulate local areas to improve services and care coordination (Department of Health 2013). 'Homeless people' were increasingly recognised as being more likely to be admitted to hospital and to stay longer, with 70% then being discharged to the street with no comprehensive care arrangements (Cornes et al 2018). The Fund provided short-term investment to address the service gaps contributing to these problems. An evidence review for discharge models for this client group (Hanratty et al 2019) recognised that better approaches work, but identified a need to develop the evidence base, especially understanding how they best work in context. Integration of services (health, social care and housing) has been proposed as a central element of the programme theory underpinning better discharge schemes, but was seen as a challenge with little evidence of how best to do and sustain it (Cornes et al 2018).

The case study sites fell in to two broad categories of hospital discharge schemes for people experiencing homelessness, namely *housing-led intermediate care* and *clinically-led care*.

The former entail a link worker with experience of local housing/homeless services and options connecting in to the hospital to assist with discharge planning, and then providing some degree of support to the person after discharge. Clinically-led approaches have a multi-disciplinary team within the hospital, often led by a nurse or medically-trained person and including expertise on homelessness, and focus on optimising the stay in hospital up to the point of discharge and then tend to disengage from further support for the person. Each attempts integration of care in various ways, though understanding this from the knowledge base of integrated care research has been lacking to date. This paper seeks to address this gap and to explore the integration issues across the two broad models of care.

### Integrated care knowledge

In understanding integration, we began with this definition:

“An integrated care service is defined as a coherent and coordinated set of services which are planned, managed and delivered to individual service users across a range of organizations and by a range of co-operating professionals and informal carers.” (Minkman et al 2011:1)

This may help to consider the conceptual and operational detail of organising integrated care, but there is still a significant knowledge gap here, especially when considering the complexity of a wicked issue such as homelessness. To help with this integration, frameworks have been developed to aid more detailed analysis and planning (e.g. Bautista et al 2016; Minkman et al 2011; Valentij et al 2019). In this project we focus on one such, the Rainbow Model of Integrated Care (RMIC) (Valentijn et al 2013 & Valentijn et al 2015). The eight elements of the model are summarised in Table 1. They span levels of systems (working with individuals, service and organisational levels, plus the overarching system) and underpinning issues (person- and population-focused views and the normative basis for an integrated system).

**Table 1: Summary of the elements of the Rainbow Model of Integrated Care (RMIC) framework**

<b>Element of the framework</b>	<b>Description</b>
A person-focused view	A bio-psychosocial view of a person’s needs, including their preferences and values. Combined with population-health focused presents a holistic view of the needs locally.
A population health-focused view	Addressing needs in a defined population. An important focus is equity and the needs of disadvantaged people, especially the multimorbidity they experience.
Macro level: system integration	A specified system for integration of structures and processes with the health of people at the heart.
Meso level: organisational integration	Inter-organisational relationships (e.g. commissioning and contracting, strategic

	alliances, knowledge networks), including common governance mechanisms, to deliver comprehensive services to the defined population.
Meso level: professional integration	Interprofessional partnerships based on shared competences, roles, responsibilities and accountability to deliver a comprehensive continuum of care to the defined population.
Micro level: clinical integration	The coordination of person-focused care in a single process across time, place and discipline.
Linking the micro, meso and macro level: functional integration	Key support functions and activities (i.e., financial, management and information systems) structured around the primary process of service delivery, to coordinate and support accountability and decision-making between organisations and professionals to add overall value to the system.
Linking the micro, meso and macro level: normative integration	The development and maintenance of a common frame of reference (i.e., shared mission, vision, values and culture) between organisations, professional groups and individuals.

A second similar framework to the RMIC, the Development Model for Integrated Care (DMIC) (Minkman et al 2009; Minkman et al 2011; Minkman 2016) was not used for this analysis as it contains more detailed elements requiring specific data collection (not the focus of this study). The structures of the DMIC and RMIC overlap (both contain an element about ‘person-centredness’) and specific investigation of these similarities in further studies would be warranted.

## Methods

As noted, this paper draws on evidence from a national, multi-method evaluation in England of models of services for discharge from hospital of people who are homeless. The project included analysis of linked data for population cohorts (Blackburn et al 2017; Aldridge et al 2019), and realist evaluation of services (Cornes et al 2018).

This paper draws on transcripts of 56 interviews in six case study sites where models of hospital discharge were evaluated in the overarching project. Interviewees included people from the following groups:

- health professionals in hospitals and primary care, including GPs, health care professionals in mental health care, and health professionals in emergency medicine and acute nursing.

- hospital management and administrative staff, including discharge leads and bed managers.
- social work, social care and housing/homeless workers based in hospitals.
- managers and practitioners from homeless support services in the community.
- strategic system leads, including commissioners, a cross-city lead for homelessness, a public health lead.
- senior managers in third sector organisations.

This reflects the range and complexity of service provision for a good discharge service for people experiencing homelessness.

The interviews focused on perceptions of local hospital discharge pathways to inform the evaluation. Interviewees were not specifically asked about integration of services. However, in initial analysis of the interviews it was apparent that integration of care was a clear concern and that secondary analysis of the transcripts focusing on this might be justified.

Interviews were analysed by the lead author for references to integration of services. Relevant ideas and quotations from the interviews were mapped to the RMIC structure. This resulted in long lists of relevant data for each element of the RMIC structure. These were reviewed and grouped into sub-themes for each part of the structure, which were further refined to convey the key issues arising in the interviews with regard to integration. The findings were checked by a co-author (MC) who was overall lead for the project, very involved with the case study sites and undertook many of the interviews. As such, the perspective of MC ensured a sense check that the emerging analysis resonated with the emerging findings from the case sites and the overarching evaluation. All other authors, especially those engaged with the case sites, were also asked to review and respond to the analysis in a draft paper, and no revisions to the analysis were made at this point.

A favourable ethical opinion for the overarching project was obtained from the London and South East Research Ethics Committee in April 2016 (16/EE/0018). Data for this analysis and case sites have been pseudonymised.

## Findings

Before discussing the findings in terms of the RMIC, it is worth conveying that there was clear evidence in the interviews for the view of this topic as a wicked policy area. Complexity was highlighted in a number of ways, one being the many needs of this population, including patterns of intertwined mental, physical and/or social needs. Some interviewees discussed clients, without being pejorative, as “the most chaotic people in our society” and “the most socially excluded” and as a group, frequently placed by organisations on the “too difficult list”.

On the other side of this coin, complexity was evident in the range of services discussed. As a social worker in one hospital discharge service noted, people in this population are generally “known to multiple services”, but not necessarily in a coordinated way. Such complexity generally means that people do not fit neatly into service categories, hence,

some interviewees noted that sequential support across services is quite likely even though holistic, concurrent care is required.

Additionally, the organisations involved vary in many other respects including contractual goals, organisational governance, funding, cultures and expectations. Each of these may be an additional barrier to integrating care.

Interviewees also discussed the complexity of coordinating support over time. People's fluctuating circumstances suggested a need for persistence and continuity from services, yet often services were time limited. For example, a hospital-based social worker discussed supporting a client over time:

"We've got a lady here (in hospital) at the moment who has been placed (in accommodation) 16 times now and it breaks down, she goes back on the streets, she drinks, she becomes unwell".

Despite the complexity of providing care and support in this sector, interviewees discussed a range of integration including linkage (referring to other services or colleagues), coordination (workers spanning boundaries) and full integration (multidisciplinary teams) (Leutz 1999). The following discussion considers issues of integrated care in more detail following the structure of the RMIC.

### *Theme 1: Person-focused view*

This feature of the RMIC concerns tailoring the offer of integrated services to the circumstances of individuals they are supporting, i.e. a holistic (bio-psycho-social) perspective appreciative of the lived-experience of people and their preferences. Such an approach ought to provide a bridge between different ways of conceptualising a person's needs, such as between medical and social perspectives, and thus across services.

Defining the narrative of person-focused across a diverse range of services involved in providing a good discharge from hospital is challenging, especially when there are diverse organisational goal and some stigma associated with clients (see also theme 8, normative integration).

Practical examples were evident in interviews of the importance of organising support around understanding a person's circumstances. One was planning medication post-discharge based on knowing whether or not the person would have access to a fridge for storage, or even whether or not they have somewhere to sleep. Others saw being person-focused as about being reassuring to individuals so that discharge from hospital felt safe and "feels like a journey rather than a cliff edge".

Interviewees gave examples of ways in which contact with services can be holistic. Coming into hospital can be a starting point for better holistic support, for example, as one social worker commented:

“making sure that they’ve had their jabs (immunisations), you know, have they been seen by Substance Misuse, even though they’ve come in for a broken arm”.

However, care was not seen as always being organised to make it feel person-focused. As a housing link worker expressed it:

“the problem is, is that what we do is through that journey we introduce them to 15 people, yeah, from all different disciplines and stuff and they have to tell their story to that person every single time”

A lack of communication with clients and the failure to deliver care were other examples of not being person-focused.

In some interviews, ‘person-focused’ practice suggested working to make services more flexible, sometimes beyond the boundaries of existing service criteria. One interviewee felt that organising flexible services “enables people to exercise their compassion”. However, pressures on the system and from how services are organised were discussed as undermining practitioners’ abilities to be person-focused. These included a shortage of resources (e.g. of hospital and other accommodation), and criteria in contracts specifying how services and staff should work.

Stigma about homelessness (see theme 8 below for stigma from staff) is a further factor which can undermine being person-focused. An example was people experiencing homelessness self-stigmatising their situations:

“a lot of people will not tell you they’re homeless, a lot of people will, you know, they feel embarrassed about it”

Obviously, not disclosing being homeless makes it difficult to holistically address a person’s needs.

An additional difficulty noted by some interviewees that could undermine practitioner ability to be fully person-focused was the personal experience they sometimes found in the stress of the work and, on some occasions, abuse from patients. A manager in a city hospital commented on how the stories and situations of some patients can be draining on staff:

“you do have some of those really awful situations that you never really want to be discussing and everyone is trying their best to find a better solution.”

## *Theme 2: Population-health focus*

This part of the RMIC addresses the need to design services based on understanding the needs and circumstances of the target population and on equity. Data are important to develop this population perspective and interviewees referred to a diverse set of data needed to understand the size and characteristics of the population, current service use, gaps and failings in the system, the impact of changes, and the economic case for

improvement. However, these data were not always available or suitable, as noted by a public health worker:

“data about housing status is not easily visible in the health systems, so whereas you might get other sorts of conditions recorded you don’t get that, so people could always say ‘well prove the case to us because we can’t see it in the data’.”

Complex journeys across agencies present a further significant challenge to collating aggregate views of local systems, as a Housing Manager described:

“of the 60 people that we’ve got sleeping rough there’s only about 15 of them have been out for more than six months, the others have cycled around in accommodation, out of accommodation, in and out of prison, in and out of hospital, but haven’t consistently been on the streets.”

Supplementing aggregate data with individual accounts of the care system was also seen as important. A public health commissioner argued it was important to:

“listen to the voices coming out of the cohort of people I’m purchasing services for [...] you’ve got to actively understand and empathise with what their needs are”

This links being population-focused with the first theme, person-focused; as another interviewee commented:

“It is absolutely essential that we design or commission around individuals and that more kind of personalised holistic approach. That we become more outcome focused rather than processed focus [...] more freedom in achieving the outcomes is what’s needed.”

This also reinforces the point in the first theme of developing services that can be flexible to have freedom to achieve outcomes.

This theme of being population-focused also requires considering how people who are homeless do/not interact with local care systems. This includes challenging what for many are routine practices, such as organising appointments and that “you can’t send letters out to people who are homeless”. It includes structural issues exacerbating inequalities, such as recognising that many people who are experiencing homelessness “don’t access Primary Healthcare when they need it”.

### *Theme 3: System-level integration*

This theme concerns organising across a system to support integration. An example in the interviews was of integration of governance arrangements, such as agreements across NHS Clinical Commissioning Groups (CCGs) and local authorities for joint commissioning or working.

Perennial problems, such as a lack of coterminous boundaries and system level instability arising from reorganisations, were noted in some sites as hampering integration. A further example of barriers was that of organisational responsibilities and identifying where money/savings could be apportioned across organisations, as this medical Consultant in A&E explained:

“the (hospital) Trust here said that we wouldn’t save money because we still have to pay for the beds, it’s the CCG that save the money so it’s them that should pay for it. The CCG said it was a particular initiative that was the [hospital’s] responsibility”

The impact of national austerity measures in the UK, and services feeling they need to find “cashable savings” in their budgets, as one manager of a charity expressed it, also worked against integration as some organisations may thus feel less inclined to worry about a system view and shunting demand/costs to others.

Insights were gleaned into ways to make progress on system integration, though often at the level of individuals and interpersonal relations, such as this local authority manager’s view of partnership working:

“it’s important to understand where they [other organisations and their managers] are coming from”

Another example of individuals being key to system integration in the absence of strong formal system was a public health interviewee with no formal responsibility for homeless discharge services, but who still advocated for the issue across the system. The sense from interviews was that building and maintaining the coalition for integration required endurance by those prepared to speak up on homelessness.

The Better Care Fund (a nationally set resource in England through which local health and social care organisations share money with a goal of better integrated care) was being used in places as a framework for system-level integration, but we have no evidence of its impact from these interviews.

Finally, overlaying consideration of system integration was the sense that important matters remain outside the purview of local system leaders, notably the welfare benefits system and provision of housing. This has a noticeable effect on the degree to which systems can deliver better integrated support. As this General Practitioner (GP) noted:

“there isn’t any housing so I don’t know how they think they can suddenly magic up this person into housing”

#### *Theme 4: Organisational integration*

This addresses making arrangements for inter-organisational relationships and working. Whilst this can happen in many domains and at various levels, in the interviews commissioning was a clear topic of organisational integration. For example, some

interviewees noted that commissioning needs to be organised in line with being person- and population-focused to support integration of care.

One challenge for organisational integration and commissioning was that of bridging commissioning and delivery; not an easy task in a wicked policy environment. For example, defining outcomes is a challenge, as this alcohol services worker commented:

“there are different types of success and it’s different for who you are working with, so yeah absolutely if we see a reduction in re-admissions to somebody at hospital, if we get somebody through a detox[ification programme] and they ... you know their life improves and they don’t need the service anymore, those are the sort of hard evidence of that success, but I mean it can be the little things, it can be if someone is having a really hard time and they’ve phoned you up instead of drinking and you managed to, you know, help that person on that day”

Contractually defining outcomes and being ‘person-focused’ to deliver flexible services to such an array of circumstances facing people who are homeless needs to walk a difficult line being rather vague and overly prescriptive. As one interviewee commented, “micromanaging” the timeframe for working with clients and being too inflexible may hinder service delivery.

It seemed clearer where commissioning can undercut delivering person-focused, integrated care. One was where separate commissioning responsibilities encouraged sequential handling of people’s needs. Another was how short-term contracts undermine flexibility and integration. This manager of a charity providing services put the alternative case to short-termism most starkly:

“it’s hard to develop a service when you don’t know if it will be funded in three months”

Of course, many of the hospital discharge schemes had been established using short-term funding, so this might be a problem rooted in the system linked to those origins.

Shared policies were identified by interviewees as an organisational means of supporting integration, though sometimes policies had not been operationalised or were old and no longer reflected local conditions, such as having fewer local hospital beds. Even clear national policies might not be enough to deliver integration, as a hospital homelessness outreach worker commented in relation to the clear NHS policy on simultaneously (rather than sequentially) addressing mental health and substance abuse needs:

“I’ve never known it to be both addressed at the same time ever”

Integrated information sharing systems was another example of organisational developments to support service integration. However, despite examples of success in this area, information governance was described as “a minefield” and an interviewee claimed “everyone is so scared about confidentiality”. Information sharing is crucial to good integration (including underpinning being person- and population-focused), but it seems to be a significant, persistent challenge for several localities.

Failure of organisational integration to support person-focused practice sometimes resulted in staff needing to be creative to work around the system. For example, a nurse in a primary care setting described having to “work outside” a service level agreement with hostels to provide support. Similarly, an outreach worker commented on providing support to clients beyond the time his service was commissioned for, even though the service is not paid for it. (See theme 6 below for more discussion of staff creatively working.)

Another organisational challenge for staff seeking to deliver integrated, person-focused care was where their roles spanned services/organisations and they felt the pressure of demands from each one. Staff from homelessness organisations working in hospitals were exposed to this ‘seeing the pressures on hospital beds but also wanting more flexibility about length of stay to be person-focused. Such a personal challenge to balance these tensions in focal roles for integration needs organisational support.

Delivering integration was not helped when change was introduced in one organisation/system without consideration for its impact on homelessness. In some case study sites, for example, interviewees discussed housing departments adopting new system for referrals, which made it harder for those supporting people who are homeless as clients often did not meet new referral criteria and/or the new policies cut across previous good interpersonal working relations with colleagues in housing.

As in the discussion of system integration, some features of systems placed limits on organisational integration, such as legal frameworks and the lack of fit with wider welfare benefits. This is potentially a significant cost to integration, as a GP commented:

“I spend an absolutely massive part of my time [...] is helping people with their appeals to get their benefits back, absolutely massive and just crazy now”

#### *Theme 5: Professional integration*

This concerns interprofessional working based on sharing skills, roles and responsibilities. In the context of homelessness, it is not helpful to narrow this theme to ‘professionals’ (i.e. those with specific levels of qualification and who are governed by a regulating body), as many key staff are not in that group. We will examine this theme as ‘professional integration’ but understanding that we are concerned with a broader group of practitioners.

The problem of commissioning and organisational arrangements leading to hand-offs and sequential support in care rather than interprofessional working has been noted. Poor communication with other professionals, including high-risk breakdowns potentially leading to neglect of care or serious adverse outcomes such as overdose, was also mentioned in interviews. Obviously, weaknesses in local systems of other elements of the RMIC framework, such as no clearly shared person-focus or weak organisational integration, raise the risk of poor communication across a complex landscape.

Indeed, it is likely that the strength of systematic (rather than individualised) professional integration rests the strength of a shared narrative about being person-focused and the goal of the system. For example, for a hospital manager it was important for colleagues on wards to not see a service as a 'discharge team' but rather as a 'health outcomes services', trying to achieve a different goal for the person and the system beyond immediately clearing a bed.

As noted, flexibility seems an important aspect of developing person-focused care in this complex context. Examples of individual staff being flexible and thereby delivering better integration were evident in the interviews, such as going beyond what is expected (e.g. purchasing clothes for individuals from charity shops) or embodying the roles of different workers in one role.

The power of individuals to be flexible and deliver integrated care is commendable, but most likely not a sufficiently robust mechanism to ensure consistency in care. Similarly, overly relying on good relationships between staff to enact integration is fragile and easily breaks down when staff change roles.

However, trying to regulate interprofessional relationships runs the risk of creating unhelpfully rigid processes. As a hospital social worker similarly commented:

"interpersonal relationships can move mountains and I think there's always a tendency to say 'well if we have a nice clear outline of eligibility criteria and you can tick those boxes and say very clearly yes or no to whether this person is eligible then you know it makes everybody's life easier' we standardise the process and it's a fair and equitable [...] but people don't fit in boxes and if you're dealing with the most vulnerable group in society. They know they don't fit in boxes, that's why they're out there"

Relying on interpersonal relationships to integrate care means there need to be reasonable steps and links in the system of care for the necessary relationships to be developed and take effect, as this hospital discharge worker commented:

"I know like other teams [...] they're not based within the hospitals and I find that really bizarre because I think you miss stuff or stuff could be missed with by not being based (there) but then space in a hospital is a premium,"

As well as supporting integration of care for an individual, these relationships can help construct a network of allies to advocate for people who are homeless more generally. An interviewee in a homeless service commented on a relationship with a hospital consultant that resulted in this clinician being an advocate for better services for people experiencing homelessness.

The work of developing interpersonal relations with other staff to deliver integrated care is an ongoing process, epically across the complex landscape of homeless care. It is not necessarily something recognised, though, in job and service descriptions.

### *Theme 6: Clinical integration*

This theme concerns coordination of a person's care into a single process across time and place. It should be noted that in this context of homelessness, our concern is with a broader range of public services than only clinical ones.

We have already noted significant first barriers to clinical integration, including people not disclosing they are experiencing homelessness (self-stigmatising); boundaries between organisations/services; difficulties in interprofessional integration; and specific targets and pressures facing individual services. As a public health interviewee commented, services might think "we might not get our money if we don't hit our targets", and this might be in direct opposition to integration.

Interviewees spoke of formal means to address some of these barriers such as joint policies, sharing information and systems and organising specific integrated teams. Roles spanning boundaries, particularly between wards and community (especially homeless) services, was another initiative, but this can place its own demands on individuals, as mentioned previously.

An informal degree of staff introducing flexibility to integrate care also present in some localities as individual staff worked creatively around systems, as noted. As a homeless worker commented:

"we probably know a lot more than most people because we know how to circumnavigate things"

Similarly, a Chief Executive of a social enterprise commented:

"There was a bit of an indication of a certain level of guerrilla activity where people were kind of saying 'I wouldn't necessarily want my Manager to know I did this with this particular client' and 'this is what I did and it appeared to achieve results', so there seemed to be a certain amount of that going on."

An example of this informal flexibility was when staff kept in touch with clients after their formal period of contact, as one interviewee commented:

"this is all the secret caseloads in that we're not funded for it but we would rather do that than see them come back through the system again"

For one interviewee, formally giving members of teams licence to define their work and organisational processes was a means of introducing this desired flexible, person-focused working.

Theme 7: Functional integration: linking micro, meso and macro

This, our penultimate theme from the RMIC, concerns support functions such as IT and finance that help achieve the primary goal to be achieved. In several case sites work there was ongoing work to develop functional integration, as noted, but there were seen to be tremendous challenges to overcome. As we have observed though, creating linked systems across organisations with different governance arrangements was a challenge. The personal knowledge and contacts of individual members of staff still seemed crucial to making integrated care happen, as imperfect as relying on this is.

Other strategies identified as supporting functional integration were the use of planning groups across organisations and varieties of shared budgets. Starting from more integrated funding streams may assist with addressing some of the other issues of integration in this area, but we were not able to explore this in our secondary analysis.

It seemed clear that functional integration needs to be understood as part of the overall RMIC framework for planning integration, rather than as an end in itself. Starting with themes 1, 2 and most likely 8, needs to form the basis of understanding the point of specific functional integration. Due to the nature of the secondary analysis, it was not clear from the case sites whether this has always been the approach, though the discussion in some sites of dormant or outdated policies suggests it was not.

#### Theme 8: Normative integration: linking micro, meso and macro

This final theme concerns establishing a common framework of reference to link the key stakeholder organisations and practitioners in mutual understanding of the expected goals and ways of working. We have already mentioned the importance of services having such a shared understanding. This can be framed as system outcomes, such as organising a quick discharge to clear pressure on hospital beds or addressing inefficient use of resources from preventable repeated admissions, and/or as person-focused goals such as facilitating better holistic outcomes for the individual. Potentially the most powerful normative narrative combines these to demonstrate to different audiences the power of better integration.

Lack of such a shared normative basis could undermine integration as pressures on individual services dominate care planning at the expense of person-focused care. Interviewees commented services whose staff decline to help as they see someone as not being their responsibility, or who try to discharge or otherwise handoff someone quickly from their service and place pressure on another one.

There was some tension in the data between seeing innate values of public service amongst staff as a basis for this shared understanding compared to other instances where interviewees commented that staff might possess negative, stigmatising attitudes to clients which undermines person-focused care. An interviewee from a social enterprise, for example, felt there was a reservoir of goodwill amongst staff, but it was often undermined by the system:

“most people in welfare provision get up in the morning hoping to do a good job and wanting to be personalised but the systemic conditions that are in place where they work make that really, really difficult.”

But a discharge nurse, for example, felt there was some stigma amongst staff:

“some people will think ‘actually if the patient has chosen to live like that why are we trying to change that?’”

Similarly, a public health interviewee argued there has been an unhelpful ‘blame culture’ across some public services towards this client group.

Relatedly, it was not clear to what degree the shared normative understanding ought to rest on deeper values or if functionally could exist at a surface, transactional level. Some interviewees, for example, commented how they integrate care with other services because they are clear in how they offer a solution to the pressures on those services and seemed to not rely on a shared set of values.

As well as addressing these tensions, the normative narrative also needs to set out realistic expectations. An example concerned colleagues thinking there was a reserve of empty accommodation so that discharge would be easy.

Finding means of communicating the normative narrative is a further issue. Gaps in the education of staff to be able to understand homelessness and the complex interplay of multiple needs was discussed as a problem by interviewees. The ongoing work of relationship building is one means of reinforcing the shared normative narrative, but it needs articulating in the first instance, and this needs to be co-produced with many stakeholders.

## Discussion

In this paper we have sought to apply an established framework for considering integrated care (the RMIC) to a wicked area of care policy and practice, namely discharge from hospital of people experiencing homelessness. The RMIC was developed in different circumstances and we ought to explore its utility in helping to structure understanding of the complexities of integration in this particularly complex area.

We feel the RMIC has been helpful here in several respects. Its framework provides a structured and interlinked means of thinking holistically about diverse and complex issues rather than haphazardly or sequentially addressing them.

It is not possible to assess from this analysis the primacy of any elements of the RMIC in this context, but the overriding view arrived at is that the structure of the RMIC needs to be approached holistically in planning integrated care. Issues discussed above have been, for example, identified by others studying homelessness support services, such as the potential for managerial targets to limit person-focused care (Clark et al 2015) and the existence of

secret caseloads amongst staff (Cornes et al 2013). The RMIC helpfully places them into a system's framework which could help local managers to consider the relative importance of issues to their location the extent to which they need urgent action, and their links to other crucial aspects of integration.

That being said, one challenge in applying the RMIC to our analysis was in the overlap between its elements. It was not always easy to discern, for example, whether an issue ought to be understood as one of clinical or professional integration, or related to functional or organisational integration. This may have been a feature of the complex context of this study, or of undertaking secondary analysis, or may be inherent in the RMIC framework. This degree of overlap would be worth further examination to identify if the RMIC can be clarified and/or streamlined.

The picture we have established, which we accept is partial one given the secondary nature of the analysis, is a delicate balance of formal and informal service integration in many sites. There were examples in sites of good formal integration work spanning the themes of the RMIC, such as basing commissioning on a person- and population-focused ethos. However, rarely was there a clear system view of integration expressed by interviewees. Perhaps this would have been different in interviews explicitly focused on integration. However, the number of times we found examples of informal arrangements for integration, such as the use of personal relationships between staff and secret caseloads, suggested there was some way to go to develop a system view of better integrated care for discharge from hospital of people experiencing homelessness.

Following our analysis, we see that it may be helpful to see wicked policy areas as environments characterised by volatility, uncertainty, complexity, and ambiguity (VUCA) (Baran & Woznyj 2020; Bennett & Lemoine 2014) to complement the insights from the RMIC focused analysis. In the context of homelessness, VUCA conditions mean:

- *Volatility* –circumstances facing people who are experiencing homelessness are prone to frequent, highly destabilising and unpredictable change. Experience from other contexts suggests volatility requires agile, flexible responses from organisations to support individuals.
- *Uncertainty* –both for individuals and for many organisations in the complex matrix of homelessness support, which requires extra (formal and interpersonal) information flows, as well as some means of reducing unnecessary uncertainty;
- *Complexity* – with many interconnected parts forming the environment of homelessness support, there is a need for better formal coordination, but not at the expense of undermining swift responses to the V, U and A aspects of the environment;
- *Ambiguity* – whilst more can be done to reduce unnecessary ambiguity in the systems of care, some significant degree is likely. Systems need to be prepared to accommodate this and help services and practitioners to manage it, including scope for flexibility and even some experimentation.

This VUCA perspective helps to develop the narrative for what good integrated care in this area needs to address. If the RMIC was used to inform developments making care system more integrated but rigid, it may become too difficult for practitioners to operate under VUCA conditions. Combining the RMIC and a VUCA understanding in the four phases to developing integrated services (Minkman et al 2009), namely 'initiative and design', 'experimental and execution', 'expansion and monitoring' and 'consolidation and transformation', we see the potential for a more rounded view of how local systems need to be planned to support integration for better outcomes for people experiencing homelessness.

We have, though, also highlighted the need to think about the possible limits of formal integration (e.g. demands on hospital beds, shortages of housing, stand-alone welfare systems) beyond the control of some care systems. It is worth exploring in more detail the impact of endogenous features to systems limiting integration of care for people who are homeless, as well as exogenous factors within the care systems.

Another specific topic for further investigation would be the forms of leadership that are needed for this integration to be effectively enacted across organisations and systems of care with very different characteristics. This could helpfully draw on debates about leadership in network modes of governance (Ferlie et al 2011) and how assemblages of actors (Hammond, Coleman and Checkland 2018) enact governance in complex and uncertain organisational circumstances. Within the governance assemblage for homeless services, it would be helpful to explore the formal roles of individuals alongside the work of the advocates without formal 'homelessness' management roles discussed above.

### Limitations of this study

The overarching evaluation project that this analysis sits within presents the most comprehensive evaluation of hospital discharge services for people who are homeless in England (authors). As such, our secondary analysis of data from interviews that were not explicitly enquiring about integration does limit opportunities to examine the fine grain of issues and consider the relative weight of themes from the RMIC. Further investigation specifically focused on integration of services for people who are homeless, using established integration frameworks and tools, is recommended.

### Conclusion

In this paper we have discussed the nature of homelessness as a wicked policy issue, i.e. one characterised by a high degree of complexity and with no simple resolutions; not one in which the idea of wicked is a judgment of anyone involved. We have drawn on interviews from an evaluation of hospital discharge services for people who are homeless. By applying the RMIC framework we have been able to begin to develop a more systems-focussed view of the challenge of integrating care in this area. The VUCA framework adds to understanding the narrative of why these are complex contexts and signals something of the required response, which the RMIC framework can flesh out in more detail. We believe this analysis

contributes to the evidence base for better integrated support for people experiencing homelessness. Questions remain about how best to organise the desired systems of care, but the analysis here using the RMIC helps to make these clearer and organises these in a system view.

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