Integrating homelessness support – developing a relational understanding
An Article for the Journal of Integrated Care

Michael Clark[1], Michelle Cornes[2], Michela Tinelli[1], Jo Coombes[3], Stan Burridge[3], Raphael Wittenberg[1], Jess Carlisle[1], & Jess Harris

1. London School of Economics and Political Science
2. University of Salford
3. Expert Focus
4. King's College London

Abstract

Purpose – People experiencing homelessness often have multiple health and other support needs, requiring complex, coordinated support. Admission to hospital is potentially an opportunity to address these needs and begin integrating care, but so often it is a missed one. Our purpose in this research was to evaluate an ongoing, roll-out programme that offered government funding to 17 'test sites' across England to develop integrated care as part of post-discharge 'step-down' support. In this paper we examine senior stakeholder experiences of seeking to implement integrated care as part of specialist step-down care.

Design/methodology/approach – In this paper we focus on data collected in interviews with key stakeholders (N=10) who managed the mobilisation of local out of hospital care models for people experiencing homelessness. Interviews were conducted and analysed from a relational perspective, i.e. focusing on relationships between interactants, through which, for example, identities, understanding and integrating practice emerge.

Findings – A relational perspective on the data provides insights to better understand the complexity of integrating care at the point of hospital discharge for people experiencing homelessness.

Research limitations/implications – Although in depth, the data were limited to certain perspectives on the issues. Other perspectives and data collection from in-depth study of case sites would be invaluable in developing the empirical evidence base for a relational understanding of integrating care.

Practical implications – A relational perspective highlights the emergent and ongoing nature of integrating care in this context of support for people experiencing homelessness. The need for different system agents to work to be constantly enacting the desired support is crucial to understanding future system changes for integrating care.

Originality/value – This is the first paper developing a relational analysis of integrating care. It highlights a different theoretical perspective on the issues and important insights.

Keywords: Relational, Integration, Homelessness, Multiple exclusion, Rainbow Model of Integrated Care, Wicked policy issue, VUCA environment
Paper type: Research paper

Introduction

Following the Covid-19 pandemic a new hospital discharge and community operating model was introduced in England. This included the evidence-based recommendation that Home First Discharge to Assess (D2A) should incorporate specialist step-down intermediate care services for people experiencing homelessness.[1] *Specialist* step-down intermediate care provides short-term accommodation and aftercare to prevent discharge to the street and hospital readmissions. It allows time for recovery and recuperation before undertaking assessments and making any decisions about longer-term housing, care and support. Support should be multi-disciplinary and offer a gateway to wider integrated support from across housing, health and adult social care.

In 2020, the Department of Health and Social Care (DHSC) launched the '*Out-of-Hospital Care Models (OOHCM) Programme for People Experiencing Homelessness.'* This provided improvement support and £16 million funding to 17 test sites across England. The aim was to facilitate learning around how to ***mobilise, integrate, scale*** and ***sustain*** specialist services as part of the D2A hospital discharge and community operating model. Services developed as part of the Programme included residential houses providing accommodation and support (step-down) and also teams of floating support workers visiting people discharged to hotels and temporary accommodation. Funding was also used to embed housing and homelessness workers inside hospitals as part of multidisciplinary discharge teams. Local service configurations varied from area to area and comprised different disciplinary compositions and staffing numbers. All services were time limited and had the primary aim of acting as a bridge between the hospital and longer term care and support.

In 2021, we were commissioned to undertake an evaluation of the OOHCM Programme (Cornes et la., 2024). This was large scale evaluation involving an economic evaluation and qualitative interviews with a wide range of stakeholders including practitioners and service users (n=80). This paper provides an insight to the "how to" of integration that was reported in interviews with the test site leaders and senior managers (n=10). In the analysis we build on our earlier work that used the Rainbow Model of Integrated Care (RMIC) to understand how to improve hospital discharge arrangements (Clark et al. 2022). Developed by Valentijn et al. (2013, 2015). RMIC is grounded in an ethos for the goal of integrated care (i.e. person-focused, holistic, biopsychosocial support including client preferences) focused through a clear, detailed population analysis. Macro (system), meso (organisational and professional) and micro (frontline practice) levels help deliver this goal-directed focus. The model includes functional (e.g. finance, information systems) and normative (e.g. shared values and mission) arrangements to coordinate micro, meso and macro levels. The RMIC was a helpful heuristic framework for this earlier work, but we had concerns that it encourages an overly structural and rigid interpretation of a highly dynamic context, and that the place of the agency of actors was not well conceptualised nor evident throughout.

Additionally, we have explored integration from an underpinning relational perspective, following the relational turn in social science (e.g. Emirbayer 1997; Dépelteau 2008; Donati 2011). Relationally, reality is conceived as ongoing, emergent processes of interactions, in which actors and structures are mutually entangled and continually reciprocally shaping interactants (Burkitt 2016). Rather than actors and structures being the starting point for understanding reality and taken as complete and given prior to the context, the conceptual

[1] Guidance about the integration of specialist homeless intermediate care in the D2A operating model can be found at: www.gov.uk/government/publications/discharging-people-at-risk-of-or-experiencing-homelessness/discharging-people-at-risk-of-or-experiencing-homelessness#:~:text=Pathway%201%3A%20discharge%20to%20usual,are%20being%20used%20for%20discharge)

focus begins with the relationships in the context through which actors and structures are emergent, continuously (re-)shaping themselves and each other. In this understanding, actors and structures:

"involved in a transaction derive their meaning, significance, and identity from the (changing) functional roles they play within that transaction. The latter, seen as a dynamic, unfolding process, becomes the primary unit of analysis rather than the constituent elements themselves." (Emirbayer 1997:287)

Understanding integrating care relationally means starting not from assumptions of fixed actors/structures but from the interactions through which actors and structures derive meaning and are mutually (re)shaping and integrating care. Complexity and dynamism in the interactions means the future is emergent (Mukumbang et al. 2023) rather than following a simple, linear causal pathway. Such a conceptualisation adds a dynamic and emergent understanding of *integrating* care to the RMIC in which agents and structures are present and relationships between them are central.

Context

The concept of homelessness includes people in highly insecure accommodation (e.g. sofa surfing and in hostels), through to those living on the streets (rough sleepers). The number of people rough sleeping grew in England in 2022, whilst core homelessness, a wider concept of the most severe forms of homelessness, has increased since a decade earlier, 206,000 to 242,000 people, and is projected to continue that trajectory in coming years (Fitzpatrick et al. 2023).

In addition to being homeless, people experiencing homelessness (PEH) generally face interacting health/mental health/substance use/financial/social needs. Admission to hospital for them is potentially an opportunity to begin to intervene in this challenging nexus of difficulties, but the point of discharge from hospital has all too often been one where people's circumstances and problems revert to how they were before admission. One-size-fits-all services are unlikely to suit this heterogeneous population and flexible, yet integrated services with specialist expertise are required, grounded in building trusting relationships with clients (Carmichael et al. 2023).

Compounding the multiple, interacting needs of many PEH are significant barriers they face to accessing good health and other care and support (Carmichael et al. 2023). Greater needs and social exclusion from care result in higher mortality rates in this group than the general population, often for conditions that good care could treat (Aldridge et al. 2019).

Treating health conditions in isolation for this population is limited in terms of effectiveness and good practice addresses biopsychosocial needs together, rather than sequentially (Stafford & Wood 2017). A particular point of challenge has been achieving good quality discharges from hospital (Cornes et al. 2021), with usual care being a serial approach to addressing needs (when not completely neglected), often resulting in recovery relapse and readmission to hospital. Trying to address a physical health issue, then a mental health one before arranging better accommodation, for example, fails to recognise the interaction of the problems.

Sites in the national roll-out programme sought to use our previous evidence and guidance to improve their discharge services to holistically address needs. The sites were diverse organisationally (e.g. some with coterminous hospital and local authority boundaries, others had overlapping responsibilities, e.g. one NHS organisation and several local authorities), and in their histories of addressing homelessness and the service foundations they had for building discharge services. Hence, there was no single service development path across sites.

Methods

This paper draws on ongoing, close contact between local sites, the national policy leaders and the evaluation team. This included the research team:

- Facilitating regular regional meetings at which local sites could discuss progress and challenges;
- Supporting sites in their data collection for the programme evaluation;
- Regularly liaising with sites, including visits by members of the team;
- Meetings with the national roll-out team.

A variety of methods sought to understand the processes of mobilising the service developments, challenges in their delivery and sustainability, the impacts of the services and an economic evaluation of these. It is not possible nor appropriate to cover all these areas in this paper, and readers interested in any aspects of the overall evaluation are referred to the final project report (Cornes et al. 2024).

The evaluation team also met together regularly to discuss sites, developments and the evaluation, drawing on the above activities. This collective reflexivity helped develop an understanding of the context of each site and challenges they faced individually and in common. It also entailed being attentive to the research processes and the roles of each of the research team in them in generating the research findings (Downey et al. 2024).

Additionally, one of the authors undertook 10 semi-structured interviews with local project leaders. These were individuals with diverse roles (e.g. project manager, commissioner), in a variety of organisations (e.g. NHS, Local Authority) and with differing overview perspectives (e.g. specific local sites, oversight of several localities). These 10 covered 9 of the 17 sites. An attempt was made to interview others, but they did not respond to requests. After analysis of the 10 it was clear that they provided sufficient data for developing our relational understanding of the process of integrating care. Reflections in the team were that nothing substantive would be added from the sites they had close liaison with other than more illustrations of the overarching relational themes. We have reflected on this and believe we have a sample of sites allowing for “an adequate degree of transferability” (Malterud 2001:485) of the broad relational understanding we sought to elucidate to similar issues and contexts of homelessness and/or integration of services addressing other ‘wicked issues’. Our sample of 10 interviews was within a range for believing that saturation of findings had been reached (Hennink & Kaiser, 2022) and whilst more interviews across the other sites may have provided specific examples of topics, they would not have added to the fundamental relational understanding developed below.

Some of the interviewees initiated the bid for funding, others started in post as the mobilisation phase formed, or later still in the process for some. The element they had in common was local oversight of how the models were developing. Interviews focused on their perspectives on mobilisation of their service plans, operational challenges, and their plans for sustaining services once the national pump-priming money ended. The RMIC helped structure questions about integration and a relational perspective underpinned the interviews and probing questions, i.e. as interviewees discussed topics the interviewee sought to step inside the relationships at the core of the issue through supplementary questions.

The full report of the evaluation (Cornes et al. 2024) covers all these aspects of the project and sources of evidence, and describes the services and assessment of their impacts more fully. Providing a complete description of each site would be complex and beyond the scope of this paper. Of the 17 total sites, some had 2 or 3 sub-sites which were self-contained locality developments within a larger organisational framework such as an Integrated Care System. Most sites sought to develop an in-reach approach to improving care, with staff in communities going into hospitals to facilitate a good discharge for PEH. Some of these developments built on existing in-reach services, others were new; some were led by health care clinicians, others by housing staff. How these services operated and the organisational patterns for integrating care all differed, as did the degree to which they mobilised their intended developments. Readers wishing to know the details of the sites are referred to the main project report (Cornes et al. 2024), particularly Appendix 1. The issues concerning integrating care and a relational understanding of the emergent nature of this ongoing process discussed below spanned the sites irrespective of the actual detailed model of service development.

In this paper we focus on analysis of the interviews and the evidence relating to integrating care in the services. Interviews were one-to-one and semi-structured, the guide being organised using the RMIC framework and a relational understanding, the latter particularly informing prompts in the interviews. They lasted about an hour and were conducted online. All interviews were transcribed by a professional service, then coded by one of the team. Key themes were developed by the lead author, and then discussed and sense checked, initially with another team member leading the evaluation overall and then the whole evaluation team. The relational perspective underpinned this analysis. We proceeded from this relational stance, i.e. stepping into sites by starting analysis of the transcripts from consideration of relationships and understanding their impacts on agents, structures and, especially work to integrate care. We proceeded to identify initial relevant themes, reflecting on these from the relational perspective and remaining open to alternative narratives in the data. With ongoing reflection on the data, the relational understanding and initial themes, we consolidated initial themes into those discussed below, understanding how the insights developed “from the relation between empirical substance and theoretical models and notions” (Malterud 2001:486)

The overall project, including this specific element, had a favourably ethics review from a Health Research Authority ethics committee (reference 22/1EC08/0016). All authors contributed to the final stages of analysis and reporting findings. Quotations are anonymised in terms of individuals and sites and referenced by interviewee codes (i.e. M1, M2 etc.).

Framing our analysis from the standpoint of a relational perspective required us as a team to very deliberately focus on the relations ahead of the actors, or to activate "a reflexivity on the relations" (Donati 2018: 435) in the interviews and then in the analysis of these. The aim here is to mindfully step "'inside' the social relation" (Donati 2018: 435) to understand its interactants and dynamism and impacts on, for example, actors. We adopted an individual and collective reflexivity to this process, allowing for alternative understandings to be considered and have been transparent in discussing the theoretical underpinnings of the research (Malterud 2001).

A brief note is in order about terminology. We have already referred to the target population for these discharge services as people experiencing homelessness, and this is our preferred description in line with current practice. In some settings they may be referred to as patients, service users or clients. To avoid confusion, we will use 'clients' from this list as our only alternative to 'people experiencing homelessness'.

Key themes

Three broad themes were developed from the interviews to structure the analysis, namely a) understanding the nature of frontline practice, b) the wider context to frontline practice, and c) understanding the work of system engineers. In developing these themes, for clarity of discussion we have imposed analytical distinctions between frontline practice and its wider context and such a clear demarcation does not occur in the real world, an understanding underpinned by a relational perspective, i.e. understanding reality as continuous, emergent through interlinked webs of interactants.

a) Understanding the nature of frontline practice

As noted, there is robust evidence describing the complex and challenging nature of working to support PEH. This was reinforced in our field work. Although interviewees were not frontline staff, they were clear about this complexity, for example, confirming the range and often fluctuating nature of health, care, housing, welfare and other issues practitioners need to work with, and, hence the array of engaged organisational partners and practice agents. The complex legal framework bounding this work was also evident in the sites, including the Duty to Refer requiring staff in public organisations to refer someone who is or is at risk of being homeless, Care Act legislation on eligibility for statutory social care, and No Recourse to Public Funds for some clients subject to immigration controls. These are only some of the complex features of this practice landscape, in which the required knowledge sat across many agents and structures. This required frontline staff to undertake "a much more day-by-day connecting bits of the system together" (M10) in their practice with individuals, "helping to unblock, understand the complexities of the system" (M8).

Practice is also complicated as many PEH have experienced stigma within statutory systems, undermining identities and trust. In many ways, PEH do not easily fit in to systems; for example, their pressing existential priorities can mean a system priority of making an appointment might not be their priority at that time:

"get checked out of this hostel to go and find another hostel to go […] and then I can think about my health or that appointment, but that might even not happen today" (M8)

The ethos of the discharge services was summarised by one interviewee as to:

“use discharge as an opportunity for being a sort of a pivotal moment, I guess, and an opportunity to move then into recovery and settled accommodation” (M10)

A ‘pivotal moment’ in these complex circumstances needs to be understood as an unfolding process over many moments, constituted by relational interactions confronting emergent challenges and opportunities. This process of incremental, pivotal moments of building trust and improvements was often a slow one:

“it is that complexity and that history and that, you know, that kind of patience that’s .. I don’t know if that’s the right word, but that sort of slowly, slowly and build it up” (M6)

As needs differ and change over time for each PEH, there was no simple trajectory to improved outcomes for all PEH. Also, outcomes that seem relatively minor from a system perspective may be highly significant for a person:

“they’ve stayed in accommodation for a week, that’s a massive outcome for some individual that’s been living on the streets and every time they’ve gone into accommodation they’ve left within 24 hours; that is an outcome, they’ve stayed there” (M6)

Navigating this complexity requires other staff as well as the main homelessness discharge staff in the unfolding process to understand this relational nature of the support if they are not to undo previous progress. This was partly because others had resources to bring to supporting someone through the next emergent moments, but also because others need to understand the impact of system priorities and requirements on the unfolding process of, e.g. trusting, engaging in care processes and re-forming identities. For example, colleagues in the hospitals need to understand that the homeless discharge services “enable a good discharge but they don’t necessarily enable a quick discharge” (M7). However, “the pressure of the system” (M7), e.g. to clear hospital beds, sometimes places stress on organising discharge arrangements:

“the [homeless discharge] teams themselves have sometimes felt like they’re constantly fighting and advocating against the tide sort of within the Acute [hospital]” (M7)

For staff in the homeless discharge services this created an ongoing responsibility of understanding and balancing different priorities. Practice with any one individual is, then contingent and emergent from the specific context and interactions of multiple actors and the structures around these moments. Ensuring this delivers optimal care requires ongoing reflection by practitioners, as one interviewee said of how one of her colleagues works, “it’s almost like a PDSA [plan-do-study-act] cycle really” (M10).

This was particularly evident when staff were new to the system and/or the system was changing, most notably during mobilisation of the local services when staff were delivering the service but also making sense of things - or “trying to revise while you’re taking the exam” (M7).

One key to managing this unfolding process was building trust to move forward together:

“there’s often a kind of lack of trust of systems and of support services [amongst PEH], so it can take some time to build that up and build that rapport up. So, it's got to be workers that are not going to be put off by that and actually know how to kind of slowly build that rapport” (M6)

And that consistency of interpersonal relationship could be significant in a person disclosing some crucial details, such as trauma they are living with:

“I can imagine it must be really challenging because they [PEH and staff] built that relationship up to then `oh it’s finished, brilliant someone else is leaving me’, or, you know there’s quite a lot of trauma in people’s lives that they’ve perhaps build that relationship up to be able to inform them about that traumatic experience that’s then being worked through to then the service being stopped.” (M8)

Again, noting the sometimes slow, in organisational terms, nature of the process, time is needed to nurture trust as a resource for further interactions:

“you’re spending time with them and that helps to build up that trust in the relationship as well, which then means you can move on to talk about those kind of practical support” (M6)

Systems needed to be flexible to support this, and even to be remolded in interactions, which may eventually evolve into a new structural aspect of the relational web. An example was staff needing small budgets to purchase items urgently needed be a PEH, such as “new clothing or footwear or phone” (M7). In some sites, from experiences of staff remolding existing systems to enable this, emerged new formalised systems operationalising this process.

Similarly, enabling new relationships between different staff could reform the relational web to improve outcomes. In some sites, for example, new links with housing staff could remold systems, or “completely shift the conversation” (M2), to deliver better outcomes as new knowledge and resources became available.

As in the case of staff-client relations, integrating practice was best founded on building trust with colleagues, e.g. through demonstrating the impact of the discharge service in helping staff and/or showing them a different pathway:

“for the staff in A & E seeing somebody coming in and going `it’s alright, it’s okay I’ll take that away, I’ll deal with that, you’ve done your bit, they’re healthy now, you know, they’re well enough to be discharged I’ll deal with the rest’ and I think that again is the thing that really helps relationships isn’t it” (M2)

Building this trust was seen to require consistency of presence by the homeless discharge staff and the support they give in hospital settings:

“you need that level of consistency from a hospital perspective, you need that sort of prominence and physical sort of visibility I guess as well because hospitals do […] need things that makes it feel like their process is easier, they don’t like things that obviously add times to their day because they’re really stretched” (M9)

The relationship and trust were ongoing and emergent, and it could not be taken for granted that without the ongoing presence of homeless discharge staff the trust would still be there when needed in the future. And of course, building these relationships with hospital staff was only one dimension to the working relationships staff in the discharge services had to develop to improve outcomes for PEH. This required, as one interviewee described it "the whole sort of system talking to each other" (M1). This relationship building was at an individual level as it often couldn't be assumed that staff in the same unit or department would have the same attitudes and approach to supporting PEH. By building a network of these relationships, ripple effects sometimes happened (e.g. more consciousness raising across the system about homelessness) and practitioners could collectively come to see how to connect parts of the system together to develop better overall impact greater than one practitioner might have otherwise achieved in those moments. An example given was of aggregating accommodation resources for clients:

"there's a lady in Care Services who managed to .. gave us access to these nine flats and they have been absolutely fundamental, and she's been a passionate supporter of the project and if we didn't have those nine flats, I really don't know what we'd have done, so you know the project would never have got going really" (M4)

These new relational practice networks were, though, contextualised to each locality and needed to be flexible to address emergent patterns of needs and interactions with PEH. The hospital discharge model developed in our previous work was a useful heuristic framework for localities, articulating significant elements and principles of homeless discharge services, but details of systems and practice were emergent and, hence, localised. For example, one site in this programme contained two cities, one of which started their model about 6 months ahead of the other and despite an initial intention to replicate the model of the initial locale in the second, they found that an alternative model was needed due to the different context:

"the initial thinking was that's great because we can take that and we can kind of learn from that when we're sort of setting up X City, I think the reality with the .. everything was different in X City, just it was so different, you know, they had a different starting point, they had a different environment, we had all the District side of things, they had a different relationship with the hospital, they had a different process so they couldn't find the same house, you know, it was" (M9)

Local structures, such as information systems and human resource policies across partner organisations, needed to be addressed in terms of whether they dis/enabled this flexible system remolding. Also, language could be a barrier to integrating care, such as if a code of "housing delay" (M3) in a hospital system encouraged hospital staff to formulate PEH as a particular sort of problem. Recognising the emergent nature of practice with individuals, some interviewees discussed the role of protocols/policies/procedures as needing to be empowering of flexible working rather than overly prescriptive.

Key issues in sites sat across agents and structures in the relational web network. Risk is one example. Staff less experienced in understanding PEH and who do not feel supported in working with this client group "can feel like they're left holding an unconscionable amount of risk" (M2), for example, hostel staff feeling unable to carry risks associated with the health needs of PEH (e.g. wound care) if left alone. However, this was seen as addressable to

a significant degree by “giving them a professional net of support which makes them feel able to manage the level of risk that they’re being asked to manage” (M2). Ultimately this builds collective capacity, as experienced staff can “show the managers of those accommodation units that they can take this cohort and they can work with more risky individuals, you know, if the support’s in place” (M4). This was another manifestation of the shared, emergent process of building and sustaining trust between agents in the system to underpin future work.

As we see, then, practice is relational, unfolding in the relationships between actors and structures. At the time of doing the interviews the biggest structural issue facing services was the uncertainty of securing ongoing, sustainable funding which manifested itself on service quality, e.g. problems of staff recruitment and retention:

“it was a lot to recruit them and train them and you know such qualified and motivated staff do not exist in abundance” (M7)

“it’s worrying that we could lose some really good services and some really good staff like we’ve been talking about who have changed, who have developed those skills, who have got that confidence around [being] ambassadors, but now they’re worried they’re going to lose their job, so do they jump, or do they wait to see whether the funding continues?” (M6)

Losing staff could undermine the collective working knowledge and relational capacity across the network:

“in some of those schemes it’s going to be a real loss that’s felt, like the actual individuals are going to leave that have created some of that enthusiasm around it and created some of those conversations around integration” (M1)

The unfolding pattern of frontline practice was always changing and could be very fragile to personnel and structural changes.

b) The wider context to frontline practice

The wider context to these services could have impacts on operations beyond the control of any actors, as we have just discussed with the problem of securing sustainable funding. Another clear example across all localities and running throughout the time of the programme was the impact of housing policies and markets, creating shortages of suitable accommodation to discharge people in to:

“The demand for the accommodation is too high, we haven’t got any more accommodation” (M4)

“in London they just haven’t got the housing and it’s very expensive and they’ve got a private rental market that’s gone haywire, and you know people are being put in temporary accommodation that’s not suitable” (M5)

This lack of accommodation significantly structured what actors could do, and could result in services becoming ‘silted up’ (M4) as clients were unable to move on from different parts of local systems.

This housing shortage was a consistent, and hence predictable, aspect of practice in many localities, but was something people had little control over. Other structural aspects of systems already noted, such as Human Resources policies, finance and access to information held by different organisations also had their impacts on the agency of practitioners but could often be changed with the right support across the relational web.

In addition to such fairly stable aspects of the environment, much about the context of frontline work was characteristic of Volatile, Uncertain, Complex and Ambiguous (VUCA) (Baran and Woznyj 2020; Bennett and Lemoine, 2014) environments, i.e. contexts which are highly dynamic due to a set of underlying characteristics. This added further dynamism shaping emergent practice and the ongoing challenge of integrating care. To expand on the aspects of VUCA in the context of these sites:

i) Volatile

As noted, people experiencing homelessness face circumstances prone to frequent, highly destabilizing and unpredictable change. The systems within which services are organised were, additionally, prone to volatile change, such as new priorities on services, budget instability, reorganisations, and political pressures. Agile, flexible responses from organisations are required to support individuals facing volatile circumstances, but this could be undermined by volatile system environments.

NHS reorganisation to form Integrated Care Systems was an example of volatility being experienced at the time of the interviews, which meant in terms of practice and sensemaking the system was being "chucked up in the air" (M9) and local priorities were being rethought, to the extent that in one site an interviewee commented:

"if I'm 100% honest it's hard to know what the priorities are" (M5)

Significantly, though, some didn't specify volatility as a unique feature of the current time period:

"It is within a changing context, and that's the thing it's always going to be changing isn't it, so we're always going to need to be working at it and deciding what integration means right now and what it looks like right now and how we can break those barriers down so that we are working more as a system" (M6)

ii) Uncertain

Being able to deliver good discharge support requires live information flows between interactants in the relational web, but uncertainty disrupts this and makes practice and integrating care difficult. We have noted how financial uncertainty was creating disruptions in relational webs as staff were leaving their roles. Uncertainty with where the issue of homelessness sat in organisational structures/responsibilities meant that making decisions and securing funding could be vexing:

“it can be quite frustrating in that we’ve gone to various different Programme Boards who all think it’s an amazing service, but you know no-one has got a pot of money to fund it kind of thing” (M7)

“it covers every inequality, every health need, every sort of like wellbeing need, so it doesn’t really sit anywhere” (M4)

iii) Complex

Complexity of individuals’ needs could mean that initial plans for the timeline of care were unrealistic as:

“when you’re talking about people who are homeless with complex needs the likelihood of moving somebody on in six weeks is pretty minimal” (M6)

This interacted with the complexity of structures we have noted in various ways above. In one locality the interviewee discussed how there were 40 people from different statutory agencies in a room to plan the PEH discharge service, whilst in another:

“we had a workshop where we brought together broader stakeholders also including hostel providers, VCSE [Voluntary, Community and Social Enterprises], Local Authority, Housing Options, Rough Sleeper Teams and, obviously from our perspective in health, a range of Clinicians but also Commissioners as well” (M10)

Adding to the complexity was that sometimes organisations’ boundaries were not coterminous and/or people moved across locality boundaries in their interactions with services. Operating across multiple organisational boundaries could mean related teams sitting within different accountability arrangements, for example:

“so Housing obviously sits with the District in [the] city but our Reablement Service sits within [the] County Council” (M9)

iv) Ambiguous

There were many aspects of ambiguity across the sites, including different expectations of partners:

“The other things that were really difficult is this relationship between what the boroughs wanted and what the hospitals wanted and also what the centre [DHSC as funder of the projects] wanted” (M10)

Another potential source of ambiguity was identifying more demand than originally anticipated and having to change expectations about what was realistic delivery:

“the demand that was uncovered was even higher than I think anyone thought” (M7)

“when we started this project there was this discussion that people would stay two weeks or something, it was completely unrealistic, I think they more likely stayed six months really but in those six months we really invested and really work with them so they made a change, you know they’ve sustained, their behaviour changed.” (M4)

Overall, as sites sought to reduce ambiguity through the mobilisation phase - “we definitely learned on the go” (M4) - ambiguity could be approached as an opportunity, seeing the new services as “a testing ground and a bringing together and a learning from each other” (M10).

Organising and delivering these services in this VUCA environment was an ongoing process of sensemaking, managing relationships, keeping attuned to opportunities and adapting:

“I kind of treated the project like it was in permanent mobilisation because things changed, because it was new, because there were new partners having to work in different ways” (M2)

Obviously the environment required skilled staff with high levels of reflexivity. With this emergent nature of practice and services there was a sense of integration being an ongoing issue:

“we’re constantly kind of learning around sort of integration” (M9)

“that understanding of integration is not a thing that you do and it’s done, but of, you know, something that it will continue and we always need to be working at” (M6)

“it [integration] is always going to be iterative because the very system we’re working [in] is never going to facilitate that integration because that’s not how it works” (M5)

c) Understanding the work of system engineers

Delivering this ongoing process of integrating care needed people who could shape the relational web and enable agency. Interviewees used various means to describe this ongoing work, including ambassadors and advocates for PEH, networking and communicating, and facilitators. This happened at the level of individual frontline practitioners, as one interviewee noted about her frontline colleague:

“her tools really are her link in with and her communication with the different bits of the system and she’s a, you know she’s a real expert around that you know she can, she’s got a very broad network across [the locality] which she can call on at any point in order to bring the relevant people together to resolve a specific case or to come round the table and talk about a bigger set of issues” (M10)

Often, frontline staff were best placed to be ambassadors or advocates for the issues:

“we had some really good clinical leadership that had been working with this client group” (M5)

“we’ve got a Lead Practitioner who’s very established in the City, who’s very, very passionate about the population, who’s very good at articulating the challenges we face” (M4)

“we wanted them [frontline colleagues] to be a bit of an ambassador within the care world for actually working with this client group as well, and again that kind of understanding of actually there’s a reason why people are behaving in the way that they are and, you know, that the mental health, the drugs and alcohol all relate to something and that kind of history that the individual and their experience of trauma.” (M6)

Frontline staff, though, were not always best placed to (re)shape the relational web to improve outcomes or do it alone. Other agents in the system were needed, often the interviewees:

“having that sort of senior responsibility in the organisation to sort of bring the threads together and make sure that it was driving and really I suppose giving that kind of guidance and a strategic view around you know how we sort of developed those pathways, how we brought people together and making sure the right links were being made, dealing with any sort of issues as I say, you know that needed to be escalated up etc.“ (M9)

“that’s where I come in to try and unblock, to make it easier for the Frontline Clinicians to get their job done” (M8)

Without such agents connecting parts of the system, a risk was that:

“people would have ended up going off on sort of their own tangents at times and potentially sort of naturally gravitated back to their sort of normal way of working which was, you know, more silo-based in nature” (M9)

This connecting by agents, then, was another aspect of the discharge services that required ongoing attention and was emergent.

One interviewee developed an ‘integration mechanic’ metaphor to explain this work:

“tuning the engine or connecting the parts, and that almost needs a constant effort, you know people move on and so forth and new things emerge and the boroughs obviously are doing some of their own things so as things emerge having to connect those in, and other pots of money are coming down, and people are doing things, and the Substance Misuse money is coming and, or how do we connect all of that, so it is a sort of continuous process of building, building and connecting” (M10)

The overall adaptive capacity of a local system was, then, the work of several agents, working on different structures, networks and layers, identifying who was best to deliver change and thereby enact a collective agency across systems:

“we would quite often divide that up between us, so it was like `right you’ve got a better relationship with that person than I have so you target them and I’ll take this one over here because I know that you know ..’ and it was about relationships” (M2)

Discussion

In our earlier paper (Clark et al. 2022) we noted the complexity of hospital discharge for people experiencing homelessness in terms of clients' interacting needs and the range of organisations, services and practitioners required to effectively address them and that this warranted conceiving of it as a wicked problem (Rittel & Webber 1973). The heterogeneity of the homeless population and their needs requires a highly flexible approach to support, and one size of service offer does not fit all (Carmichael et al. 2023).

In this paper we have explored the process of integrating care for PEH to a deeper conceptual and empirical level to better guide policy and practice to overcome the nihilism that may come from the label 'wicked problem' (Termeer, Dewulf & Biesbroek, 2019). We adopted a relational perspective to do this, following the relational turn in social sciences. This is referred to as a 'turn' because there is no one 'relational' theory, but rather a broad understanding of the importance of starting from understanding relations between actors and structures, rather than treating relations as secondary to those actors and structures. The goal is to understand how phenomena emerge from these interactions through the underlying generative process, and how this carries forward into the next phase of interactions. The relational perspective entails:

"the analysis of relational connections between interactants; that is, webs or networks of relations and interdependencies, both interpersonal and impersonal, in which interactants and their joint actions are embedded" (Burkitt 2016:323).

Within the context of this study there is a complex relational web of interactants, all operating in a VUCA environment – collectively interacting to create the wickedness people experience of a seemingly insoluble problem. Conceiving of solutions as predictable, linear and final exacerbates the sense of wickedness and creates the feeling of nihilism. From the relational perspective we see, rather, than the whole issue is actually emergent with no single path or solution to a set model of 'integrated care' always delivering the desired outcomes in the timeframes some organisations focus on. Understanding this character to the system and these processes is crucial to enabling integrating care to overcome the wickedness of the challenge.

In the system as it usually operated, interactants acted in their own sections of the relational web, i.e. that set of complex relations and interactions between actors and structures that people are immersed in as they move through society, at different points in time and space, e.g. in the ward or a community setting after discharge. Actions of one actor would have an impact on the circumstances for the next cycle of interactions, but there would be no coordination of these nor, often, understanding of the interaction patterns. The example of the case sites in this study, though, is that it is possible to create adaptive capacity in the relational web and new patterns of interaction such that processes we call 'integrating care' occur and better outcomes are achieved. There is no need for nihilism, just for a reframing of how we understand the reality of the issues and, importantly, the expectations of key stakeholders.

Understanding the agency of interactants in this context is important. We are accustomed to thinking of the agency of a person as something they possess and bring to shape an interaction with another. However, from a relational perspective agency sits across the

relational web (of actors and structures) and is an outcome of the interactions, in other words:

“the relational point of view sees agency as inseparable from the unfolding dynamics of situations, especially from the problematic features of those situations.” (Emirbayer 1997:294)

Agency does not depend on individuals, nor is it determined by structures. Rather, it is situationally and relationally embedded, entwined in the “on-going conversation” (Emirbayer 1997: 294) of interactions, hence:

‘*social relationships should not be understood as merely constraining or enabling agency, but as constituting the very structure and form of agency itself*.” (Burkitt 2016:336) (original emphasis)

In this relational web, agency is, then, an ongoing, emergent process, rarely completely independent of or determined by structures, nor a completed stage. Similarly, the entwined experience of identity is emergent in interactions – not wholly preformed with all facets given ahead of the interaction and not necessarily all fixed or stable throughout the process. Shifting to understand the interactional, emergent nature of identity can be challenging. We are, after all, accustomed to understanding identity as fixed, but we also discuss many phenomena as discrete entities when they are actually processes; for example ,we say ‘the wind is blowing’ and ‘the river is flowing’ separating entities and their processes, when to be the wind is to the process of blowing and being a river is to flow (Elias 1992).

In this context of integrating care for PEH as they are discharged from hospital, this means we need to understand that the identities of the individuals are not wholly pregiven and immutable, but are to some extent (re-)constituted in each interaction, giving the potential for the narrative of each individual’s identities to take different trajectories depending on the interactions. Good relationships between frontline staff and PEH are the basis of developing better trajectories encompassing positive identities and enhanced agency for clients as foundations to better outcomes.

Relational goods emerge from these interactions which help shape the unfolding of interactions and which are not possessed by any one person in the relationship but which sit across interactants in the relational web (Donati 2010). Trust, as an example of these goods from the case sites, if successfully generated in the relational web, can carry on to the next phase of interactions shaping how they unfold – (re)shaping identities of agents and working to support the emergent and unfolding series of ‘pivotal moments’.

Recognising relational goods we must also explicitly acknowledge and understand the (potential) impact of relational evils arising from interactions. These include the opposite of trust and the impact of stigma that many PEH have experienced from statutory systems. These too can carry in the relational web across space and time, shaping the next phases of interactions, but in negative ways. Indeed, one of the first challenges of staff in their interactions in the case sites was to overcome relational evils from previous phases of interactions the clients had with other services.

From this relational perspective we understand the ongoing, emergent process of *integrating* care, which interviewees saw as the reality rather than an end state of a rigid 'integrated care system' in which the job is completed. Given the emergent nature of practice, especially in the VUCA environment, no set relational web of integrated care is achieved in the short to medium term (and the longer term remains unknown, but is likely to also be emergent requiring flexible systems, and not amenable to rigid, predefined prescriptions of integrated care). Practitioners need to be reflexive, engaging in what one interviewee compared to the action learning cycle of Plan Do Study Act. Similarly, system agents/engineers need to engage in adaptive management (Mitchell 2009; Rist, Campbell & Frost 2013; Allen & Garmestani 2015) – drawing in a wider pool of knowledge about the context, constantly scanning information about the relational web and what they might do to remold it to improve outcomes, reviewing actions and effects and planning again for the next phase of interactions, understanding that this too will be emergent and not wholly controllable.

This relational perspective chimes with the critical realist understanding of the causes of homelessness, a topic earlier characterised by unsatisfactory distinctions and fluctuations between understanding individual and structural causes, but which is now understood as contingent and emerging from complex and multiple causal mechanisms (Fitzpatrick et al. 2011). The relational perspective accords with this, stressing the need to focus on the relationships between the structural and individual factors and how these interactions cause and maintain homelessness, and the processes of interaction that could end homelessness, such as those highlighted in the forgoing analysis of integrated care in this area.

Integration initiatives in the UK have tended to focus on one approach to change at a time, such as establishing joint protocols to empower/direct staff agency, or strategic-level or bottom-up initiatives (Alonso & Andrews 2022). The RMIC points to the need to develop a system set of developments to support integration. The evidence from our examination of the context of homelessness discharge services is that this needs to go further and adopt a relational perspective underpinning the implementation of such frameworks for understanding integration as the RMIC. This entails understanding the emergent and dynamic nature of reality and not focusing on the structures of the RMIC alone; integration always happens as an emergent process from interactions and is always contingent and having to be achieved. The place of relational goods/evils in addressing homelessness for an individual, and how these exist across relational webs adds understanding to key issues to be attentive to in integrating care in this area.

Whilst this is evidence in the 'wicked problem' context of homelessness, further empirical investigation of how a relational perspective could help in understanding integrating care in other contexts would be worthwhile. There is a need to develop better evidence of the mechanisms facilitating integrating care in different contexts (Alonso & Andrews 2022), and a relational perspective would be beneficial in this – understanding the relationships between structures and agents and the place of such phenomena as relational goods/evils across these, and how these dis/enable agency and better outcomes. A relational understanding of *integrating* care in contexts other than homelessness may be a helpful shift in perspective.

<u>Study implications and limitations</u>

There are powerful insights from a relational understanding of integrating care in this context of homelessness, and more generally. By understanding that integrating is an ongoing and emergent process, across different levels of practice and organisational contexts, we hope that those endeavouring to integrate care for individuals see that if attention is overly focused on rigid structures expecting a definite point of integrated care for all is achieved, they run the risk of disappointment, particularly with more complex client groups/contexts. The scope for different patterns of interaction to occur and, hence for various pathways to integrating, means that the focus has to be on processes and considering what structures need to be adapted/adopted to enable the agency of individuals to allow integrating care for each person, and how different actors play key roles, such as system engineers. Also, system planners can be vigilant to examine the roles of relational goods in their systems and whether their arrangements for integrating care facilitate these or encourage relational evils. A further note of comfort to decision makers is that although we discuss the future as emergent, meaning it is uncertain and can't be strictly anticipated and controlled, not every scenario is possible – developments will take place within a range of options, some more explicitly knowable than others – and there can be a degree of direction given to these developments. There will be tendencies towards some possible paths, each with barriers and resistance as well as enablers – which can be considered using such frameworks as RMIC and VUCA, if not wholly predefined and tightly managed.

We should acknowledge a methodological issue for this study and our discussion of implications. Whilst we argue that the number of interviews reached a certain level of saturation for findings, we acknowledge that the number of sites in such a study will always be limited and leave open questions concerning the generalisability of findings to other contexts (Malterud 2001).Further, we have sought the experiences of leaders of these initiatives, and not every actor connected with them, and they may have highlighted separate issues in the sites. We do not argue, then, that we have exhausted all issues or contexts. Indeed, our relational perspective indicates that different contexts could have highlighted different specific examples of issues. The specific issues discussed above are not exhaustive nor would they all apply in every case. Rather, we use them to illustrate the insights from the relational perspective we would encourage others to adopt to plan, operationalise and research integrating care.

Conclusion

It has been commented that integrating care is more of a craft than a science (Dickinson 2014; Bailey & Mutale 2021). Our relational analysis of integrating care for PEH post-discharge from hospital certainly resonates with this view.

The interjection of the pump priming initiative to develop the discharge services was a catalyst to change local relational webs to improve hospital discharge support. It helped change narratives, norms and expectations, and was permissive and helped empower local agents to change the pattern of the relational web around this issue which otherwise leads to rigid systems that people don't connect with/in, causing it to be a wicked issue.

From the relational perspective we see that good discharge arrangements which link the necessary parts of the relational web for each client are emergent from an ongoing process of interactions. Agents need to be supported to be constantly enacting the art of making these links and engaging others in building relational goods, including trusting relationships,

hopes and positive identities. Environments in health and social care will always be characterised as VUCA, to varying degrees, which means it is essential to have an emergent understanding of how care and support are bought together for each person, rather than a rigid structural view.

It is, then, not helpful to talk of *integrated* services and support as this can lead to a sense of an end point where a clear model of practice and one fixed set of arrangements amongst the complex set of interactants can be fully and finally achieved. This is a reading of the RMIC model which is unhelpful. Rather, discussing *integrating* as an ongoing process of adapting the relational web for everyone's circumstances and the current system is a more accurate and helpful way of comprehending what is needed to address the wicked issue of improving hospital discharge for people experiencing homelessness. Such a dynamic understanding adds to the RMIC framework. Effective practice that brings together different disciplines and organisations in this context is like the river; its very nature is to be flowing, to be in ongoing processes of integrating.

References

Aldridge, R.W., Menezes, D., Lewer, D., Cornes, M., Evans, H., Blackburn, R.M., Byng, R., Clark, M., Denaxas, S., Fuller, J. and Hewett, N., 2019. Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. Wellcome open research, 4.

Allen, C.R. and Garmestani, A.S., 2015. Adaptive management (pp. 1-10). Springer Netherlands.

Alonso, J.M. and Andrews, R., 2022. Does vertical integration of health and social care organizations work? Evidence from Scotland. Social Science & Medicine, 307, p.115188.

Bailey, D. and Mutale, G.J., 2021. Can a case lead approach deliver the "craft and graft" of integration?. Journal of Integrated Care, 29(1), pp.72-84.

Baran, B.E. and Woznyj, H.M., 2020. Managing VUCA: The human dynamics of agility. Organizational dynamics.

Bennett, N. and Lemoine, G.J., 2014. What a difference a word makes: Understanding threats to performance in a VUCA world. Business horizons, 57(3), pp.311-317.

Burkitt, I., 2016. Relational agency: Relational sociology, agency and interaction. European Journal of Social Theory, 19(3), pp.322-339.

Carmichael, C., Schiffler, T., Smith, L., Moudatsou, M., Tabaki, I., Doñate-Martínez, A., Alhambra-Borrás, T., Kouvari, M., Karnaki, P., Gil-Salmeron, A. and Grabovac, I., 2023. Barriers and facilitators to health care access for people experiencing homelessness in four European countries: an exploratory qualitative study. International Journal for Equity in Health, 22(1), p.206.

Clark, M., Cornes, M., Whiteford, M., Aldridge, R., Biswell, E., Byng, R., Foster, G., Fuller, J.S., Hayward, A., Hewett, N. and Kilminster, A., 2022. Homelessness and integrated care: an application of integrated care knowledge to understanding services for wicked issues. Journal of Integrated Care, 30(1), pp.3-19.

Cornes, M., Aldridge, R. W., Biswell, E., Byng, R., Clark, M., Foster, G., Fuller, J., Hayward, A., Hewett, N., Kilmister, A., Manthorpe, J., Neale, J., Tinelli, M., & Whiteford, M. (2021). Improving care transfers for homeless patients after hospital discharge: a realist evaluation. NIHR Journals Library. https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr09170/#/abstract [Accessed 20.02.24].

Cornes, M., Tinelli, M., Clark, M., Coombes, J., Harris, J., Burridge, S., Robinson, J. and Wittenberg, R., 2024. Evaluation of the Out-of-Hospital Care Models Programme for People Experiencing Homelessness. (available at https://doi.org/10.18742/pub01-178; accessed 9/09/2024)

Dépelteau, F., 2008. Relational thinking: A critique of co-deterministic theories of structure and agency. Sociological theory, 26(1), pp.51-73.

Dickinson, H., 2014. Making a reality of integration: less science, more craft and graft. Journal of Integrated Care, 22(5/6), pp.189-196.

Donati, P., 2010. Relational sociology: A new paradigm for the social sciences. Routledge.

Donati, P., 2018. An original relational sociology grounded in critical realism. In F. Dépelteau (ed.) The Palgrave handbook of relational sociology. Chapter 22, pp.431-456.

Downey, J., Harris, N., Rybczynska-Bunt, S., Golder, E., Shearn, K. and Bradley, N., 2024. Reflecting on Reflexivity in Realist Evaluation: A Call to Action. International Journal of Qualitative Methods, 23, p.16094069241284206.

Elias, N. 1978. What Is Sociology? New York: Columbia University Press.

Emirbayer, M. 1997. Manifesto for a relational sociology, American Journal of Sociology, 103, 2, 281–317.

Fitzpatrick S, Bramley G, McMordie L, Pawson H, Watts-Cobbe B, & Young G (2023) The Homelessness Monitor: England 2023. London: Crisis

Fitzpatrick S, Pawson H, Bramley G, Wilcox S (2011) The homelessness monitor Tracking the impacts of policy and economic change in England 2011-2013 Year 1: Establishing the baseline. London: Crisis

Hammond, J., Coleman, A. and Checkland, K., 2018. Enacting localist health policy in the English NHS: the 'governing assemblage' of Clinical Commissioning Groups. Journal of health services research & policy, 23(1), pp.49-56.

Malterud, K., 2001. Qualitative research: standards, challenges, and guidelines. The Lancet, 358(9280), pp.483-488.

Mitchell, S.D., 2009. Unsimple truths: Science, complexity, and policy. University of Chicago Press.

Mukumbang, F.C., De Souza, D.E. and Eastwood, J.G., 2023. The contributions of scientific realism and critical realism to realist evaluation. Journal of Critical Realism, pp.1-21.

Rist, L., Campbell, B.M. and Frost, P., 2013. Adaptive management: where are we now?. Environmental conservation, 40(1), pp.5-18.

Rittel, H.W. and Webber, M.M., 1973. Dilemmas in a general theory of planning. Policy sciences, 4(2), pp.155-169.

Stafford A, Wood L. Tackling Health Disparities for people who are Homeless? Start with Social Determinants. Int J Environ Res Public Health. 2017

Termeer, C.J., Dewulf, A. and Biesbroek, R., 2019. A critical assessment of the wicked problem concept: relevance and usefulness for policy science and practice. Policy and Society, 38(2), pp.167-179.

Valentijn, P.P., Schepman, S.M., Opheij, W. and Bruijnzeels, M.A., 2013. Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. International journal of integrated care, 13.

Valentijn, P.P., Vrijhoef, H.J., Ruwaard, D., Boesveld, I., Arends, R.Y. and Bruijnzeels, M.A., 2015. Towards an international taxonomy of integrated primary care: a Delphi consensus approach. BMC family practice, 16, pp.1-15.