1 **NATIONAL INSTITUTE FOR HEALTH AND CARE**
2 **EXCELLENCE**

3 # Guideline

4 # Integrated health and care for people
5 # experiencing homelessness

6 **Draft for consultation, October 2021**

7

This guideline covers providing integrated health and social care services for people experiencing homelessness. It aims to improve access to and engagement with health and social care.

Who is it for?

- local authorities
- commissioners and providers of services
- healthcare professionals in primary, secondary and tertiary care
- social care practitioners
- people who experience homelessness, their families, advocates, and the public

What does it include?

- the guideline context
- the recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect services.

Information about how the guideline was developed is on the guideline's webpage. This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

8

1 # Contents

20

1 **Context**

2 This guideline includes recommendations on ways to improve access to and
3 engagement with health and social care services for people experiencing
4 homelessness. It also gives advice on how commissioners, planners, providers and
5 practitioners across disciplines and agencies can work together to support and
6 improve outcomes for people experiencing homelessness.

7 In this guideline 'people experiencing homelessness' means people aged 16 and
8 over who:

9 • are sleeping rough
10 • are temporary residents of hostel accommodation
11 • are in unsupported temporary accommodation
12 • use day centres that provide support for people experiencing homelessness
13 • are staying temporarily with family and friends ('sofa surfing')
14 • are squatting
15 • have a history of homelessness (as defined above), and are at high risk of
16   becoming homeless again because of ongoing complex health and social care
17   needs.

18 Underlying causes of homelessness include structural, societal and economic
19 factors, such as poverty and deprivation, unaffordable housing, unemployment,
20 exclusion and discrimination. In addition to housing needs, people experiencing
21 homelessness often have complex and intersecting physical and mental health
22 needs, drug and alcohol recovery needs, and social care needs that may be
23 contributing factors for becoming homeless as well as consequences of
24 homelessness. Experiences of psychological trauma, adverse childhood events,
25 neurobehavioural differences and brain injury are also common in people
26 experiencing homelessness. Homelessness is a public health issue, not only a
27 housing issue.

28 People experiencing homelessness have far worse health and social care outcomes
29 than the general population. The average age of death for the homeless population
30 is around 30 years lower than for the general population according to the Office for

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1 [National Statistics' Deaths of homeless people in England and Wales: 2019](#)
2 [registrations](#).

3 'Inclusion health' is a term developed to address the health and care needs of groups
4 that are traditionally excluded, including people experiencing homelessness. The
5 needs of the homeless population overlap considerably with other inclusion health
6 groups. Internationally, these groups have mortality rates that are 8 times higher
7 than the general population for men and 12 times higher for women ([Aldridge et al.](#)
8 [[2017] Morbidity and mortality in homeless individuals, prisoners, sex workers, and](#)
9 [individuals with substance use disorders in high-income countries: a systematic](#)
10 [review and meta-analysis](#)). Many of these premature deaths are from preventable
11 and treatable conditions according to a 2019 study by the same authors ([Aldridge et](#)
12 [al. [2019] Causes of death among homeless people: a population-based cross-](#)
13 [sectional study of linked hospitalisation and mortality data in England](#)). The Office for
14 National Statistics' 2019 report showed that the causes of most deaths of people
15 experiencing homelessness in England and Wales were registered as drug-related
16 poisonings, suicides and alcohol-specific deaths.

17 People experiencing homelessness use more acute hospital services and
18 emergency care than the general population. When admitted to a hospital, the length
19 of hospital stay is usually much longer. Barriers to access and engagement with
20 preventive, primary care and social care services can mean that problems remain
21 untreated until they become very severe and complex. These barriers include stigma
22 and discrimination; lack of trusted contacts; fragmented, siloed and rigid services;
23 strict eligibility criteria; and lack of information sharing and communication.

24 In addition to a moral responsibility, there is an economic imperative to tackle
25 homelessness. The costs of homelessness to society are significant. The [Pleace and](#)
26 [Culhane (2016) report Better than cure?](#), published by Crisis, estimated the total
27 public sector costs of a person experiencing homelessness to be as much as
28 £38,736 per year in England (based on 2019/20 prices). This estimate included the
29 NHS costs (£4,298), mental health services (£2,099), drug and alcohol services
30 (£1,320), criminal justice sector costs (£11,991) and homelessness services
31 (£14,808). On average, it was estimated that preventing homelessness for 1 year
32 would reduce the public expenditure by approximately £10,000 per person. In

1 2020/21, 11,580 single households were assessed as rough sleeping in England

2 ([Ministry of Housing, Communities & Local Government, 2021](#)), and if these people

3 were prevented from experiencing 1 year of homelessness, annual public spending

4 would fall by as much as £115.8 million. If other forms of homelessness were

5 included, these cost savings would be substantially higher. Given the financial

6 implications of homelessness to society and the far worse health and social care

7 outcomes, most interventions that address homelessness are likely to be cost

8 effective or even cost saving from the wider public sector perspective.

9 The [Ministry of Housing, Communities & Local Government's rough sleeping](#)

10 [strategy](#) outlines its commitment to ending rough sleeping and preventing

11 homelessness. The [Homelessness Reduction Act 2017](#) includes duties for local

12 authorities to assess, prevent and relieve homelessness. The [NHS Long Term Plan](#)

13 includes a commitment to improve access to specialist homelessness mental health

14 support for people sleeping rough in areas with the highest rates of rough sleeping.

15 During the COVID-19 pandemic, local authorities, health services, and the voluntary

16 and charity sector have worked in partnership to respond to homelessness, including

17 the 'Everyone In' initiative. This has shown that with appropriate funding, integrated

18 working and prioritisation of the most vulnerable in the society, there are

19 opportunities for positive change.

20 This guideline aims to provide guidance on models of service provision, including

21 services that are specific to people experiencing homelessness, as well as how to

22 improve access and engagement with mainstream services, with the aim of

23 integrating services as much as possible.

24

1 Recommendations

> People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.
>
> Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 How services should be delivered

General principles

1.1.1 Recognise that more effort and targeted approaches are often needed to ensure that health and social care for people experiencing homelessness is available, accessible, and provided to the same standards and quality as for the general population.

1.1.2 Recognise the value of co-designing and co-delivering services with people with lived experience of homelessness, to improve the quality of health and social care (see the section on the role of peers). See also the section on involving people in service design and improvement in NICE's guideline on people's experience in adult social care services and NICE's guideline on community engagement.

1.1.3 Promote engagement with services by using a friendly, non-judgmental and culturally sensitive approach, and consider using psychologically informed environments or trauma-informed care. Recognise that people's behaviour and engagement with services is influenced by traumatic experiences and their previous experiences of services.

1.1.4 Recognise the importance of professional expertise and longer contact times in developing and sustaining trusting relationships between frontline health and social care staff and people experiencing homelessness (see

1   also [recommendation 1.2.9 in the section on planning and](#)

2   [commissioning](#)).

3   1.1.5   Promote shared decision making, building self-reliance and using

4   [strengths-based approaches](#) to care (also known as assets-based

5   approaches). See also [NICE's guideline on shared decision making](#).

6   1.1.6   Recognise that people experiencing homelessness, especially those with

7   experience of rough sleeping, need services that provide a long-term

8   commitment to care to promote recovery, stability and lasting positive

9   outcomes (see the [section on long-term support](#)).

10   1.1.7   Be aware that people experiencing homelessness may find it difficult to

11   look after themselves and engage with services because of their

12   circumstances. Actively support re-engagement with services for people

13   who disengage from or refuse health and social care services, even if they

14   have capacity.

> For a short explanation of why the committee made these recommendations and how they might affect practice, see the [rationale and impact section on general principles](#).
>
> Full details of the evidence and the committee's discussion are in [evidence review A & B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches and evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

15   **Communication and information**

16   1.1.8   Follow the recommendations on communication and information in NICE's

17   guidelines on:

18   • [patient experience in adult NHS services](#)

19   • [people's experience in adult social care services](#)

20   • [service user experience in adult mental health](#)

21   • [babies, children and young people's experience of healthcare](#).

1 1.1.9 Health and social care staff working with people experiencing
2 homelessness should:

3 • be friendly, non-judgmental and use [recovery-oriented language](#) that
4 avoids jargon
5 • use communication methods based on the person's preferences, for
6 example, phone call, text message, email, letter
7 • ensure that clear information about contacts or appointments reaches
8 people in time.

9 1.1.10 Take into account each person's communication and information needs
10 and preferences, and their circumstances. For example:

11 • provide translation and interpretation services if needed
12 • ensure that written information is available in different formats and
13 languages, including Easy Read
14 • provide extra support for people with low literacy levels.

15 1.1.11 Consider involving an advocate to support communication even when this
16 is not a statutory requirement. This may be someone nominated by the
17 person or an appointed advocate who can, for example:

18 • support people to overcome stigma and previous negative and
19 traumatic experiences
20 • help people with low literacy levels to access information and services
21 • reinforce information about available services and appointments.

22 1.1.12 Give people experiencing homelessness information about:

23 • their rights to health and social care services
24 • how to access health and social care services, including:
25 − primary care services
26 − specialist health services that can be accessed directly, such as
27 maternity, blood-borne virus, drug and alcohol recovery, mental
28 health, sexual health, and family planning services
29 − outreach services

1   −   local authority services, including housing services

2   •   voluntary and charity sector services.

> For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on communication and information.
>
> Full details of the evidence and the committee's discussion are in evidence review C: views and experiences of health and social care for people experiencing homelessness.

3 **1.2   Planning and commissioning**

4 These recommendations are for commissioners.

5   1.2.1   Commissioners across health and social care and housing services
6   should work together to plan and fund integrated multidisciplinary health
7   and social care services for people experiencing homelessness and
8   contribute to the government's aim of ending rough sleeping and
9   preventing homelessness.

10   1.2.2   Recognise that people experiencing homelessness often need additional
11   resources and a more targeted service delivery to ensure that resources
12   are allocated according to need and disadvantage, improve long-term
13   outcomes and address health inequalities.

14   1.2.3   Conduct a local homelessness health and care needs assessment and
15   use this to design, plan and deliver services according to need. Include
16   thorough engagement with service providers (including voluntary and
17   charity sector service providers), service users and experts by experience.
18   In the assessment, also:

19   •   quantify and characterise the population experiencing homelessness or
20   at risk of homelessness, and identify trends

- assess the quality and capacity of existing mainstream and specialist service provision to inform the need for service development and investment
- assess access to and engagement with current services by people experiencing homelessness
- identify opportunities for more integrated service delivery
- take into consideration relevant findings from Safeguarding Adults Reviews.

1.2.4 Work with health and social care providers to improve recording of homelessness status for care provision and audit.

1.2.5 When developing services for people experiencing homelessness commissioners should:

- work together to strategically plan and deliver health and social care across larger areas, recognising that people move between areas
- enable long-term support for those who need it (see the section on long-term support)
- ensure that health and social care services are designed to meet the level of local need (see the section on models of multidisciplinary service provision)
- define and measure outcomes
- consider using long-term contracts for providers
- support statutory bodies to fulfil their legal responsibilities and use their powers
- encourage and promote the contribution of peers (experts by experience) in supporting people experiencing homelessness and delivering and designing more effective services (see the section on the role of peers).

1.2.6 Consider providing services and support aimed at the needs of particular groups of people experiencing homelessness, as appropriate, such as:

1   • women (also see the NICE guideline on pregnancy and complex social
2   factors)

3   • young people

4   • older people

5   • people without recourse to public funds because of their immigration
6   status

7   • LGBT+ people

8   • people from different minority ethnic or religious backgrounds.

9   1.2.7   Develop strategies across services to improve access to health and social
10   care for people experiencing homelessness. See the section on improving
11   access to and engagement with health and social care.

12   1.2.8   Ensure that there are processes to:

13   • support people experiencing homelessness to register with a GP **and**
14   • document and address any problems with GP registrations for people
15   experiencing homelessness.

16   1.2.9   Consider reducing caseloads and lengthening contact time for health and
17   social care practitioners working with people experiencing homelessness
18   to enable them to use approaches that sustain engagement with services.

> For a short explanation of why the committee made these recommendations and
> how they might affect practice, see the rationale and impact section on planning
> and commissioning.
>
> Full details of the evidence and the committee's discussion are in evidence review
> A & B: effectiveness of approaches to improve access to and engagement with
> health and social care and joined up approaches and evidence review C: views
> and experiences of health and social care for people experiencing homelessness.

19 **1.3   Models of multidisciplinary service provision**

20   1.3.1   Provide care through specialist homelessness multidisciplinary teams
21   across sectors and levels of care, tailored according to local needs.

1 1.3.2   Homelessness multidisciplinary teams should:

2 • act as an expert team, providing and coordinating care across
3   outreach, primary and secondary care, social care and housing
4   services

5 • identify people experiencing homelessness through outreach or when
6   they present to health and social care services

7 • support mainstream providers to identify and refer people to the
8   homelessness multidisciplinary team

9 • undertake and support needs assessments for safeguarding, physical
10   and mental health, alcohol and drug recovery needs, and social care,
11   including informing Care Act assessments (see the section on
12   assessing people's needs)

13 • offer person-centred case management and ensure continuity of care
14   for as long as it is needed by the person

15 • offer wraparound health and social care support that encompasses the
16   person's needs, including:

17   – physical health needs

18   – mental health and psychological needs (such as psychological
19   therapies)

20   – physical rehabilitation needs (such as occupational therapy and
21   physiotherapy)

22   – drug and alcohol recovery needs

23   – social care needs

24   – practical needs, such as help with benefits and housing

25 • support mainstream providers to ensure safe, timely and appropriate
26   hospital discharge and engagement with onward care (see the section
27   on transitions between different settings)

28 • advise homelessness leads in nearby areas that are without
29   homelessness multidisciplinary teams as needed.

30 1.3.3   Homelessness multidisciplinary teams may include:

31 • experts by experience (see the section on the role of peers)

Integrated health and care for people experiencing homelessness:

1   • healthcare professionals with relevant specialist expertise

2   • social workers and allied social care professionals

3   • housing options officers or homelessness prevention officers

4   • voluntary and charity sector professionals

5   • staff with practical expertise in accessing benefits and entitlements for

6   people experiencing homelessness.

7 1.3.4 Homelessness multidisciplinary teams should engage in reflective

8   practice, including opportunities to share experience and learning with

9   other specialist teams and to review complex or difficult situations.

10 1.3.5 Homelessness multidisciplinary teams should directly contribute to local

11   needs assessments, service quality improvement, and reviews of complex

12   or difficult situations including Safeguarding Adults Reviews.

13 1.3.6 In areas assessed as not needing a full-time homelessness

14   multidisciplinary team because of low numbers of people experiencing

15   homelessness, establish links with multidisciplinary teams in nearby areas

16   and designate homelessness leads in mainstream services, for example

17   in primary and secondary care, and in adult and child social services.

18 1.3.7 The homelessness leads should:

19   • support their organisation to provide appropriate care for people

20   experiencing homelessness and implement this guideline

21   • have detailed local knowledge of specialist services to support the care

22   of people experiencing homelessness

23   • work with and coordinate care with homelessness leads in other

24   mainstream services

25   • consult homelessness multidisciplinary teams in nearby areas as

26   needed.

> For a short explanation of why the committee made these recommendations and
> how they might affect practice, see the rationale and impact section on models of
> multidisciplinary service provision.

Full details of the evidence and the committee's discussion are in [evidence review A & B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches and evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

1.4 The role of peers

1.4.1 Offer peer support to people experiencing homelessness, for example to help with:

- forming trusting relationships with practitioners and improving communication
- understanding how others with similar experiences have changed their lives (role modelling)
- developing self-efficacy
- navigating services
- supporting attendance at appointments
- providing peer advocacy at appointments.

1.4.2 Involve peers (experts by experience) in delivering and designing services, for example by:

- directly delivering health and social care interventions, for example, as part of outreach
- providing a user perspective to support the design and development of services
- data collection, for example, to support service audits, needs assessments and quality improvement.

1.4.3 Support peers to deliver services effectively and maintain their own wellbeing and development by providing:

- training, supervision and governance structures appropriate to the role
- psychosocial support according to their changing needs and circumstances

1   • tailored support for professional development, including access to
2   further training and employment opportunities.

3   1.4.4   Take into account the experience, background and language skills of
4   peers and how these can be used to meet the needs and preferences of
5   people experiencing homelessness.

> For a short explanation of why the committee made these recommendations and
> how they might affect practice, see the rationale and impact section on the role of
> peers.
>
> Full details of the evidence and the committee's discussion are in evidence review
> A & B: effectiveness of approaches to improve access to and engagement with
> health and social care and joined up approaches and evidence review C: views
> and experiences of health and social care for people experiencing homelessness.

6   **1.5   Improving access to and engagement with health and**
7   **social care**

8   **Supporting access to and engagement with services**

9   1.5.1   Design and deliver services in a way that reduces barriers to access and
10   engagement with health and social care, for example, by providing:

11   • outreach services (see the section on outreach services)
12   • low-threshold services
13   • flexible opening and appointment times
14   • self-referral
15   • drop-in services
16   • 'one-stop shops' for multiple services
17   • incentives and help to access care, such as transport support,
18   vouchers or digital connectivity
19   • advocates (see recommendation 1.1.11 in the section on
20   communication and information)
21   • peer support (see the section on the role of peers)

1   • care navigation.

2   1.5.2   Do not penalise people experiencing homelessness for missing
3   appointments, for example by discharging people from the service.
4   Consider seeking specialist help such as peer supporters or independent
5   advocates to support the person to attend appointments and re-engage
6   with care after missing appointments (see the section on the role of
7   peers).

8   1.5.3   Ensure that people can access help when needed, and avoid policies that
9   withdraw support and close cases after a standard duration, unless a safe
10   transfer of care to another service has been arranged or the person
11   agrees that they no longer need the service.

12   1.5.4   Commissioners and service providers should follow the recommendations
13   on improving access to services in NICE's guideline on common mental
14   health problems.

15   1.5.5   Ensure that restrictive eligibility criteria do not exclude people
16   experiencing homelessness who have coexisting mental health issues
17   and problem substance use from services. See also NICE's guideline on
18   coexisting severe mental illness and substance misuse.

19   1.5.6   Ensure that people experiencing homelessness who are considered frail
20   and in need of social care support get long-term care packages
21   irrespective of their age.

22   1.5.7   Ensure that paper or digital forms to access health or social care or get
23   help with NHS costs are readily available and that people are supported to
24   fill them in, including providing translation when needed.

25   1.5.8   Ensure that people experiencing homelessness can access online health
26   and social care information and are supported to use online services, for
27   example by providing internet access at places where people
28   experiencing homelessness spend time, such as day centres or hostels.

1   1.5.9   Primary care service providers should ensure that people without an

2   address can register with a GP practice, in line with the NHS Primary

3   medical care policy and guidance manual.

4   1.5.10   Ensure that frontline health and social care staff who come into contact

5   with people experiencing or at risk of homelessness are able to fulfil their

6   duties under the Homelessness Reduction Act 2017.

7   1.5.11   Ensure that frontline health and social care staff are able to identify when

8   a person needs to be referred for specialist homeless health and social

9   care, and that processes are in place to support timely referral.

10   1.5.12   Consider moving people up waiting lists for health and social care

11   appointments if they are experiencing homelessness, taking into account

12   that they may need higher levels of support and have disadvantages,

13   including the risk of premature death.

> For a short explanation of why the committee made these recommendations and
> how they might affect practice, see the rationale and impact section on supporting
> access to and engagement with services.
>
> Full details of the evidence and the committee's discussion are in evidence review
> A & B: effectiveness of approaches to improve access to and engagement with
> health and social care and joined up approaches and evidence review C: views
> and experiences of health and social care for people experiencing homelessness.

14   **Outreach services**

15   1.5.13   Take health and social care services to people experiencing

16   homelessness by providing outreach care in non-traditional settings, such

17   as on the street, hostels or day centres.

18   1.5.14   Offer outreach services that include support for people who:

19   • have primary healthcare needs

20   • have drug and alcohol recovery needs

21   • have mental healthcare needs

1 • fear engaging with services because of, for example, previous negative
2   experiences from providers or concerns about eligibility including
3   immigration status
4 • may lack capacity or need support to recognise their care needs and
5   engage with providers.

6 1.5.15 Consider making outreach teams multidisciplinary to enable them to meet
7   the range of needs of people experiencing homelessness.

8 1.5.16 Use outreach to identify health problems earlier, promote health and
9   support engagement with care. For example, supporting access to
10   national screening programmes, testing for long-term conditions and
11   infectious diseases, and providing preventive health opportunities such as
12   vaccination, drug and alcohol recovery services, harm minimisation,
13   smoking cessation and nutrition advice.

14 1.5.17 Offer assertive outreach that is proactive, persistent and collaborative, to
15   start and maintain engagement with health and social care for people
16   experiencing homelessness with coexisting severe mental health and
17   problem substance use. See also the section on maintaining contact with
18   services in NICE's guideline on coexisting severe mental illness and
19   substance misuse.

20 1.5.18 Consider assertive outreach for all people experiencing homelessness
21   who could benefit from support but who are disengaging with services.

> For a short explanation of why the committee made these recommendations and
> how they might affect practice, see the rationale and impact section on outreach
> services.
>
> Full details of the evidence and the committee's discussion are in evidence review
> A & B: effectiveness of approaches to improve access to and engagement with
> health and social care and joined up approaches and evidence review C: views
> and experiences of health and social care for people experiencing homelessness.

1 **1.6   Assessing people's needs**

2 1.6.1   Be aware that health and social care professionals have a statutory and

3   professional duty to identify immediate risk of harm to self or others. See

4   also, the [section on assessment and treatment under the Mental Health

5   Act in NICE's guideline on service user experience in adult mental health].

6 1.6.2   Assess the health and social care needs of the person experiencing

7   homelessness, taking into account the person's capacity, [safeguarding]

8   needs and rights to autonomy and self-determination. Include:

9   • a comprehensive assessment of physical and mental health, including

10   acute and long-term conditions, and social care needs

11   • understanding the historical context of their situation, including past

12   psychological trauma and experience of services.

13 1.6.3   In assessments to inform a health and social care plan for people who

14   might benefit from high levels of support, use a multidisciplinary approach

15   to enable a comprehensive and holistic assessment of their needs,

16   involving:

17   • the person, and their advocate if one is nominated or appointed

18   • input from professionals with specialist expertise who have detailed

19   knowledge of the person's health and social care needs.

20 1.6.4   Use hospital admissions, planned or unplanned, as an opportunity to

21   assess people's needs in a comprehensive and holistic way.

22 1.6.5   Recognise the important role that peers and advocates can have in

23   helping people to access and engage with the assessment process.

24 1.6.6   Use the multidisciplinary assessment to inform the local authority-led care

25   and support needs assessment, under the [Care Act 2014] (see the [section

26   on care and support needs assessment and care planning in NICE's

27   guideline on people's experience in adult social care services]).

1 1.6.7 Review the person's needs, strengths and aspirations whenever their
2 circumstances change or whenever they request a review, rather than
3 using standard review periods.

> For a short explanation of why the committee made these recommendations and
> how they might affect practice, see the rationale and impact section on assessing
> people's needs.
>
> Full details of the evidence and the committee's discussion are in evidence review
> C: views and experiences of health and social care for people experiencing
> homelessness.

4 ## 1.7   Intermediate care

5 1.7.1 Provide intermediate care services with intensive, time-limited
6 multidisciplinary team support for people experiencing homelessness who
7 have healthcare needs that cannot be safely managed in the community
8 but who do not need inpatient hospital care. These may be for people who
9 are:

10 • discharged from hospital (step-down care)
11 • referred from the community who are at acute risk of deterioration and
12 hospitalisation (step-up care).
13
14 See also NICE's guideline on intermediate care including reablement.

> For a short explanation of why the committee made this recommendation and how
> it might affect practice, see the rationale and impact section on intermediate care.
>
> Full details of the evidence and the committee's discussion are in evidence review
> A & B: effectiveness of approaches to improve access to and engagement with
> health and social care and joined up approaches.

1 **1.8** **Transitions between different settings**

2 1.8.1 Homelessness multidisciplinary teams or leads should support people
3 experiencing homelessness through transitions between settings (such as
4 the street, hostels, Housing First and other supported housing, hospital,
5 mental health services, social care, residential and community drug
6 treatment, and custody) and consider providing time-limited intensive
7 support, which includes:

8 • having a key practitioner coordinating care
9 • building a relationship of trust
10 • providing links to services in the community
11 • gradual lowering of intensity of support, as appropriate.

12 1.8.2 Practitioners in any setting supporting people experiencing homelessness
13 should:

14 • ensure that all handovers of care responsibilities are planned and
15 coordinated, and relevant information is shared if agreed
16 • offer pre-emptive, structured support before, during and after transitions
17 • recognise that people may be vulnerable during periods of transition,
18 but also that there may be opportunities for intervention.

19 1.8.3 Hospital discharge teams should have procedures for reviewing any
20 potential self-discharge or discharge to the street.

21 1.8.4 Follow the recommendations in NICE's guidelines on:

22 • [transition between inpatient mental health settings and community or
23 care home settings](#)
24 • [transition between inpatient hospital settings and community or care
25 home settings for adults with social care needs](#)
26 • [transition from children's to adults' services for young people using
27 health or social care services](#).

> For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section for transitions between different settings.
>
> Full details of the evidence and the committee's discussion are in evidence review A & B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches and evidence review C: views and experiences of health and social care for people experiencing homelessness.

1.9 Housing with health and social care support

These recommendations are for commissioners and service providers working together across health, social care and housing services.

1.9.1 Recognise that providing suitable accommodation that matches the person's assessed health and social care needs (see the section on assessing people's needs) can support access to and engagement with health and social care services and long-term recovery and stability.

1.9.2 Provide wraparound health and social care support that is flexible to the person's changing needs and circumstances and helps them stay in their accommodation.

1.9.3 Recognise the need for a range of accommodation types that are suitable for the varied needs of people experiencing homelessness, such as self-contained accommodation and accommodation with specialist onsite support for people who are particularly vulnerable or who might otherwise benefit from higher levels of support.

1.9.4 Be aware that moving to independent accommodation in the community with tenancy responsibilities can be an extremely challenging, stressful and isolating experience for some people. Provide emotional and practical support for as long as it is needed.

1.9.5 When a person experiencing homelessness moves into new accommodation, help them to assess the risks associated with their new

1 living arrangement, while also recognising their strengths, and plan ways
2 to mitigate the risks.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on housing with health and social care support.

Full details of the evidence and the committee's discussion are in evidence review A & B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches and evidence review C: views and experiences of health and social care for people experiencing homelessness.

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3 **1.10   Safeguarding**

4 1.10.1   Designate a person to lead on safeguarding the welfare of people
5   experiencing homelessness, including engagement and face-to-face
6   practical safeguarding support.

7 1.10.2   If a social worker is embedded in the homelessness multidisciplinary
8   team, local authorities should consider appointing that person to lead on
9   safeguarding enquiries about people experiencing homelessness.

10 1.10.3   Local authorities should consider having a safeguarding lead on the
11   Safeguarding Adults Board for people experiencing homelessness.

12 1.10.4   Safeguarding Adults Boards should include specific objectives about
13   safeguarding people experiencing homelessness as part of their strategic
14   plan.

15 1.10.5   Safeguarding Adults Boards should cover issues relevant to safeguarding
16   people experiencing homelessness as part of their annual report.

17 1.10.6   Safeguarding Adults Boards should share recommendations and key
18   learning from Safeguarding Adults Reviews that cover homelessness with
19   key stakeholders.

1 1.10.7 Safeguarding Adults Boards should establish ways of analysing and
2 interrogating data on safeguarding notifications about people experiencing
3 homelessness so that they can check that local safeguarding
4 arrangements protect these people.

5 1.10.8 Commissioners and service providers should support health and social
6 care staff to understand and apply laws relevant to people experiencing
7 homelessness and who are in need of safeguarding.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on safeguarding.

Full details of the evidence and the committee's discussion are in evidence review A & B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches.

8 **1.11   Long-term support**

9 1.11.1 For people who struggle to engage with services, plan long-term
10 engagement to help meet the person's needs at their own pace.

11 1.11.2 Give priority to building a relationship of trust, for example by:

12 • taking time with the person, particularly at the beginning of the
13 relationship
14 • being prepared to meet in an informal setting, such as a park or café
15 (with appropriate lone worker policies in place)
16 • having regular contact
17 • ensuring consistency of practitioner, so that they meet with 1 person or
18 a small team
19 • meeting immediate expressed needs to encourage long-term
20 engagement.

21 1.11.3 Recognise that people experiencing homelessness do not always follow a
22 linear recovery journey and that apparent progress may hide risks.

1 1.11.4 Consider providing 'open-door' services that people can self-refer to and
2 access after any initial support ends, to reduce the risk of becoming
3 homeless again because of unmet health, care and support needs.

> For a short explanation of why the committee made these recommendations and
> how they might affect practice, see the rationale and impact section on long-term
> support.
>
> Full details of the evidence and the committee's discussion are in evidence review
> A & B: effectiveness of approaches to improve access to and engagement with
> health and social care and joined up approaches and evidence review C: views
> and experiences of health and social care for people experiencing homelessness.

4 ## 1.12 Staff support and development

5 1.12.1 Consider providing training for all health and social care practitioners, at a
6 level suitable for their professional role, on:

7 • understanding the health and social care needs of people experiencing
8 homelessness, and their rights to access services
9 • homelessness as part of equality and diversity training, including the
10 impact of discrimination and stigma and of intersectional, overlapping
11 identities
12 • trauma-informed care
13 • legal duties and powers
14 • legal entitlements for migrants.

15 1.12.2 Healthcare professionals working within secondary care mental health
16 services should follow the recommendations in the section on
17 competence in NICE's guideline on coexisting severe mental illness
18 (psychosis) and substance misuse.

19 1.12.3 Consider regular and ongoing support, professional supervision and
20 reflective practice for staff working with people experiencing
21 homelessness.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on staff support and development.

Full details of the evidence and the committee's discussion are in evidence review A & B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches and evidence review C: views and experiences of health and social care for people experiencing homelessness.

1 Terms used in this guideline

2 This section defines terms that have been used in a particular way for this guideline.
3 For other definitions see the NICE glossary and the Think Local, Act Personal Care
4 and Support Jargon Buster.

5 Assertive outreach

6 A proactive and persistent approach to outreach that involves repeated contact with
7 people who are initially unwilling to engage.

8 Care navigation

9 Helping people navigate the complex health and social care systems to overcome
10 barriers in accessing services. This could be done by case workers, other
11 practitioners or peers supporting the person, or by designated care navigators in a
12 local authority.

13 Complex needs

14 Persistent, problematic and interrelated health and social care needs that affect a
15 person's life and may include repeat homelessness; mental, psychological and
16 physical health needs; drug and alcohol recovery needs; and criminal justice
17 involvement. People with complex needs may have underlying adverse childhood
18 experiences or experiences of trauma. They may have had sporadic and
19 inconsistent contact with services or been serially excluded from services.

1 **Low-threshold services**

2 Services which avoid restrictive eligibility criteria and make minimal demands on the

3 client by offering support and care without trying to influence their habits.

4 **Mainstream services**

5 Services designed to be delivered to the general population.

6 **Multidisciplinary team**

7 In the context of this guideline, a multidisciplinary team involves a range of

8 professionals across disciplines as well as agencies working together to assess and

9 support the needs of a person experiencing homelessness.

10 **Outreach**

11 Bringing health and care services to people who might not otherwise have access to

12 or engage with existing services, provided in a mobile way in the locations where

13 people are, for example on the street, in temporary accommodation facilities and in

14 day centres. This can be done by mainstream services or dedicated outreach teams.

15 **People experiencing homelessness**

16 In the context of this guideline, people experiencing homelessness is defined as

17 people aged 16 and over who:

18 • are sleeping rough (people without homes who sleep outside or somewhere not

19   designed for habitation)

20 • are temporary residents of hostel accommodation (such as emergency night

21   shelters, short-stay hostels, longer-stay hostels, domestic violence safehouses,

22   safehouses for victims of modern slavery, and probation hostels)

23 • are in unsupported temporary accommodation (such as B&Bs)

24 • use day centres that provide support (such as food, showers, clothing and advice)

25   for people experiencing homelessness

26 • are staying temporarily with family and friends ('sofa surfing')

27 • are squatting.

1 It also includes people with a history of homelessness (as defined above) who are at

2 high risk of becoming homeless again because of ongoing complex health and social

3 care needs.

4 **Psychologically informed environment**

5 A model developed within homelessness services in the UK. Service provision and

6 practice that takes into account individuals' psychological and emotional needs, and

7 their experiences of trauma. It includes building organisational awareness of

8 psychological and emotional needs; staff training and ongoing support; service

9 evaluation and learning; and reflective practice. It focuses on safety and healthy

10 working relationships. For more information see the Good practice guide on

11 psychologically informed services for homeless people (Pathway, CQC, College of

12 Medicine, Homeless Healthcare CIC, Department of Communities and Local

13 Government, 2012). See also trauma-informed care.

14 **Recovery-oriented language**

15 Language that is person-centred, respectful, non-judgmental and strengths based. It

16 conveys a sense of hope and commitment to the potential of every person and their

17 recovery journey. It includes non-verbal aspects of communication and aims for

18 consistency between verbal language and body language.

19 **Reflective practice**

20 A process for staff to:

21 • reflect on previous practice

22 • talk about why they made the decisions they made, and why they acted or

23   behaved in particular ways

24 • talk about their emotional responses to their actions and the actions of others

25 • engage in continuous learning.

26 Reflective practice may also provide insight into personal values and beliefs, and

27 help staff understand how these influence action and decision making.

Safeguarding

The collective responsibility and process to protect the health, wellbeing and human rights of people at risk, enabling them to live safely, free from harm, abuse and neglect. See also the [Think Local, Act Personal Care and Support Jargon Buster definition for safeguarding](#).

Safeguarding Adults Board

A statutory multi-agency group set up by a local authority made up of different professionals from a local authority, NHS and police to prevent abuse or neglect of adults who have care and support needs, and to make sure that action is taken if abuse occurs. See also the [Think Local, Act Personal Care and Support Jargon Buster definition for Safeguarding Adults Board.](#)

Safeguarding Adults Review

A statutory multi-agency learning process arranged by a Safeguarding Adults Board that reviews cases if:

- there is reasonable cause for concern that partner agencies could have worked more effectively to protect an adult **and**
- serious abuse or neglect is known or suspected **and**
- certain conditions are met, in line with [section 44 of the Care Act 2014](#) and related statutory guidance.

Strengths-based approaches

Sometimes called assets-based approaches. These involve the person who uses services and the practitioners who support them working together to achieve the person's intended outcomes, in a way that draws on the person's strengths. The quality of the relationship between those providing support and those being supported is particularly important, as are the skills and experience that the person using support brings to the process (see [Social Care Institute for Excellence's Care Act guidance on strengths-based approaches](#)). See also [NICE's quick guide on evidence for strengths and asset-based outcomes](#).

Trauma-informed care

An approach to providing services that involves understanding, recognising, and responding to the effects of all types of trauma. It emphasises physical, relational, and emotional safety for both service users and providers, and helps survivors of trauma to rebuild narratives of connection, control and empowerment. See also [psychologically informed environment](#).

Wraparound health and social care support

A multidisciplinary team-based collaborative approach to support the person experiencing homelessness holistically, taking into consideration their individual needs, including physical and mental health needs, drug and alcohol recovery needs, care and social needs, and practical needs, in addition to their housing needs.

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Psychologically informed environments

What is the effectiveness and acceptability of clinical-psychology-led psychologically informed environments and psychological approaches for people experiencing homelessness?

> For a short explanation of why the committee made this recommendation for research, see the [rationale section on general principles](#). Full details of the evidence and the committee's discussion are in [evidence review A & B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#).

2 Health and social care to support housing

What structural and systems factors help or hinder commissioning and delivery of wraparound health and social care that is integrated with housing, for people experiencing homelessness?

> For a short explanation of why the committee made this recommendation for research, see the [rationale section on housing with health and social care support](). Full details of the evidence and the committee's discussion are in [evidence review C: views and experiences of health and social care for people experiencing homelessness]().

3 Longer health and social care contacts

What is the effectiveness and cost effectiveness of longer health and social care contacts compared with usual care for people experiencing homelessness?

> For a short explanation of why the committee made this recommendation for research, see the [rationale section on planning and commissioning](). Full details of the evidence and the committee's discussion are in [evidence review A & B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches]().

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice or services.

General principles

[Recommendations 1.1.1 to 1.1.7]()

Why the committee made the recommendations

There was qualitative evidence that people experiencing homelessness feel that the care they are offered is less or lower quality than for the general population. Although the committee agreed that there were some limitations to the evidence, their experience corresponded with this. The evidence also highlighted various barriers to accessing care. Considering the multiple disadvantages and disproportionately poor outcomes observed in this population, the committee agreed that more effort and targeted approaches are often needed to level up outcomes.

1   Good qualitative evidence showed that that people experiencing homelessness want

2   to give feedback on processes and their care, but ways to do this were not always

3   available. Based on their experience, the committee agreed that people often do not

4   feel able to do this because of their experience of stigma and discrimination.

5   However, involving people with lived experience of homelessness in service design

6   is likely to improve services and people's engagement with services. Involving

7   people in service design was also highlighted in the NICE guideline on people's

8   experience in adult social care services which references the Local Government and

9   Public Involvement in Health Act 2007. The 2007 Act mandates local authorities to

10 provide opportunities for people who use services to be involved in strategic decision

11 making about services. NICE's guideline on community engagement also gives

12 guidance on community engagement approaches for local authorities and health

13 bodies.

14 The committee's experience as well as both qualitative and effectiveness evidence

15 on using peers in health and social care shows that using peers to deliver services

16 can also be beneficial for the person experiencing homelessness. The committee

17 agreed that there are likely benefits for the peers themselves and for the service.

18 Good qualitative evidence highlighted that many people experiencing homelessness

19 encounter or perceive stigma, discrimination and lack of understanding from health

20 and social care practitioners. There was also limited evidence showing that many

21 service providers are not aware of the impact that traumatic experiences can have

22 on a person's life and how it can manifest in their behaviour.

23 From their experience, the committee agreed that psychological trauma is common

24 among most people experiencing homelessness, and is particularly prevalent among

25 certain groups, such as women and young people. They also heard from experts

26 who highlighted the importance of 'professional curiosity' in understanding the

27 person's backstory and the use of trauma-informed practices. They agreed to

28 highlight the importance of using approaches that take into account the impact of

29 trauma and consider the person's past experiences as well as their current situation.

1 There was a lack of evidence on psychologically informed environments and
2 psychological approaches to care so the committee developed a research
3 recommendation (see research recommendation 1).

4 Good qualitative evidence showed that many people experiencing homelessness
5 reported feelings of apprehension, fear and distrust when receiving care. Some
6 people reported a lack of trust in service providers or in the healthcare system,
7 mostly because of previous negative experiences. They felt judged, stereotyped and
8 disrespected in healthcare settings, leading to unwillingness to engage with care.

9 There was good qualitative evidence highlighting that people reported positive
10 experiences with care providers and increased engagement with services when they
11 were able to develop a trusting relationship with a provider who paid attention,
12 showed sincere interest and had time available for them. The importance of a
13 genuine, friendly relationship in which the professional listens, remembers, uses
14 humour and shows concern helps to build a trusting relationship, which in turn
15 enables the person to feel safe in the health or social care environment. The
16 committee agreed that this was key to promoting engagement. However, many
17 people reported experiencing discrimination and feelings of apprehension, fear and
18 distrust, leading to reluctance to engage with care. There was also good qualitative
19 evidence that people experiencing homelessness value culturally sensitive and non-
20 judgmental communication from professionals, and the evidence emphasised the
21 importance of staff understanding the impact that trauma may have.

22 Good qualitative evidence showed that people experiencing homelessness valued
23 continuity of care and spoke positively about practitioners with whom they had
24 formed trusting relationships. The evidence also emphasised respect as an essential
25 component in sustaining trusting relationships. The committee's experience aligned
26 with the evidence, and they emphasised that consistency and continuity of care
27 throughout a person's journey can lead to improved engagement and better
28 outcomes.

29 The qualitative evidence also showed that the length of appointments or contacts in
30 current practice is often inadequate to meet the complex needs of many people
31 experiencing homelessness. Despite some limitations in the evidence, the committee

1 agreed with this and discussed how longer appointment times can give an

2 opportunity to better assess, engage and build trust with people who may otherwise

3 rarely have contact with services, and who are marginalised and have

4 disproportionately worse outcomes. Good qualitative evidence and information from

5 experts emphasised that giving people agency – involving them and promoting

6 shared decision making – helps to improve engagement in care. High-quality

7 evidence from qualitative studies highlighted that focusing on the person's strengths

8 and assets encouraged people experiencing homelessness to use services.

9 Good evidence from qualitative studies showed that people experiencing

10 homelessness often experience lack of consistency and continuity from health and

11 social care services which can lead to disengagement. The evidence also showed

12 that ongoing, sustained support and a service provider's patience and continued

13 attempts to re-engage can improve the person's engagement when they might

14 otherwise be resistant to support. The committee were aware that the Safeguarding

15 Adults Reviews highlighted the prominence of 'self-neglect' in homeless people. The

16 committee discussed how many people experiencing homelessness may find it

17 difficult to look after their health and personal care because of their environment and

18 circumstances. This can present as disengagement with health and social care and

19 emphasises the importance of actively supporting re-engagement with services.

20 **How the recommendations might affect practice or services**

21 The recommendations outline principles of good practice that in the committee's view

22 should be happening across all services for people experiencing homelessness.

23 However, practice is variable and this may represent a change in practice for some

24 services. Most recommendations would not lead to a significant resource impact, but

25 may involve staff training and longer contact times. Any additional costs are likely to

26 be offset by the benefits of improved engagement with care, for example, by

27 accessing care before a crisis and reducing the burden on emergency services.

28 Economic analysis also suggested that reducing caseloads (and thus increasing time

29 spent with clients) for practitioners working with people experiencing homelessness

30 could be cost effective.

31 <u>Return to recommendations</u>

1 Communication and information

2 [Recommendations 1.1.8 to 1.1.12](#)

3 Why the committee made the recommendations

4 There was good qualitative evidence that people experiencing homelessness often
5 experience stigma and discrimination and feel oppressed and unwelcome. Good
6 evidence also reported that insensitive communication and closed body language
7 are common experiences for them. Service users reported preferring simple
8 language and explanations, instead of jargon, because it gives a sense of comfort
9 and is more accessible.

10 The committee agreed with the evidence and discussed the merits of non-
11 judgmental, [recovery-oriented language](#). They agreed that the way in which
12 practitioners communicate can have an impact on people's recovery journey, their
13 willingness to engage with services, their sense of hope and their potential for
14 recovery. The committee discussed the importance of using sensitive language that
15 does not lead to the person feeling blamed for their issues (for example, avoiding
16 phrases like substance 'abuse' or 'failed' to attend).

17 There was limited qualitative evidence on people's preferred communication
18 methods, which reported that receiving appointment information by letter was
19 ineffective for people without a reliable address. The committee discussed that
20 letters are still the main method of communication for many service providers. Good
21 qualitative evidence also showed that people without access to the internet and
22 those without a phone have difficulties accessing healthcare (digital exclusion). The
23 evidence corresponded with the committee's experience, recognising that various
24 methods based on the person's preferences should be available to improve timely
25 contact and access to services.

26 The committee discussed that resources and forms are often written in a complex
27 way and mostly available only in English. They agreed that this is a further barrier for
28 people whose first language is not English. Good qualitative evidence also
29 suggested that low literacy levels among some people experiencing homelessness
30 can add to difficulties in accessing care. The committee agreed that this could
31 include some migrants and people with learning difficulties or acquired brain injury.

1 They therefore emphasised the need to tailor communication and information

2 provision to the person's needs.

3 Good qualitative evidence showed that the presence of an advocate (including a

4 peer advocate) helps people experiencing homelessness to gain confidence and a

5 sense of control over their health and care needs. The committee had confidence in

6 the evidence and agreed, based on their experience, that advocates (including peer

7 advocates) can play a significant role in supporting people with correspondence and

8 attending appointments and in bridging the gap between practitioners and people

9 experiencing homelessness. The committee were also aware that NICE is

10 developing a guideline on advocacy services for adults with health and social care

11 needs (publication expected July 2022).

12 The committee noted that the advocate could be someone who the person is familiar

13 with, such as a family member or a friend. But they were also aware that the Care

14 Act 2014 mandates that local authorities must appoint an independent advocate to

15 support and represent a person to assist in their involvement (for example in a local-

16 authority-led care and support needs assessment or safeguarding enquiry) if the

17 person has substantial difficulty in being involved in the process, and if they do not

18 have an appropriate person to support them.

19 Moderate quality evidence from qualitative studies showed that people experiencing

20 homelessness felt that there was a lack of help or information about services

21 available to them (such as overall entitlement to care, oral health, maternity services,

22 screening and infectious diseases). This corresponded with the committee's

23 experience, and they agreed that to improve engagement with health and social care

24 services it is important to give people information, support access, and make sure

25 that they know their rights to health and social care. They considered this particularly

26 relevant for migrant populations who may not be familiar with the local health and

27 social care system and their entitlements, or who may not have recourse to public

28 funds.

29 **How the recommendations might affect practice and services**

30 These recommendations reinforce existing NICE guidelines on communication and

31 information provision for the general population. However, there are some aspects

1 that may need particular attention when working with people experiencing

2 homelessness. There may be a need for some extra staff training on communication,

3 and on the available health and social care services and support for people

4 experiencing homelessness, including legal entitlements for care.

5 Giving everyone – including staff – the right information about what services are

6 available will help relationship and trust building, and may lead to better access and

7 engagement with services. For example, people may be more likely to access

8 primary care services or specialist services directly instead of relying on emergency

9 services. This can lead to problems being picked up and dealt with earlier, reducing

10 morbidity and mortality and associated costs such as crisis care, unplanned or

11 emergency care.

12 Services already use various communication methods to support access to and

13 engagement with services. But tailoring the method to each person's preferences

14 and needs may need some reorganisation of current practice.

15 Advocate roles could be carried out by a professional or a peer supporter, or

16 sometimes a family member or a friend. There are various advocacy models aimed

17 at facilitating the relationship with service providers, and supporting people to access

18 information and services or attend appointments. Any additional costs could be offset

19 by the beneficial effect on the person's recovery including potential reductions in

20 morbidity and mortality. For example, there is a link between non-attendance at

21 appointments and increased morbidity and mortality in people experiencing

22 homelessness.

23 [Return to recommendations](#)

Planning and commissioning

25 [Recommendations 1.2.1 to 1.2.9](#)

Why the committee made the recommendations

27 The [rough sleeping strategy by the Ministry of Housing, Communities & Local](#)

28 [Government](#) highlights the need for agencies to work together to end rough sleeping

29 and prevent homelessness. Cooperation and integrated working between agencies

1 and partners are also mandated in legal frameworks including the [Care Act 2014](#) and

2 the [National Health Service Act 2006](#).

3 Based on their experience, the committee discussed that integrated working among

4 commissioners across different sectors is essential to bring all the knowledge and

5 services together to ensure that there is a strategy and funding for coordinated and

6 holistic support for people experiencing homelessness. Joined-up working is also

7 likely to improve long-term outcomes; improve people's experience of services;

8 minimise duplication of work and make services more efficient; improve

9 understanding of the needs of the homeless population in the local area; and

10 improve practitioners' work by making it easier to collaborate with colleagues.

11 People experiencing homelessness are to varying degrees disadvantaged and

12 marginalised, and their outcomes are considerably worse than the general

13 population, including having disproportionate rates of premature mortality. The

14 committee discussed the concept of 'proportionate universalism', introduced in

15 [Marmot et al. (2010) Fair Society Healthy Lives (The Marmot Review)](#), meaning that

16 resourcing and delivering of services are done universally but at a scale and intensity

17 proportionate to the level of need or disadvantage. The committee agreed that more

18 resources and targeted approaches are justified to address the inequalities facing

19 this population.

20 The committee agreed that to plan and commission adequate services to meet the

21 needs of the homeless population in a local area, a comprehensive homelessness

22 health and care needs assessment is needed. This assessment will help understand

23 the scale and nature of homelessness, and how existing services could be

24 developed and integrated to better meet the needs of the people experiencing

25 homelessness. The committee agreed that it should involve service users and

26 experts by experience to fully understand the needs, experiences, circumstances

27 and service use of people experiencing homelessness. The committee also agreed

28 that to improve services and to prevent abuse, neglect and death, service planning

29 and design should be informed by Safeguarding Adults Reviews. They heard from

30 an expert who also highlighted this.

1   The committee discussed, based on their experience, that data on the needs and

2   service use of people experiencing homelessness can come from homelessness

3   status in the person's records if this is accurately recorded. Public Health England's

4   Homelessness: applying All Our Health advises frontline health and care

5   professionals to ask about and record people's housing circumstances. The

6   committee recognised that recording this information can create fear of

7   stigmatisation in people experiencing homelessness. But they agreed that this was

8   outweighed by the benefits of accurate data that can be used to improve services

9   and ensure that there are adequate resources.

10 Many people experiencing homelessness have multiple intersecting issues or high

11 support needs, such as physical and mental health issues, drug and alcohol

12 recovery needs and social care needs. High-quality evidence from qualitative studies

13 highlighted the importance of joint working to address these complex needs. The

14 evidence suggested that many services work in silos with minimal coordination and

15 cooperation between agencies. People felt that their issues were often dealt with

16 individually by different providers rather than holistically addressing all of their

17 intersecting needs. The committee heard from experts about adult social care and

18 safeguarding, who similarly highlighted the need for joint commissioning and

19 integrated working across agencies and professions.

20 The committee agreed, based on their experience and expertise, that commissioners

21 working across larger areas and across sectors could help services collaborate to

22 meet strategic aims, cover varying and intersecting needs, share resources, and

23 enable economies of scale. This could be at the level of integrated care systems or

24 place-based systems, with collaboration across an area's health and care partners in

25 different sectors.

26 The committee also agreed on the importance of enabling long-term, consistent

27 support regardless of contract lengths so that people experiencing homelessness

28 who may need high levels of support, including long-term medical care, can progress

29 in their recovery journey. They agreed that long-term contracts can provide stability

30 and can support the improvement and extent of services as long as there is flexibility

31 to adapt to changing local needs.

1 The committee heard from expert witnesses about the importance of supporting

2 service providers and practitioners to exercise their legal duties and powers when

3 working with people experiencing homelessness. The committee agreed that the

4 current systems do not always support public bodies and practitioners to do this, for

5 example the duty to refer based on the [Homelessness Reduction Act 2017](#).

6 The committee also agreed that commissioners should define and measure

7 outcomes related to homelessness, including health and social care outcomes and

8 service use, to inform local and national homelessness assessments and help

9 improve and design relevant policies and services.

10 Effectiveness evidence showed that peers (experts by experience) can be a useful

11 and cost-effective way of supporting people experiencing homelessness and

12 delivering services. Based on their knowledge and experience, the committee also

13 agreed that peers are valuable in co-designing services. Involving peers can improve

14 people's engagement with services, leading to better outcomes; improve the quality

15 of services; and reduce pressure on practitioners, as well as having benefits to the

16 peers themselves.

17 The committee agreed that the particular needs of specific population groups need to

18 be considered. For example, women may have different needs and vulnerabilities

19 compared with men, and young people compared with older people. People with no

20 recourse to public funds have particular disadvantages and risks for poor outcomes

21 because of barriers to accessing care and support. Specialised support for the

22 particular needs of LGBT+ people or people with a particular family background or

23 from a particular faith group may be helpful in reaching people and providing

24 appropriate support. The committee discussed how the causes of homelessness are

25 complex. Some people may experience homelessness as a result of disparities in

26 access to or appropriateness of services because of a certain characteristic they

27 have. People may face particular challenges because of their characteristics, such

28 as their age, gender, family background or being a migrant, including different

29 intersections of these which may multiply inequalities.

30 Qualitative evidence of mixed quality from many different studies highlighted various

31 barriers to accessing health and social care, such as transport costs and services

1 being too far away, siloed or in multiple locations. The committee agreed that it is

2 important for commissioners to consider ways to remove barriers to local services to

3 improve access and engagement among people experiencing homelessness.

4 There was good qualitative evidence that people experiencing homelessness faced

5 challenges registering for GP services and were sometimes refused registration if

6 they did not have an address or ID. Being denied access to GP services can further

7 alienate, cause distrust and prevent already marginalised people from engaging with

8 services. The evidence also corroborated the committee's experience that when

9 people are refused access to GP services, they turn to emergency care services.

10 The NHS Primary medical care policy and guidance manual outlines that everyone in

11 England can register with a primary care provider free of charge. This includes

12 people experiencing homelessness, people without a stable address, asylum

13 seekers and refugees. The committee agreed that commissioners and planners

14 need to ensure that there are processes in place to support GP registration, and

15 document, challenge and redress refusals. There is also NHS England guidance on

16 improving GP registration among socially excluded groups.

17 Reducing caseloads for practitioners working with people experiencing

18 homelessness would allow them to spend longer with each client. Longer contact

19 time is likely to improve engagement with services, help build a trusted relationship

20 and ultimately lead to improved outcomes and sustained recovery. There would also

21 be likely benefits from improved staff satisfaction and retention, and continuity of

22 care. The committee made research recommendation 3 to better understand the

23 effectiveness and cost effectiveness of longer health and social care contacts for

24 people experiencing homelessness.

25 **How the recommendations might affect practice or services**

26 Although there are legal requirements to collaborate under the Care Act 2014 and

27 the National Health Service Act 2006, health and social care services have different

28 legislative and commissioning frameworks and the committee discussed that

29 collaboration is sometimes challenging and the level of integration varies.

1   Services working in silos can increase the risk of undiagnosed or misdiagnosed

2   conditions across the mental, physical and disability spectrum, cause morbidity and

3   mortality and result in substantial costs to services. Commissioners and planners will

4   need to ensure that frameworks are in place to support integrated multidisciplinary

5   health and social care services where this is not already happening. For example, by

6   facilitating coordinated multi-agency and multidisciplinary working, and strengthening

7   information sharing and communication systems.

8   Improving integrated service provision should lead to improved outcomes, more

9   appropriate use of services, and a lower need for emergency care and hospital

10   admissions, reducing associated costs. Services will need targeted efforts to improve

11   outcomes and to meet the needs of people experiencing homelessness, and

12   commissioners will need to plan for more funding per person than in a general

13   universal service. But this should lead to savings down the line.

14   Health needs assessments are already widely done by public health teams within

15   local authorities, but there is some variation in the extent to which service users and

16   experts by experience are involved. When done thoroughly and with all the relevant

17   information, including relevant findings from Safeguarding Adults Reviews, it can

18   inform targeted and efficient provision (for example, specialist service provision) and

19   identify opportunities for more integrated services. This will also ensure that services

20   meet local needs, and improve access and engagement. This will reduce morbidity

21   and mortality, and reduce public sector costs associated with homelessness.

22   Most services have ways to record data on people experiencing homelessness for

23   audit purposes. This would not be a new practice, although some services might not

24   be doing it or have processes flexible enough to record it in a meaningful way.

25   Services could improve this in various low-cost ways.

26   Compared with current practice, commissioners may need to look across a larger

27   footprint to develop services. This approach will also enable them to account for

28   mobility and people experiencing homelessness not being tied to a specific place.

29   This may mean commissioning groups coming together to form partnerships.

30   Involving peers in delivering care or support and co-designing services is already

31   happening in some areas and organisations, particularly in the voluntary and charity

1   sector. It will involve costs in terms of training and support for peers and potential

2   incentives or remunerations; however, involving peers can reduce pressure on

3   practitioners and therefore result in cost savings. There was evidence that it can be

4   cost effective.

5   Access and engagement with services may not be straightforward in this population,

6   so commissioners will need to ensure multiple ways of enhancing access to care.

7   There are examples of good practice across the country, but practice is variable.

8   Services will have to consider approaches that can be tailored to the specific needs

9   of the people. Currently, because of the lack of flexible services, people often end up

10   in crisis and use expensive emergency services, or do not access services, resulting

11   in disproportionately complex morbidity and premature mortality.

12   GP registration refusals are relatively common in current practice and

13   commissioners and planners will need to reinforce NHS guidance and support GP

14   practices to ensure that people experiencing homelessness can access GP services.

15   Finally, economic analysis carried out for the guideline suggested that reducing

16   caseloads for practitioners who work with people experiencing homelessness could

17   be cost effective.

18   Lower caseloads will mean that services will have to recruit more staff, which might

19   be challenging in some areas. However, availability of trained staff should not be a

20   barrier; for example, services may find it easier to recruit staff to junior roles and

21   provide on-the-job training.

22   [Return to recommendations]

23   Models of multidisciplinary service provision

24   [Recommendations 1.3.1 to 1.3.7]

25   Why the committee made the recommendations

26   The committee discussed that people experiencing homelessness often have

27   overlapping and intersecting care needs, which need the expertise and skills of

28   different professionals to assess, plan and manage care jointly. They may also have

29   needs and challenges that are not typical to the general population so the committee

1 recognised the value of practitioners with specialist knowledge on homelessness

2 issues.

3 Good qualitative evidence from various studies described health and care systems

4 as siloed, complex and fragmented, with little coordination between agencies and

5 providers. There was also evidence from qualitative studies that people experiencing

6 homelessness want more individualised care that meets their needs, and hope to

7 develop trusting relationships with service providers.

8 There was limited effectiveness evidence available on multidisciplinary team

9 approaches to health and social care support for people experiencing homelessness.

10 There was evidence on the Housing First approach, which involves intense case

11 management or assertive community treatment by a multidisciplinary team for

12 people with moderate to severe mental health problems experiencing homelessness.

13 This showed a positive impact on housing status and tenancy sustainment. There

14 was also some economic evidence showing that having multidisciplinary

15 homelessness teams in hospitals resulted in some cost savings. Furthermore, the

16 committee heard from experts who emphasised the importance of integrated and

17 collaborative working, and a multidisciplinary approach with clear roles and

18 responsibilities and effective communication and information sharing.

19 Based on the evidence and their own experience, the committee agreed that the

20 best way to provide health and social care to people experiencing homelessness

21 would be through specialist homelessness multidisciplinary teams. A combination of

22 expertise from a variety of disciplines and agencies would enable holistic and

23 individualised care based on the person's needs. The committee discussed that a

24 successful joined-up care approach providing holistic wraparound support based on

25 individual needs would integrate service providers from a range of health and social

26 care settings.

27 The committee discussed that multidisciplinary teams can provide person-centred,

28 tailored support with continuity of care, and help build trusted relationships with

29 service providers that could improve engagement with services and long-term

30 outcomes. Multidisciplinary teams can coordinate care based on the person's needs

31 by providing care themselves or signposting to other services. Having a dedicated

1   team with specialist knowledge can help streamline support and make it more

2   efficient, avoid duplication of work and inappropriate referrals, and improve staff

3   motivation. The committee were confident that there would be benefits for the person

4   being supported, the team members and services in general.

5   The committee also discussed that the specialist multidisciplinary teams could bring

6   value and expertise in working with other 'inclusion health' groups (groups of people

7   who are traditionally socially excluded) who may be at risk of homelessness and

8   whose needs often overlap considerably with people experiencing homelessness.

9   The committee discussed the various experts who could form the multidisciplinary

10 team. The qualitative evidence highlighted that people experiencing homelessness

11 value support from peers who have similar experiences and can be role models in

12 their recovery journey. Some qualitative evidence also reported the benefits of

13 involving people with lived experience of homelessness in shaping and providing

14 care. The committee agreed that experts by experience can bring an important

15 service-user point of view to a multidisciplinary team to help better meet the needs of

16 people experiencing homelessness. The committee discussed that other members of

17 the multidisciplinary team could be an array of different professionals spanning

18 different agencies and disciplines, including healthcare, social work, housing, and

19 the voluntary and charity sector. They discussed that voluntary and charity

20 organisation staff often have the closest relationships to the client. The committee

21 were aware that the characteristics of people experiencing homelessness vary

22 across different areas and agreed that it is important to use the local needs

23 assessment to tailor the composition of the team to local needs.

24 The committee discussed that working with people experiencing homelessness can

25 be challenging and can have a psychological impact on those providing care. They

26 agreed that homelessness multidisciplinary teams should be given time, in a

27 protected space, to reflect on their practice and experiences to promote continuous

28 learning and professional wellbeing.

29 Homelessness multidisciplinary teams have a comprehensive understanding of the

30 needs and service use of people experiencing homelessness, so the committee

31 agreed that these teams make a crucial contribution to assessing local needs,

1 improving quality of services, and reviewing complex cases including Safeguarding

2 Adults Reviews.

3 The committee also recognised that specialist homelessness multidisciplinary teams

4 would not be feasible in areas where levels of homelessness are low. For example,

5 in some areas services might encounter one person experiencing homelessness per

6 month. In areas where forming a homelessness multidisciplinary team is not justified,

7 the committee agreed that existing practitioners could act as homelessness leads in

8 mainstream services, for example, in general practice, A&E departments, hospitals,

9 drug and alcohol recovery services, mental health services, palliative care services,

10 sexual assault referral centres, maternity care, disability services and adult and child

11 social services. The homelessness leads would champion, coordinate, advise and

12 collaborate with colleagues and professionals within and across services to enable

13 appropriate provision of care and support for people experiencing homelessness.

14 Partnering with homelessness multidisciplinary teams in nearby areas for advice

15 could further improve care and support for people experiencing homelessness in

16 these areas.

17 **How the recommendations might affect practices or services**

18 Models of service provision vary in current practice. In some areas with high rates of

19 homelessness, there are no specialist homelessness multidisciplinary teams, or

20 services are often focused on one aspect or are mainly medically led; for example,

21 mental health teams, drug and alcohol recovery services, community-based or

22 hospital-based multidisciplinary teams, or housing-related multidisciplinary teams.

23 Many multidisciplinary teams do not cover the wide range of support that is needed.

24 Services will need to involve practitioners from across the agencies to make sure

25 that the team has relevant expertise.

26 Recommendations on multidisciplinary teams may mean a change in service

27 configuration. However, there may not be a need to employ new staff but to

28 reorganise, collaborate with other agencies and form a team from existing

29 professionals. Forming a multidisciplinary team may entail pulling together a team

30 from different services working with the person or having a permanent integrated

31 multidisciplinary team under single management within a service (that is, a

1 coexisting co-located team). Having coexisting co-located teams would represent a
2 more substantial change.

3 In areas with low rates of homelessness, having designated leads on homelessness
4 may be a change in practice but it is unlikely to have a significant resource impact
5 because these are not expected to be entirely new job roles. These arrangements
6 will be different across the country, and will depend on the demand and the level of
7 need.

8 There is also economic evidence that homelessness multidisciplinary teams
9 represent value for money and are potentially cost saving. Having specialist
10 multidisciplinary teams or designated leads should mean better integration and
11 efficiency of services, more streamlined and individualised care and improved
12 engagement with care and support, which in turn should lead to reduced morbidity
13 and mortality, and associated costs. There will likely be a reduction in wider public
14 sector costs, including local authority homelessness services and the criminal justice
15 system costs, because people will be more likely to progress in their recovery
16 journey and maintain their accommodation. Such a service model can also mean
17 better management of resources, for example a reduction in inappropriate referrals,
18 inappropriate use of hospital beds, and duplication.

19 [Return to recommendations]

20 **The role of peers**

21 [Recommendations 1.4.1 to 1.4.4]

22 **Why the committee made the recommendations**

23 The was some effectiveness evidence that suggested that peer support to navigate
24 hepatitis C screening and services might help people to engage with services, and
25 this was found to be cost effective. Other effectiveness studies also suggested that
26 peers could increase uptake of tuberculosis screening and hepatitis vaccination as
27 much as professional staff did. Although there were some concerns about the quality
28 of the evidence on peer approaches, the committee were confident, based on their
29 experience, that involving peers in delivering care or support and co-designing
30 services is efficient and beneficial, not only for the services and the people

1 experiencing homelessness but also for the peers themselves. They also heard from

2 expert witnesses who highlighted the value of involving people with lived experience

3 in the development of policies, procedures and protocols.

4 The qualitative evidence also highlighted that people experiencing homelessness

5 value support from peers who have similar experiences and have recovered and

6 grown from that experience. The committee highlighted their experience and

7 knowledge of the beneficial impact of being a peer, describing how peers can

8 progress to become professionals if supported.

9 Based on the evidence and their expertise, the committee agreed to list ways in

10 which peers may be able to support people experiencing homelessness and how

11 peers can improve services. Peers can take up different roles in terms of intensity,

12 responsibility and tasks, and may gradually progress in these roles. The committee

13 emphasised that it is important to support peers with training, supervision and

14 governance structures, including confidentiality and data protection.

15 Qualitative evidence highlighted the obstacles and challenges that peers might

16 encounter, including supporting someone with similar issues to their own while trying

17 to maintain their own recovery. The committee agreed that peers should be

18 supported to continue their own recovery journey and development by encouraging

19 them to progress to become professionally employed, which is beneficial in many

20 ways for the person acting as peer support, the people they are supporting, and

21 services.

22 The committee also discussed that it is important to consider how to match the peers

23 with people they support. For example, some people may prefer or request peer

24 support from someone with the same cultural or language background, but

25 sometimes this may be a reason for a person to refuse peer support because of the

26 risk of stigma or confidentiality breech.

27 **How the recommendations might affect practice or services**

28 There are existing peer networks, for example, for people recovering from problem

29 drug or alcohol use. There are also peers working with people experiencing

30 homelessness in some areas and in some organisations, in the voluntary and charity

1   sector in particular. But the committee agreed that there is the potential to involve

2   more experts by experience in service design and delivery. Peer support has the

3   potential to improve access to and engagement with services, and reduce morbidity

4   and mortality, and associated public sector homelessness costs. There may also be

5   important benefits to peers themselves, leading to better long-term outcomes.

6   Peers could be recruited through homelessness services or in collaboration with

7   voluntary and charity sector organisations. Services will also need to provide support

8   and training for peers as well as some kind of incentive or remuneration. Involving

9   peers can reduce pressure on practitioners and can result in cost savings.

10   [Return to recommendations]

11   **Supporting access to and engagement with services**

12   [Recommendations 1.5.1 to 1.5.12]

13   **Why the committee made the recommendations**

14   People experiencing homelessness are often unable to access health and social

15   care because of barriers at systemic, local and individual levels. Various themes

16   from mixed qualitative evidence highlighted examples, such as strict eligibility

17   criteria, rigidity of appointment systems, limited opening times, short appointments,

18   long waiting lists, siloed services in multiple locations, cost of transport and

19   experiences of stigma and discrimination. The committee also drew on their own

20   expertise on these barriers to access.

21   The committee agreed that an outreach model, in which the services go to the

22   people instead of expecting people to come to them, is a helpful established

23   approach to reaching people who do not access services. There is limited

24   effectiveness evidence on outreach models. A London-based outreach service to

25   screen vulnerable people for hepatitis C and offer peer support to link to treatment in

26   secondary care was shown to be cost effective. Moderate quality evidence from

27   qualitative studies suggested various benefits of outreach services, including

28   increased access to immediate care and increased knowledge of health issues,

29   available services, and healthcare entitlements. The evidence also highlighted that

30   outreach services can be more flexible than traditional healthcare services and that

1 bringing services to people builds a feeling of trust and connection with service

2 providers while reducing the sense of isolation. The committee considered outreach

3 services important to identify people who might otherwise be missed. They had

4 confidence in the evidence and agreed that it corresponded with their experience.

5 There was good but limited effectiveness evidence that community drop-in services

6 are helpful in reaching people and are preferred by service users. There was also

7 good qualitative evidence that services are often complex, fragmented and difficult to

8 navigate. The committee agreed that providing information and support to navigate

9 care and services can improve people's access to and engagement with health and

10 social care. Based on their knowledge and experience, the committee suggested

11 approaches that could improve access and engagement. For example, low-threshold

12 services that avoid restrictive eligibility criteria and make minimal demands on the

13 client by offering support and care without trying to influence their habits; and

14 providing food, vouchers, transport support, internet access or other practical help

15 can incentivise and enable people to engage with care.

16 The rigidity of appointment systems can lead to people being dropped from services

17 if they miss appointments. There was some limited qualitative evidence illustrating

18 the difficulties people experiencing homelessness face when they miss

19 appointments. Some services have policies that prevent people accessing care at

20 that service again. Some have financial penalties for missing appointments. Based

21 on the committee's experience, this is a major problem for many people experiencing

22 homelessness and they agreed that services should show flexibility and

23 understanding to facilitate engagement. The committee discussed the clear

24 association between missed appointments and premature death and agreed that

25 providing more flexible appointment systems and alternative ways of accessing care

26 is therefore essential in improving outcomes.

27 Good qualitative evidence also highlighted that some people are unaware of the free

28 or low-cost services available to them, particularly dental care, if relevant paperwork

29 has been processed. The committee discussed their experience that often these

30 forms that enable free access to essential services such as eye care, prescription

31 costs and dental care (such as HC1 and HC2) are not readily available, or are only

1 available electronically. The forms can be challenging to fill in and only available in

2 English.

3 High-quality evidence from qualitative studies highlighted that strict eligibility criteria

4 to access healthcare services sometimes forced people into crisis situations before

5 help could be provided, or excluded them from accessing services altogether. Based

6 on the committee's expertise, this is particularly prevalent among people with

7 coexisting mental health problems and problem substance use, which are common

8 among people experiencing homelessness. Some services, particularly social care,

9 may have minimum age criteria that can stop people getting the support they need.

10 Premature aging and frailty, defined by the British Geriatrics Society and the Royal

11 College of General Practitioners as 'a distinctive health state related to the ageing

12 process in which multiple body systems gradually lose their in-built reserves', are

13 common among people experiencing homelessness with multiple and complex

14 needs, so care and support should be based on assessed need, not biological age.

15 Flexibility in the eligibility criteria could prevent the situation from escalating and help

16 people to receive support earlier, leading to better outcomes.

17 The committee considered digital exclusion to be a major barrier to accessing health

18 and social care. Qualitative evidence showed that people without access to the

19 internet and those without a phone experienced difficulties in accessing healthcare.

20 The NHS Primary medical care policy and guidance manual states that everyone in

21 England can register with a primary care provider free of charge. This includes

22 people experiencing homelessness, people without a stable address, asylum

23 seekers and refugees. However, according to good qualitative evidence and the

24 committee's experience, many people experiencing homelessness are still refused

25 registration with a GP. Resources are available from the NHS on improving GP

26 registration among socially excluded groups.

27 The committee were keen to highlight the legal duties of public sector workers as

28 mandated by the Homelessness Reduction Act 2017. In particular, the duty to refer

29 anyone who is identified as being homeless or at risk of homelessness to the local

30 authority. They discussed that despite the legal requirement, this does not always

31 happen in current practice because processes are not in place to do this, and

1 frontline staff lack time and knowledge. An expert also highlighted the need for

2 health and social services to improve legal knowledge among their staff. Guidance

3 on duty to refer from the Ministry of Housing, Communities & Local Government

4 gives an overview of the legal duty. The Ministry of Housing, Communities & Local

5 Government's Homelessness code of guidance advises local authorities on how they

6 should exercise their homelessness functions in accordance with the Homelessness

7 Reduction Act 2017. The committee discussed that every encounter with a person

8 experiencing homelessness could be an opportunity for engagement with care and

9 support. Approaches such as Making Every Contact Count and Making Every Adult

10 Matter could be used to facilitate this and help frontline staff better understand the

11 services available for onward referral.

12 The qualitative evidence highlighted that long waiting times are a barrier to

13 accessing and engaging with health and social care, affecting people experiencing

14 homelessness in particular. The committee agreed that people experiencing

15 homelessness are a priority because of their complex needs and increased risk of

16 premature mortality and morbidity. They discussed that long waiting times can be

17 particularly challenging for people experiencing homelessness and it can mean that

18 the opportunity to engage with them is missed altogether. People may move

19 between areas or have trouble remembering the appointment time. They also

20 discussed that people experiencing homelessness may have particular difficulty

21 coping psychologically with long waiting times because of the fundamental feeling of

22 unsafety and exclusion that homelessness causes. Long waiting times could lead to

23 further deterioration of physical and mental health, and could compound feelings of

24 disengagement and exclusion.

25 **How the recommendations might affect practice or services**

26 Currently practice is variable. For services that do not have multiple points of access

27 to care, or flexible services, these recommendations will represent a change in

28 practice. Services will need a variety of approaches that can be tailored to specific

29 needs. Currently, because of the lack of flexible services, people are using

30 expensive emergency services or are not accessing services at all, resulting in

31 excess morbidity and mortality, and associated high public sector homelessness

32 costs. For example, inflexible appointment systems increase the risk of missing

1 appointments, and there is a link between missed appointments and premature

2 mortality. Missed appointments also cost the NHS millions of pounds a year; for

3 example, missed GP appointments in the general population cost [NHS England

4 around £216 million] a year in addition to the disruption for staff and other patients.

5 Transport costs are a considerable barrier to access to and engagement with

6 services, and continuity of care. Practice is variable between different areas. People

7 experiencing homelessness often have multiple morbidities, which could make them

8 eligible for a free travel pass, but often do not have one because of bureaucratic

9 challenges. Currently, a clinician (usually a doctor) needs to sign the paperwork for a

10 free travel pass. Services could broaden the list of professionals able to approve

11 applications, which could make free travel easier to access. The cost of providing

12 free travel will be relatively low compared with the cost of missed appointments and

13 the costs relating to unaddressed needs. For example, an annual bus pass in

14 London costs approximately £900 ([Transport for London bus and tram fares]), but if a

15 person with a leg ulcer misses multiple appointments then this may lead to an

16 infection and in some cases amputation costing the NHS at least £8,000 ([NHS

17 England National cost collection for the NHS]), in addition to the impact on the

18 person. Services will need to work collaboratively to agree who will cover travel costs

19 within their local system.

20 Some mental health or drug and alcohol recovery services will need to modify their

21 eligibility criteria. This may lead to more people accessing services. But there may

22 also be savings from avoiding crisis situations and unplanned care and providing

23 more efficient support, leading to better long-term outcomes.

24 More practitioner time may be needed to help people with forms and other

25 paperwork. But this can help prevent deterioration and the need for more expensive

26 care, for example, emergency care, in the future.

27 In recent years there has been an increase in the use of digital approaches to

28 providing support within the homelessness sector. To avoid this leading to digital

29 exclusion, some services may need to improve access to online health and social

30 care information and support. There may be some costs associated with this, but

1 providing access to digital services and information can improve engagement with

2 services and avoid the need for costly emergency care.

3 A significant barrier to accessing health and care services for people experiencing

4 homelessness is that GP practices ask for an address when registering.

5 Recommendations on this reinforce NHS guidance and should result in more people

6 registering with a GP and accessing services that they are eligible for and entitled to.

7 This has the potential for substantial reductions in morbidity and mortality, and public

8 sector costs associated with homelessness.

9 There is variation in the extent to which frontline staff are aware of their legal duties

10 under the Homelessness Reduction Act 2017, including the duty to refer. Services

11 may need to support their staff in legal literacy and to have the skills and knowledge

12 to identify and support people experiencing homelessness. Training could be

13 delivered in low-cost ways, such as remotely, using pre-recorded sessions, and

14 could coincide with existing training. Both governmental and voluntary organisations

15 have produced materials that are readily available online. The cost for this is

16 therefore not expected to be significant and it could lead to better and more efficient

17 care. Timely and appropriate care can avert the need for expensive crisis care and

18 A&E visits, and reduce other public sector costs associated with homelessness.

19 Long waiting times for appointments in current practice are a significant barrier for

20 engagement and timely care. Situations can quickly deteriorate, or the person might

21 disengage because their needs are not being met. Shorter waiting times for people

22 experiencing homelessness may prevent the situation from escalating to a point of

23 crisis, lowering the chance of needing expensive emergency services, and prevent

24 complex morbidity and premature death.

25 Return to recommendations

26 **Outreach services**

27 Recommendations 1.5.13 to 1.5.18

1 **Why the committee made the recommendations**

2 Qualitative evidence highlighted that people experiencing homelessness often face

3 barriers to accessing services through standard routes, and are often disengaged

4 with health and social care. Outreach is an established way to bring services to

5 people who may otherwise find it hard to reach them. There is limited effectiveness

6 evidence on outreach models, although evidence on a London-based outreach

7 service to screen vulnerable people for hepatitis C and offer peer support for getting

8 treatment in secondary care was shown to be cost effective.

9 There was good qualitative evidence suggesting that outreach services can increase

10 access to immediate care and increase knowledge of health issues, available

11 services, and healthcare entitlements. The evidence also highlighted that outreach

12 services can be more flexible than traditional healthcare services and that bringing

13 services to people builds a feeling of trust and connection with service providers

14 while reducing the sense of isolation. The committee considered outreach services

15 important to identify people who might otherwise be missed.

16 Because of the range of needs that people experiencing homelessness have, the

17 committee agreed that it would be useful if outreach teams were multidisciplinary.

18 Good qualitative evidence showed that some people who are resistant to support or

19 who feel overwhelmed by it might feel more motivated if ongoing support is available,

20 including repeated attempts to engage with the person without placing pressure on

21 them. The committee agreed, based on their knowledge and experience, that an

22 'assertive outreach' approach is useful in improving engagement for those who may

23 be reluctant to engage with services and who would benefit from a high level of

24 support. 'Assertive outreach' is most often used for people with complex mental

25 health needs with problem substance use. This is in line with the recommendations

26 about maintaining contact with services in the NICE guideline on coexisting severe

27 mental illness and substance misuse. The committee agreed that this approach

28 could also be considered for other people experiencing homelessness who are likely

29 to benefit from health and social care but who are disengaged, for example, because

30 of lack of trust or previous negative experiences.

How the recommendations might affect practice or services

Outreach is used in current practice in many areas to deliver a range of services, including primary care, mental health, opiate prescribing, and testing for chronic or infectious diseases such as hepatitis and tuberculosis, although the services provided through outreach vary depending on location. Outreach can happen in multiple settings, such as streets, parks, hostels, day centres, or soup kitchens. Services generally understand its value in enabling access and engagement with health and social care, but commissioning of outreach services for people experiencing homelessness varies.

Additional resources may be needed to set up outreach in areas where it is not happening already. However, it has great potential to support this population, and improve engagement with services and long-term outcomes. It can also bring savings, for example by avoiding missed appointments and visits to the A&E department.

Assertive outreach is used in some areas in current practice, particularly when engaging with people with complex mental health needs. It takes more practitioner time and may be more expensive, but persevering with people and improving engagement among people who would benefit from support is likely to substantially improve the health and wellbeing of people who have been marginalised, and reduce morbidity and mortality and associated public sector homelessness costs.

[Return to recommendations](#)

Assessing people's needs

[Recommendations 1.6.1 to 1.6.7](#)

Why the committee made the recommendations

There was no evidence on the effectiveness of different approaches to improving access to services through needs assessments, so the committee used their knowledge and experience to make the recommendations.

The committee were keen to emphasise the statutory and professional duty that health and social care professionals have to identify immediate risk of harm to self or

1 others, in line with the [Care Act 2014](#) and the [Mental Health Act 1983](#) and

2 professional codes such as the [Nursing and Midwifery Council Code](#), [General](#)

3 [Medical Council's Good medical practice](#) and [Social Work England's Professional](#)

4 [standards](#). The committee were aware of case reviews and Safeguarding Adults

5 Reviews on people experiencing homelessness showing that this risk had been

6 missed, leading to death. This is particularly relevant in the context of homelessness

7 because there is a significant link between homelessness and risk of abuse, neglect

8 and violence, serious mental health problems, self-harm and self-neglect,

9 underpinning the disproportionate rate of premature mortality in this population.

10 The committee agreed that a comprehensive, holistic needs assessment improves

11 access to health and social care and support that matches the person's needs. They

12 agreed that a multidisciplinary approach is needed to ensure that the full range of

13 health and social care needs are identified, including considering risk and

14 safeguarding issues. Collaborative working also reduces unnecessary duplication

15 and improves communication between professionals working in different services.

16 The committee were aware that hospital admissions related to homelessness have

17 been increasing. They agreed, based on their knowledge and experience, that

18 hospital admissions are an opportunity for a comprehensive and holistic assessment

19 of a person's needs to enable appropriate personalised care planning that integrates

20 health, social care and housing needs. A hospital stay can be an opportunity to start

21 addressing the often complex and underlying issues that have led people to their

22 situation.

23 The committee were concerned that assessment is commonly perceived by people

24 experiencing homelessness as a process of exclusion. People often have to keep

25 repeating their stories and the assessments can turn into an assessment of eligibility

26 for support rather than a person-centred attempt to understand a person's needs and

27 circumstances. The committee agreed that involving the person in their own

28 assessment process and recognising the contribution of a peer or an advocate could

29 help improve the assessment process. Peers and advocates (who may be peer

30 advocates) can play an important role in bridging the gap between the person

31 experiencing homelessness and professionals. They can make the assessment

1 process feel less formal and therefore more acceptable or accessible to people

2 experiencing homelessness.

3 The committee agreed that a comprehensive understanding of the person's physical,

4 mental and social care needs as well as the underlying circumstances of their

5 situation will help when conducting the statutory care and support needs assessment

6 under the Care Act 2014, which sets out local authorities' duties to assess people's

7 needs and their eligibility for publicly funded care and support.

8 The committee noted that [NICE's guideline on people's experience in adult social

9 care services](#) provides advice on conducting the care and support needs

10 assessment under the Care Act.

11 The committee were also aware that the Care Act 2014 mandates that local

12 authorities must appoint an independent advocate to support and represent a person

13 in the local-authority-led care and support needs assessment or safeguarding

14 enquiry if the person has substantial difficulty in being involved in the process, and if

15 they do not have an appropriate person to support them.

16 The committee pointed out that after the person's needs are established and support

17 planned to meet these needs, many people experience difficulties with ongoing

18 support. Because the needs assessment process can be emotionally and otherwise

19 challenging, the committee agreed that the person's support needs should be

20 reviewed as needed, when their situation changes or if they request it, but not based

21 on standard review periods.

22 **How the recommendations might affect practice or services**

23 Identifying immediate risk of harm to self or others reinforces a statutory and

24 professional duty, and does not represent a change in practice.

25 A comprehensive assessment of health and social care and support needs involves

26 a multidisciplinary approach, can be time-consuming and needs collaboration

27 between professionals from different agencies. This should be happening across all

28 services. However, practice is variable and these recommendations may represent a

29 change in practice and result in a resource impact for some services.

1   Hospital admissions are good opportunities to provide a comprehensive and holistic

2   assessment of safeguarding, physical and mental health, drug and alcohol recovery

3   needs, and social care needs for people experiencing homelessness. This often

4   doesn't happen in current practice and the committee thought that this was a missed

5   opportunity to assess the person's comprehensive needs and start integrated care.

6   The recommendations in this area may mean that services will need to plan for more

7   tests, procedures and practitioner time. This could prolong a hospital stay, although

8   discharge to the community would likely be safer and future admissions could be

9   avoided. Such a proactive approach could have benefits in the long term, such as

10 preventing people from getting into crisis because of unidentified needs, and

11 reducing morbidity and mortality and associated homelessness costs.

12 As a result of the recommendations, more people experiencing homelessness who

13 may benefit from high levels of support may have an assessment of social care

14 needs and go on to engage with services. But an appropriate assessment of the

15 health and social care needs of some of the most marginalised people in society will

16 ensure timely and appropriate care and support for them, with a potential for reduced

17 morbidity and mortality and associated public sector costs.

18 Return to recommendations

19 **Intermediate care**

20 Recommendation 1.7.1

21 **Why the committee made the recommendation**

22 Intermediate care is a multidisciplinary service that helps people to be as

23 independent as possible and provides support and rehabilitation to people at risk of

24 hospital admission or who have been in hospital. Evidence from several economic

25 studies suggested that it is cost effective and potentially cost saving. The committee

26 agreed that providing such services would help avoid hospital admissions and

27 ensure safe and timely discharge from hospital and transition to the community.

28 Intermediate care can also prevent or shorten expensive inpatient care and provide

29 appropriate care and support to people in need of more intense support than

30 otherwise provided in the community.

1 **How the recommendations might affect practice**

2 Intermediate care, including step-down and step-up care, would represent a change

3 in practice because this service is currently rare for people experiencing

4 homelessness. This would need some funding but there is evidence that

5 intermediate care represents value for money. Furthermore, considering the

6 immense human and societal costs of homelessness, providing care that can

7 support recovery and prevent repeat homelessness is likely to be beneficial to

8 society overall. Intermediate care does not necessarily need a facility of its own but

9 can be delivered in the community, such as in temporary accommodation or hostels.

10 [Return to recommendation](#)

11 **Transitions between different settings**

12 [Recommendations 1.8.1 to 1.8.4](#)

13 **Why the committee made the recommendations**

14 The committee discussed that people experiencing homelessness can be vulnerable

15 during transition periods. However, testimony by expert witnesses also highlighted

16 that these can also be opportunities for engagement and intervention. The

17 committee agreed that transition periods can be a chance to build foundations for

18 lasting support in the community.

19 The committee noted that a phased, focused and person-centred approach to

20 support is currently unusual. Often the person is discharged or moves between

21 services, settings or areas without thorough planning, follow up or coordination. For

22 example, sometimes the person's homeless status and related needs are identified

23 only at the point of discharge from hospital into the community. Identifying needs and

24 collaboration between professionals and agencies is therefore essential.

25 Effectiveness evidence comparing 'critical time intervention' (time-limited intensive

26 support during a transition period) with usual care among people experiencing

27 homelessness, including discharge from psychiatric inpatient care and moving from

28 a homeless shelter to the community, showed benefits in terms of mental health

29 service use, housing status and reduced psychiatric re-hospitalisation, although no

30 difference in quality of life was reported. Despite some methodological limitations

1 and mixed results in the evidence, the committee agreed that the general approach

2 and key principles of critical time intervention should form the basis of

3 recommendations on support for key transitions. This is because any transition

4 between settings can be challenging, with a risk of falling through the gaps, but with

5 appropriate support it can also be an opportunity for improved engagement and

6 recovery.

7 The 'critical time intervention' model includes establishing a trusting and enduring

8 relationship, and a gradual decrease in the intensity of support over a fixed period of

9 time. The time period in the studies was 9 months, but the committee agreed that the

10 length of time needed for intense support during transition would depend on the

11 circumstances and needs of the person. The committee agreed that, to make

12 successful transitions, it is fundamental to start support before the move and

13 continue it during and after transition. This needs an effective and coordinated

14 handover across teams and practitioners. Good qualitative evidence highlighted that

15 staff from all types of services recognised that most care is provided in silos with

16 minimal coordination between agencies and providers. The findings emphasised the

17 need for a more coordinated approach with appropriate information sharing. Good

18 quality evidence from qualitative studies also emphasised the importance of

19 information sharing between practitioners so that people do not have to repeatedly

20 give the same information. A trusting relationship is also more likely when support is

21 from a single person throughout, or a coordinated team, reducing the need to repeat

22 life stories and any associated trauma. Critical time interventions are seen as a

23 holistic approach to support. The committee wished to reflect this, emphasising the

24 need to link people with other services and the wider community, according to their

25 needs and preferences.

26 Irregular discharge (self-discharge against medical advice) represents a missed

27 opportunity for services to engage with a person experiencing homelessness and to

28 start integrated care. A common cause of self-discharge is when people

29 experiencing homelessness have a history of problem opioid use and do not have

30 access to the right dose of methadone according to their treatment plan in the

31 community, so they self-discharge to address their withdrawal symptoms.

1 For example, for some people with drug and alcohol recovery needs, a hospital
2 admission is an opportunity to detox. If people experiencing homelessness are
3 discharged back onto the streets without appropriate support after detox, they have
4 an increased risk of overdose and a risk that any care plans will fail. It is important
5 for hospital discharge teams to have procedures to review self-discharges and
6 discharges to the street so that risks can be reduced, and discharges are as safe as
7 possible.

8 The committee also highlighted other NICE guidelines that cover important transition
9 periods that may be applicable to people experiencing homelessness.

10 **How the recommendations might affect practice or services**

11 There is wide variation in the support provided during transition between settings.
12 The recommendations should increase sustained support and lead to a more
13 coordinated response to needs. This in turn could lead to reduced re-attendance
14 after leaving hospital or breakdown of tenancy, and reduced morbidity and mortality.

15 Procedures to review cases when a person experiencing homelessness has self-
16 discharged or has been discharged to the street may be a change in practice for
17 some hospitals. But, by learning from these situations and improving practice, there
18 would be an opportunity to prevent irregular discharge in the future and improve
19 outcomes for patients. Having a dedicated homelessness multidisciplinary team or
20 designated homelessness lead working with the discharge team can help strengthen
21 links to community services where people get methadone to ensure they continue to
22 receive the right dose in hospitals. Enhanced connections with social services and
23 local authorities will help link people experiencing homelessness to the right support.
24 This may need additional resources, but reductions in morbidity, mortality and
25 associated costs should offset additional costs in the long run. There was evidence
26 that effective hospital discharge represents value for money.

27 Return to recommendations

28 **Housing with health and social care support**

29 Recommendations 1.9.1 to 1.9.5

1 **Why the committee made the recommendations**

2 Access to suitable accommodation is a key determinant of health and social care

3 outcomes. The committee discussed, based on their knowledge and experience, that

4 there are various aspects of accommodation that can either hinder or help a person's

5 recovery process and their engagement with health and social care. This might

6 include practical and logistical considerations such as the distance to health or social

7 care services, accessibility, aids, and appropriate storage for medication.

8 There was good effectiveness evidence from the Housing First studies that people

9 are more likely to stay housed if their accommodation has wraparound support.

10 There was also evidence that this approach could be cost effective. The committee's

11 experience of health and social care services designed to support housing was

12 positive, and tenancy sustainment was commonly achieved through this wraparound

13 approach. The committee agreed, based on their knowledge and experience, that

14 the level of support depends on the person's needs, with some people needing

15 specialist onsite support. These could be people with high levels of need or complex

16 needs who are vulnerable to abuse and exploitation, young people who have no

17 experience of independent living, people who have experienced domestic abuse, or

18 people with particular care needs who need support in everyday life because of

19 premature aging, acquired brain injury or disability.

20 The committee discussed the lack of evidence on how to improve needs-based

21 wraparound support for people with complex needs and premature frailty, particularly

22 those who have experience of rough sleeping. The committee was particularly

23 interested in the structural and systems factors in health and social care that could

24 help or hinder commissioning and delivery of wraparound support integrated with

25 housing (see research recommendation 2).

26 Moving into independent accommodation may seem like a positive transition, but

27 based on the committee's experience this can be one of the most difficult times for

28 people who may have a history of traumatic experiences, have complex needs, feel

29 profoundly unsafe or have low self-confidence. Such a transition often causes the

30 person to reflect on what has happened to them, which can be triggering and cause

31 re-experiencing of trauma. It can lead to relapses in recovery, including problem drug

1 or alcohol use. Furthermore, people living in temporary accommodation or on the

2 streets can form bonds with their peers that provide mutual support and a sense of

3 belonging. This may be replaced by a feeling of isolation and loneliness when

4 moving into independent accommodation. Effectiveness evidence on 'critical time

5 interventions' showed that time-limited intense support, gradually lowered over time

6 during transition periods, did not sustain all benefits over time, so the committee

7 agreed that emotional and practical support should be provided for as long as is

8 needed in this situation.

9 The emotional challenges of independent living are also suggested in evidence from

10 the Housing First studies, which showed increased suicidal ideation and suggested a

11 possible increase in suicide attempts with the Housing First approach. The

12 committee agreed that an assessment of risks that could jeopardise the person's

13 recovery, alongside recognition of their strengths, can help recovery, inform

14 appropriate support needs and help people to stay in housing.

15 **How the recommendations might affect practice or services**

16 There is variation in current availability and provision of health and social care

17 support associated with housing. The recommendations aim to reduce variation in

18 practice.

19 The Housing First model has been used in England to some extent and there is

20 evidence that it represents value for money, but the associated wraparound support

21 is variable and sometimes lacking. To provide wraparound care and support, better

22 collaboration is needed between housing, health and social care services. Services

23 may need to reorganise existing resources, including improving communication

24 between agencies and services and allowing more practitioner time.

25 Local authorities should already have a range of housing options for differing support

26 needs, although in some areas accommodation with onsite support might be limited.

27 Additional costs of providing wraparound support with accommodation, according to

28 needs, are likely to be offset by improved health and social care engagement and

29 outcomes, sustained tenancy, reduced use of expensive emergency services and a

30 reduced return to homelessness and associated costs.

1 Risk assessment at the start of residency is a low-cost intervention that can

2 potentially mitigate significant harmful outcomes.

3 [Return to recommendations](#)

Safeguarding

5 [Recommendations 1.10.1 to 1.10.8](#)

Why the committee made the recommendations

7 No effectiveness evidence was identified on the role of adult social work, and

8 safeguarding in particular, in an integrated response to the needs of people

9 experiencing homelessness. The recommendations on safeguarding are based on

10 testimony by experts who were invited by the committee to speak about the role of

11 social work and adult safeguarding.

12 The experts highlighted the importance of understanding the person's backstory and

13 historical context that led to the current situation, recognising the link between

14 homelessness and self-neglect, the impact of trauma and how risk taking can be a

15 coping strategy. Because of the value of having a trusting relationship with the

16 person experiencing homelessness, the experts emphasised the importance of

17 having a single key person as a safeguarding lead in an integrated service model.

18 [Section 42 of the Care Act 2014](#) requires local authorities to make a safeguarding

19 enquiry if an adult with care and support needs is experiencing or at risk of abuse or

20 neglect. The committee agreed that a social worker within a homelessness

21 multidisciplinary team would often be the best placed to lead on these enquiries for

22 people experiencing homelessness because of their professional expertise on the

23 assessment and related legal duties and powers.

24 The experts suggested that safeguarding issues related to homeless populations

25 have historically not been widely considered by Safeguarding Adults Boards. The

26 committee agreed that having a homelessness lead in the Safeguarding Adults

27 Boards could enhance learning and improve practice. The committee also agreed

28 that Safeguarding Adults Boards have an important role in promoting understanding

29 and best practice within local agencies related to safeguarding people experiencing

1 homelessness, including through their statutory strategic plan and annual report and

2 learning from Safeguarding Adults Reviews. By analysing and interrogating

3 safeguarding notifications related to homelessness, the Safeguarding Adults Boards

4 can also enhance their understanding of the appropriateness of local safeguarding

5 arrangements.

6 Finally, the experts highlighted the need for health and social care staff to

7 understand the legal duties and powers related to safeguarding people experiencing

8 homelessness so that their welfare could be protected, concerns could be identified

9 and addressed early, and harm mitigated.

10 **How the recommendations might affect services or practice**

11 There are legal duties for safeguarding under the Care Act 2014 and the

12 recommendations in this area only highlight the existing safeguarding responsibilities

13 of service managers and local authorities. Teams involved in active safeguarding

14 cases should already have legal literacy around safeguarding relevant legislation

15 and the intersection of homelessness and multiple disadvantages, but may need

16 more training.

17 Currently, based on the committee's experience, people experiencing homelessness

18 often fall through the gaps, and safeguarding concerns are not identified and

19 safeguarding notifications are not made. There may be a resource impact for

20 services with practices that are sub-optimal and not aligned with legislation.

21 Safeguarding will ensure that appropriate support plans are in place to manage the

22 risks identified. For example, a person might be supported to move to more suitable

23 accommodation.

24 Return to recommendations

25 **Long-term support**

26 Recommendations 1.11.1 to 1.11.4

27 **Why the committee made the recommendations**

28 People experiencing homelessness often have complex issues that they need

29 support with, including intersecting physical and mental health needs, psychological

1 trauma, drug and alcohol recovery needs, and social care needs. The committee

2 agreed that sustained effort and commitment from services is needed to support

3 their recovery journey, which may often be non-linear.

4 Good quality evidence from qualitative studies showed that people experiencing

5 homelessness often experience a lack of consistency and continuity from health and

6 social care services. There was also good qualitative evidence that ongoing,

7 sustained support, and a service provider's patience and continued attempts to offer

8 support, can improve the person's engagement when they might otherwise be

9 resistant to support. Conversely, discontinuity or interruption of care could lead to

10 disengagement with services.

11 There was plenty of good quality evidence from qualitative studies emphasising the

12 importance of a trusting and respectful relationship between the person experiencing

13 homelessness and the person supporting them. The evidence showed that continuity

14 of care enabled people to form a relationship with their care provider. The committee

15 agreed, based on their experience, that a trusting relationship is rarely built through a

16 short-term contact but usually needs consistent and sustained contact from 1 main

17 lead or a small team of people who are part of integrated services across agencies.

18 Good qualitative evidence suggested that people experiencing homelessness often

19 prioritise their immediate needs over receiving care. The committee discussed that

20 addressing immediate needs can be an opportunity to build long-term engagement

21 with services.

22 From their knowledge and experience, the committee were aware that people

23 experiencing homelessness did not always follow a linear recovery journey and can

24 encounter a relapse or crisis. Therefore, the committee thought it was important that

25 services were flexible in allowing people to easily re-engage with services so that

26 their situation would not escalate or deteriorate further.

27 **How the recommendations might affect services**

28 The recovery journey for some people can take a long time, and services need to be

29 persistent, invest in building trust, and recognise that the process will often not be

30 linear. Currently, long-term continued support is quite rare, and funding of services is

1   often not aligned with such an approach. For example, tenancy sustainment teams

2   are often underfunded and only offer time-limited support of varying quality. Offering

3   long-term support could cost more because it may, for example, need lower

4   caseloads, although for many people the intensity and frequency of support will likely

5   lessen over time. But the value of investing in systems that facilitate longer-term

6   support and sustained care and engagement is likely to outweigh additional costs

7   through, for example, reduced homelessness and morbidity and mortality, and

8   associated public sector costs. Investing in longer-term support will likely help

9   prevent people from returning to homelessness and needing more acute support.

10   Services may need more capacity initially, but longer-term provision of timely help

11   can stabilise people and prevent a crisis, which will be more detrimental for the

12   person and more costly to services.

13   [Return to recommendations](#)

14   **Staff support and development**

15   [Recommendations 1.12.1 to 1.12.3](#)

16   **Why the committee made the recommendations**

17   Good qualitative evidence showed that healthcare professionals felt ill-equipped and

18   had insufficient knowledge of social determinants of health and homelessness, and

19   the associated health needs for complicated health problems such as addiction and

20   mental health problems. The evidence also showed that people experiencing

21   homelessness felt that service providers did not understand the practicalities of

22   being homeless and their specific needs. The committee discussed that further

23   training and support was needed to strengthen the capacity of health and care

24   providers to address people's complex and diverse needs.

25   The qualitative evidence also showed that training would raise awareness and

26   improve provider knowledge in this area, and improve sensitivity and understanding

27   for this population, so that care providers overcome preconceived ideas and

28   judgmental behaviour. Good qualitative evidence showed that most people

29   experiencing homelessness reported experience of discrimination on some level,

30   with a majority recounting some form of prejudiced behaviour from service providers.

31   The committee discussed that health and care providers should be trained to

1 consider people's preferences rather than making assumptions about their needs

2 and care solely based on their behaviour or appearance, for example. Furthermore,

3 the committee discussed the importance of practitioners understanding the

4 intersectionality of multiple disadvantages that people experiencing homelessness

5 may face because of their characteristics.

6 Limited evidence from qualitative studies among service providers also showed that

7 some lack awareness of the impact that trauma has on a young person's life and

8 how it may manifest in their behaviour. The evidence suggested that providers who

9 do not operate from a trauma-informed care approach may inadvertently serve as a

10 barrier.

11 Experts also highlighted the importance of health and social care professionals' legal

12 literacy and understanding of their duties and powers in relation to homelessness

13 and safeguarding.

14 The committee were aware that there is various existing training and materials that

15 organisations could use, such as [e-learning for healthcare resources on tackling

16 homelessness](#), free [online training modules by the Faculty for Homeless and

17 Inclusion Health](#) and [Public Health England's guidance on homelessness: applying

18 All Our Health](#).

19 Experts highlighted the importance of staff support and supervision, which enables

20 reflection on experiences and practices to enable continuous learning for staff and

21 development of both the staff and practices. The committee agreed that reflective

22 practice and supervision can increase staff motivation and wellbeing, quality of care

23 and services.

24 **How the recommendations might affect services**

25 Currently, there is variation in training opportunities for health and social care staff

26 who encounter people experiencing homelessness. Most statutory agencies

27 regularly train their staff, but training on some issues relevant to homelessness, such

28 as legal duties and powers, is not common practice for all services. This extra

29 training could be delivered alongside existing staff training programmes in a variety

30 of low-cost ways, for example by remotely using pre-recorded sessions, and could

1 coincide within existing training. Because of existing training and materials, there is

2 no expected significant resource impact.

3 Training to understand the needs of people experiencing homelessness may mean

4 that more people access specialist homelessness services. Training and ongoing

5 support will facilitate joined-up and more connected services, for example between

6 specialist services and mainstream services, and ensure a holistic approach and a

7 framework of support. Improved knowledge and understanding will improve access

8 and care for people experiencing homelessness. Practitioners will be better placed to

9 give information about available health and social care services, and enable services

10 to meet people's needs before their problems escalate. For example, most people

11 could be legally housed by local authorities and councils if more professionals had a

12 better understanding of homelessness law and guidance.

13 The recommendations encourage services to include these elements in their training

14 more consistently. They can also influence the development of professional

15 competencies for trainees and future practitioners.

16 Return to recommendations

17 Finding more information and committee details

18 To find NICE guidance on related topics, including guidance in development, see the

19 NICE webpage on patient and service user care.

20 For details of the guideline committee see the committee member list.

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