

NICE National Institute for
Health and Care Excellence

 **Centre for
Homelessness Impact**



Integrated health and social care for people experiencing homelessness

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

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Overview

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, and ensure care is coordinated across different services.

Who is it for?

- Local authorities
- Commissioners and providers of services
- Healthcare practitioners in primary, secondary and tertiary care
- Social care practitioners
- People who experience homelessness, their families, advocates, and the public

This guideline was developed by the National Guideline Alliance, which is hosted by the Royal College of Obstetricians and Gynaecologists (RCOG). The guideline was developed with complete independence from RCOG governance.

NICE worked with the Centre for Homelessness Impact on this guideline.

Context

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

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

- are sleeping rough
- are temporary residents of hostel, B&B, nightly-paid, privately managed accommodation and other types of temporary accommodation
- use day centres that provide support for people experiencing homelessness
- are obliged to stay temporarily with other people
- are squatting
- are newly homeless
- have a history of homelessness (as defined above), and are at high risk of becoming homeless again because of ongoing severe and multiple health and social care needs.

Underlying causes of homelessness include structural, societal and economic factors, and inequalities, such as poverty and deprivation, unaffordable housing, unemployment, exclusion and discrimination. People experiencing homelessness often experience severe and multiple disadvantage and unmet health and social care needs that may be contributing factors for becoming homeless as well as consequences of homelessness. Experience of psychological trauma and adverse childhood events are common in people experiencing homelessness, and the prevalence of people who are neuroatypical or have a brain injury is higher than in the general population. Homelessness and access to appropriate housing is a public health issue.

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

Statistics' Deaths of homeless people in England and Wales: 2019 registrations.

'Inclusion health' is a term developed to address the health and care needs of groups that are traditionally excluded, including people experiencing homelessness. The needs of the homeless population overlap considerably with other inclusion health groups.

Internationally, these groups have mortality rates that are 8 times higher than the general population for men and 12 times higher for women ([Aldridge et al. 2017](#)). Many of these premature deaths are from preventable and treatable conditions according to a 2019 study by the same authors ([Aldridge et al. 2019](#)). The Office for National Statistics' 2019 report showed that the causes of most deaths of people experiencing homelessness in England and Wales were registered as drug-related poisonings, suicides and alcohol-specific deaths.

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

In addition to a moral responsibility, there is an economic imperative to tackle homelessness. The costs of homelessness to society are significant. The report by [Pleace and Culhane \(2016\)](#), published by Crisis, estimated the total public sector costs of a person experiencing homelessness to be as much as £38,736 per year in England (based on 2019/20 prices). This estimate included the NHS costs (£4,298), mental health services (£2,099), drug and alcohol services (£1,320), criminal justice sector costs (£11,991) and homelessness services (£14,808). On average, it was estimated that preventing homelessness for 1 year would reduce the public expenditure by approximately £10,000 per person. In 2020/21, 11,580 single households were assessed as rough sleeping in England ([Ministry of Housing, Communities & Local Government, 2021](#)), and if these people were prevented from experiencing 1 year of homelessness, annual public spending would fall by as much as £115.8 million. If other forms of homelessness were included, these cost savings would be substantially higher. Given the financial implications of homelessness to society and the far worse health and social care outcomes, most interventions that address homelessness are likely to be cost effective or even cost saving from the wider public sector perspective.

The [Ministry of Housing, Communities & Local Government's rough sleeping strategy](#) outlines its commitment to ending rough sleeping and preventing homelessness. The [homelessness legislation](#) includes duties for local authorities to assess, prevent and relieve homelessness. The [NHS Long Term Plan](#) includes a commitment to improve access to specialist homelessness mental health support for people sleeping rough in areas with the highest rates of rough sleeping. During the COVID-19 pandemic, local authorities, health services, and the voluntary and charity sector have worked in partnership to respond to homelessness, including the 'Everyone In' initiative, recognising that rough sleeping and homelessness are public health issues. This has shown that with appropriate funding, integrated working and prioritisation of the most vulnerable in the society, there are opportunities for positive change.

This guideline provides guidance on models of service provision, for services that are specific to people experiencing homelessness, as well as improving access and engagement with [mainstream services](#). It aims to integrate services as much as possible as a way to improve outcomes for people experiencing homelessness and contribute to ending homelessness.

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 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.

Co-design and co-delivery of services

- 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](#).

Supporting engagement with services

- 1.1.3 Promote engagement by providing services that:
- are person-centred, empathetic, non-judgemental

- aim to address health inequalities
 - are inclusive and pay attention to the diverse experiences of people using the service.
- 1.1.4 Consider using psychologically informed environments and trauma-informed care. Recognise that people's behaviour and engagement with services is influenced by their traumatic experiences, socioeconomic circumstances and previous experiences of services.

Sustaining engagement with services

- 1.1.5 Recognise the importance of longer contact times in developing and sustaining trusting relationships between frontline health and social care staff and people experiencing homelessness (see also recommendation 1.2.9 in the section on planning and commissioning).
- 1.1.6 Promote shared decision making, building self-reliance and using strengths-based approaches to care (also known as assets-based approaches). See also NICE's guideline on shared decision making.
- 1.1.7 Recognise that people experiencing homelessness, especially those with experience of rough sleeping, need services that provide a long-term commitment to care to promote recovery, stability and lasting positive outcomes (see the section on long-term support).

Supporting re-engagement with services

- 1.1.8 Be aware that some people experiencing homelessness may find it difficult to look after themselves because of their circumstances and may find services difficult to engage with. For people who disengage from or refuse health and social care services:
- actively support re-engagement

- enable people to re-engage with services at the same point as they left, if appropriate.

For a short explanation of why the committee made these recommendations and how they might affect services, see the [rationale and impact section on general principles](#).

Full details of the evidence and the committee's discussion are in:

- [evidence reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#)
- [evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

Communication and information

1.1.9 Follow the recommendations on communication and information in NICE's guidelines on:

- [patient experience in adult NHS services](#)
- [people's experience in adult social care services](#)
- [service user experience in adult mental health](#)
- [babies, children and young people's experience of healthcare](#).

1.1.10 Health and social care staff working with people experiencing homelessness should:

- be empathetic, non-judgemental and use [recovery-oriented language](#) that avoids jargon and acronyms
- use communication methods based on the person's preferences, for example, phone call, text message, email, letter, face to face
- send clear information about contacts or appointments and reminders that

reach people in time, and follow up people who do not attend.

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

- provide translation and interpretation services if needed
- ensure that written information is available in different formats and languages, including Easy Read
- provide extra support for people with low literacy levels or with speech, language and communication difficulties
- consider the person's access to phone or internet.

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

- support people to overcome stigma and previous negative and traumatic experiences
- help people with low literacy levels to access information and services
- reinforce information about available services and appointments.

1.1.13 Give people experiencing homelessness information about:

- their rights to health and social care services, including for those with no or limited recourse to public funds
- how to access health and social care services, including:
 - primary care services and how to register with a GP without a permanent address
 - specialist health services that can be accessed directly, such as maternity, blood-borne virus, drug and alcohol recovery, mental health, sexual health, and family planning services
 - outreach services

- local authority services, including housing services and social care
- voluntary and charity sector services.

For a short explanation of why the committee made these recommendations and how they might affect services, 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](#).

1.2 Planning and commissioning

These recommendations are for commissioners of health and social care and housing services.

Planning integrated multidisciplinary health and social care services

- 1.2.1 Commissioners of health, social care and housing services should work together to plan and fund integrated multidisciplinary health and social care services for people experiencing homelessness, and involve commissioners from other sectors, such as criminal justice and domestic abuse, as needed. These services should contribute to the government's aim of ending rough sleeping and preventing homelessness.
- 1.2.2 Recognise that people experiencing homelessness often need additional resources and a more targeted service delivery to:
- ensure that resources are allocated according to need and disadvantage
 - take into account the [social determinants of health](#)
 - improve long-term outcomes and address [health inequalities](#).

Local homelessness health and social care needs assessment

- 1.2.3 Conduct and maintain an up-to-date local homelessness health and social care needs assessment and use this to design, plan and deliver services according to need. Include thorough engagement with service providers (including voluntary and charity sector service providers) and experts by experience.
- 1.2.4 Local homelessness health and social care needs assessments should:
- quantify and characterise the population experiencing homelessness or at risk of homelessness, including health inequalities, diversity and inclusion issues and specific needs 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.

Recording housing status

- 1.2.5 Work with health and social care providers to improve recording of housing status so that the information can be used by services to:
- best meet people's needs **and**
 - plan, audit and improve services.

Developing services

- 1.2.6 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

- work with other relevant services, such as prison and probation services and domestic abuse services
- 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 and type of local need (see the [section on models of multidisciplinary service provision](#))
- define and measure outcomes, including health and social outcomes and service use
- consider the likely benefits of using long-term contracts for providers
- support statutory bodies to fulfil their legal responsibilities and use their powers
- encourage and enable 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](#)).

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

- women (also see the [NICE guideline on pregnancy and complex social factors](#))
- young people
- older people
- disabled people
- people with no or limited recourse to public funds because of their immigration status
- LGBT+ people
- people from different minority ethnic or religious backgrounds.

- 1.2.8 Develop strategies across services to improve access to health and social care for people experiencing homelessness. See the [section on improving access to and engagement with health and social care](#).
- 1.2.9 Ensure that there are processes to:
- support people experiencing homelessness to register with a GP **and**
 - document and address any problems with GP registrations for people experiencing homelessness.
- 1.2.10 Consider reducing caseloads and lengthening contact time for health and social care practitioners working with people experiencing homelessness 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 services, see the [rationale and impact section on planning and commissioning](#).

Full details of the evidence and the committee's discussion are in:

- [evidence reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#)
- [evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

1.3 Models of multidisciplinary service provision

Homelessness multidisciplinary teams

- 1.3.1 Provide care through specialist [homelessness multidisciplinary teams](#) across sectors and levels of care, tailored according to local needs.
- 1.3.2 Homelessness multidisciplinary teams should act as expert teams, providing and

coordinating care across [outreach](#), primary, secondary and emergency care, social care and housing services. Homelessness multidisciplinary teams may include:

- experts by experience (see the [section on the role of peers](#))
- healthcare professionals with relevant specialist expertise (for example, drug and alcohol treatment, mental health, primary care, emergency care, palliative care)
- social workers
- housing options officers or homelessness prevention officers
- outreach and homelessness practitioners
- voluntary and charity sector professionals
- staff with practical expertise in accessing benefits and entitlements for people experiencing homelessness.

1.3.3 Homelessness multidisciplinary teams should have protocols and systems in place for communication and sharing information to support integrated working within the team and between services.

1.3.4 Homelessness multidisciplinary teams should:

- identify people experiencing homelessness through outreach or when they present to health and social care services
- support [mainstream](#) providers to identify and refer people to the homelessness multidisciplinary team
- undertake and support assessments for [safeguarding](#), physical and mental health, alcohol and drug treatment needs, and social care, including informing Care Act assessments (see the [section on assessing people's needs](#))
- support mainstream providers to ensure safe, timely and appropriate hospital discharge and engagement with onward care (see the [section on transitions between different settings](#)).

1.3.5 Homelessness multidisciplinary teams should:

- offer person-centred case management by a designated practitioner within the multidisciplinary team and ensure continuity of care for as long as it is needed by the person
- offer wraparound health and social care support that encompasses the person's needs, including:
 - physical health
 - mental health and psychological support (such as psychological therapies)
 - physical rehabilitation (such as occupational therapy and physiotherapy)
 - drug and alcohol treatment
 - social care
 - palliative care
 - communication support
 - practical support, such as help with benefits, housing and referral for legal advice.

1.3.6 Homelessness multidisciplinary teams should engage in reflective practice, including opportunities to share experience and learning with other relevant teams, including homelessness multidisciplinary teams, and to review complex or difficult situations.

1.3.7 Homelessness multidisciplinary teams should directly contribute to local needs assessments, service quality improvement, and reviews of complex or difficult situations including Safeguarding Adults Reviews.

1.3.8 Homelessness multidisciplinary teams should advise homelessness leads, when needed, in nearby areas that do not have a homelessness multidisciplinary team and share examples of good practice.

Homelessness leads in mainstream services

- 1.3.9 In areas assessed as not needing a full-time homelessness multidisciplinary team because of low numbers of people experiencing homelessness, establish links with multidisciplinary teams in nearby areas and designate homelessness leads in all relevant mainstream services, for example, in primary, secondary and emergency care, palliative care and in adult and child social services.
- 1.3.10 The homelessness leads should:
- support their organisation to provide appropriate care for people experiencing homelessness and implement this guideline
 - have detailed local knowledge of specialist services to support the care of people experiencing homelessness
 - work with and coordinate care with homelessness leads in other mainstream services
 - consult homelessness multidisciplinary teams in nearby areas, as needed.

For a short explanation of why the committee made these recommendations and how they might affect services, 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 reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#)
- [evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

1.4 The role of peers

- 1.4.1 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 influence the design and development of services
 - providing training for health and social care staff
 - carrying out participatory research and data collection, for example, to support service audits, needs assessments and quality improvement.
- 1.4.2 Offer peer support to people experiencing homelessness, for example to help with:
- 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 or in A&E
 - forming trusting relationships with practitioners and improving communication.
- 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 and tailored to the person's needs
 - psychological and social support, for example reflective practice, according to their changing needs and circumstances
 - tailored support for professional development, including access to further training and inclusive employment opportunities.
- 1.4.4 Take into account the experience, background and language skills of peers and

how these can be used to meet the needs and preferences of people experiencing homelessness.

For a short explanation of why the committee made these recommendations and how they might affect services, see the [rationale and impact section on the role of peers](#).

Full details of the evidence and the committee's discussion are in:

- [evidence reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#)
- [evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

1.5 Improving access to and engagement with health and social care

Supporting access to and engagement with services

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

- [outreach](#) services (see the [section on outreach services](#))
- [low-threshold services](#)
- flexible opening and appointment times
- self-referral
- drop-in services
- 'one-stop shops' for multiple services
- incentives and help to access care, such as transport support, vouchers or digital connectivity

- [advocates](#) (see [recommendation 1.1.12 in the section on communication and information](#))
 - [peer support](#) (see the [section on the role of peers](#))
 - [care navigation](#)
 - [psychologically informed environments](#) and [trauma-informed care](#).
- 1.5.2 Do not penalise people experiencing homelessness for missing appointments, for example, by discharging people from the service. Consider seeking specialist help, such as peer supporters or independent advocates, to support the person to attend appointments and re-engage with care after missing appointments (see the [section on the role of peers](#)).
- 1.5.3 Ensure that people can access help when needed, including through emergency care, and avoid policies that withdraw support and close cases after a standard duration, unless a safe transfer of care to another service has been agreed with the person or the person agrees that they no longer need the service.
- 1.5.4 Commissioners and service providers should follow the recommendations on [improving access to services in NICE's guideline on common mental health problems](#).
- 1.5.5 Ensure that people experiencing homelessness with multiple health or social care needs are not excluded from services because of restrictive eligibility criteria. For example, people with mental health problems are not denied access to mental health services because they have drug and alcohol treatment needs (see also [NICE's guideline on coexisting severe mental illness and substance misuse](#)).
- 1.5.6 Ensure that people experiencing homelessness who are assessed as frail and in need of social care and support get long-term care packages, including residential care or supported housing, irrespective of their age.
- 1.5.7 Ensure that paper or digital forms needed to access health or social care or to get help with NHS costs are readily available and that people are supported to fill them in, including providing translation when needed.

- 1.5.8 Ensure that people experiencing homelessness can access online health and social care information and are supported to use online services, for example by providing internet access at places where people experiencing homelessness spend time, such as day centres or hostels.
- 1.5.9 Primary care service providers should ensure that people without an address can register with a GP practice, in line with the [NHS Primary medical care policy and guidance manual](#).
- 1.5.10 Ensure that frontline health and [social care staff](#) who come into contact with people experiencing or at risk of homelessness are able to fulfil their duties under the [Homelessness Reduction Act 2017](#).
- 1.5.11 Ensure that frontline health and social care staff are able to identify when a person needs to be referred for specialist homeless health and social care, and that processes are in place to support timely referral.
- 1.5.12 Consider moving people up waiting lists for health and social care appointments if they are experiencing homelessness because their circumstances may mean they are at higher risk of deterioration and premature death.

For a short explanation of why the committee made these recommendations and how they might affect services, 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 reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#)
- [evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

Outreach services

- 1.5.13 Take health and social care services to people experiencing homelessness by providing multidisciplinary outreach care in non-traditional settings, such as on the street, hostels or day centres.
- 1.5.14 Offer outreach services that include support for people who:
- have primary healthcare needs
 - have drug and alcohol treatment needs
 - have mental healthcare needs
 - fear engaging with services, for example, because of previous negative experiences from providers, discomfort using male-dominated services or concerns about eligibility including immigration status
 - may lack mental capacity or need support to recognise their care needs and engage with providers.
- 1.5.15 Use outreach to identify health problems earlier, promote health and support engagement with care, for example by:
- supporting access to national screening programmes
 - assessing people for long-term conditions, infectious diseases and mental health needs
 - providing preventive health opportunities, such as vaccination, drug and alcohol treatment services, harm minimisation, smoking cessation and nutrition advice.
- 1.5.16 Offer collaborative, [assertive outreach](#) to start and maintain engagement with health and social care for people experiencing homelessness with coexisting severe mental health and drug or alcohol treatment needs. See also the [section on maintaining contact with services in NICE's guideline on coexisting severe mental illness and substance misuse](#).
- 1.5.17 Consider assertive outreach for all people experiencing homelessness who could

benefit from support but who find services difficult to engage with.

For a short explanation of why the committee made these recommendations and how they might affect services, see the [rationale and impact section on outreach services](#).

Full details of the evidence and the committee's discussion are in:

- [evidence reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#)
- [evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

1.6 Assessing individual needs

- 1.6.1 Be aware that health and social care practitioners have a statutory and professional duty to identify immediate risk of harm to self or others. See also the [section on assessment and treatment under the Mental Health Act in NICE's guideline on service user experience in adult mental health](#).
- 1.6.2 Assess the health and social care needs of the person experiencing homelessness. When carrying out the assessment:
- take into account their capacity, rights to autonomy and self-determination, and any [safeguarding](#) issues **and**
 - avoid unnecessary and potentially distressing repetition of their history if it is already on record
 - involve [peers](#) or advocates as appropriate (see also the [section on the role of peers](#)).
- 1.6.3 Include in the assessment:
- A comprehensive assessment of the person's physical and mental health needs (including acute and long-term conditions) and social care needs. This

should take into consideration their housing and benefits situation, bearing in mind the need to address [health inequalities](#), and be responsive to diversity, and [inclusion needs](#).

- Asking if the person has children or dependents and assessing how this affects their needs.
- Understanding the historical context of their situation, including past psychological trauma and experience of services.

- 1.6.4 In assessments to inform a health and social care plan for people who might benefit from high levels of support, use a multidisciplinary approach to enable a comprehensive and holistic assessment of their needs, involving:
- the person, and their advocate if one is nominated or appointed
 - input from professionals with specialist expertise and practitioners who have detailed knowledge of the person's health and social care needs, including staff working in homelessness and housing services.
- 1.6.5 Use hospital admissions as an opportunity to offer a comprehensive, holistic needs assessment, including referral, if indicated.
- 1.6.6 Use the multidisciplinary assessment to inform the local authority-led care and support needs assessment, under the [Care Act 2014](#) (see the [section on care and support needs assessment and care planning in NICE's guideline on people's experience in adult social care services](#)).
- 1.6.7 Review the person's needs, strengths and aspirations whenever their circumstances change or whenever they request a review, rather than 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](#).

1.7 Intermediate care

1.7.1 Provide [intermediate care](#) services with intensive, multidisciplinary team support for people experiencing homelessness who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care. These may be for people who are:

- discharged from hospital (step-down care)
- referred from the community who are at acute risk of deterioration and hospitalisation (step-up care).

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 services, see the [rationale and impact section on intermediate care](#).

Full details of the evidence and the committee's discussion are in [evidence reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#).

1.8 Transitions between different settings

1.8.1 [Homelessness multidisciplinary teams](#) or [leads](#) should support people experiencing homelessness through transitions between settings (such as the street, hostels, Housing First and other supported housing, hospital, mental

health services, social care, residential or community drug and alcohol treatment, and custody) and consider providing time-limited intensive support, which includes:

- having a key practitioner coordinating care
- building a relationship of trust
- providing links to services in the community
- gradually lowering the intensity of support, as appropriate.

1.8.2 Practitioners in any setting supporting people experiencing homelessness should:

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

1.8.3 Clinical teams, working with hospital discharge teams and specialist homelessness multidisciplinary teams, where available, should have procedures to:

- minimise self-discharge **and**
- prevent discharge to the street.

If self-discharge or discharge to the street happens, review the circumstances and implement learning.

1.8.4 For people moving between different care settings, follow the recommendations in NICE's guidelines on:

- [transition between inpatient mental health settings and community or care home settings](#)
- [transition between inpatient hospital settings and community or care home settings for adults with social care needs](#)

- [transition from children's to adults' services for young people using health or social care services](#).

For a short explanation of why the committee made these recommendations and how they might affect services, see the [rationale and impact section for transitions between different settings](#).

Full details of the evidence and the committee's discussion are in:

- [evidence reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#)
- [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 accommodation suitable for 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 maintain suitable 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 at risk 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 living arrangement, while also recognising their strengths, and plan ways to mitigate the risks.

For a short explanation of why the committee made these recommendations and how they might affect services, 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 reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#)
- [evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

1.10 Safeguarding

Also see the [NICE guideline on domestic violence and abuse](#).

- 1.10.1 Designate a person to lead on [safeguarding](#) the welfare of people experiencing homelessness, including engagement and face-to-face practical safeguarding support.
- 1.10.2 Where a social worker is embedded in the [homelessness multidisciplinary team](#), local authorities should consider appointing them to lead on safeguarding enquiries about people experiencing homelessness.
- 1.10.3 Local authorities should consider having a lead for people experiencing homelessness on the [Safeguarding Adults Board](#).

- 1.10.4 Safeguarding Adults Boards should ensure that specific reference is made to people experiencing homeless in their annual reports and strategic plan.
- 1.10.5 Safeguarding Adults Boards should share recommendations and key learning related to homelessness from [Safeguarding Adults Reviews](#) with key stakeholders.
- 1.10.6 Safeguarding Adults Boards should establish ways of analysing and interrogating data on safeguarding notifications about people experiencing homelessness so that they can check that local safeguarding arrangements offer the necessary protection.
- 1.10.7 Commissioners and service providers should support health and [social care staff](#) to understand and apply laws relevant to people experiencing homelessness and who are in need of safeguarding. This should include ensuring that they can recognise signs of abuse and neglect (including self-neglect) and how to make a safeguarding referral.

For a short explanation of why the committee made these recommendations and how they might affect services, see the [rationale and impact section on safeguarding](#).

Full details of the evidence and the committee's discussion are in [evidence reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#).

1.11 Long-term support

- 1.11.1 For people who struggle to engage with services, plan long-term engagement to help meet the person's needs at their own pace.
- 1.11.2 Give priority to building a relationship of trust, for example by:
- taking time with the person, particularly at the beginning of the relationship
 - being prepared to meet in an informal setting, such as a park or café (with appropriate lone worker policies in place)

- having regular contact
 - ensuring consistency of practitioner, so that they meet with 1 person or a small team
 - aiming to meet immediate expressed needs to encourage long-term engagement.
- 1.11.3 Recognise that people experiencing homelessness do not always follow a linear recovery journey and that apparent progress may hide risks.
- 1.11.4 Consider providing 'open-door' services that people can self-refer to and access after any initial support ends, to reduce the risk of becoming homeless again because of unmet health, care and support needs.
- 1.11.5 Recognise that some people experiencing homelessness experience frailty at an earlier age (both physical and cognitive) than the general population and their long-term care should be tailored to meet this.
- 1.11.6 If a person experiencing homelessness is likely to be approaching the end of their life, for example, if death would not be unexpected in 6 to 12 months, discuss palliative care needs with the person and the multidisciplinary team, and provide coordinated palliative care to meet the person's needs.

For a short explanation of why the committee made these recommendations and how they might affect services, see the [rationale and impact section on long-term support](#).

Full details of the evidence and the committee's discussion are in:

- [evidence reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#)
- [evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

1.12 Staff support and development

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

- understanding the health and social care needs of people experiencing homelessness, and their rights to access services
- homelessness as part of equality and diversity training, including being responsive to [health inequalities](#), diversity issues and [inclusion needs](#) and understanding the impact of discrimination and stigma, and how intersectional, overlapping identities can affect people experiencing homelessness
- [psychologically informed environments](#) and [trauma-informed care](#)
- legal duties and powers
- legal entitlements for migrants.

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

1.12.3 Consider regular and ongoing support, professional supervision and [reflective practice](#) for staff working with people experiencing homelessness.

For a short explanation of why the committee made these recommendations and how they might affect services, see the [rationale and impact section on staff support and development](#).

Full details of the evidence and the committee's discussion are in:

- [evidence reviews A and B: effectiveness of approaches to improve access to and engagement with health and social care and joined up approaches](#)
- [evidence review C: views and experiences of health and social care for people experiencing homelessness](#).

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions, see the [NICE glossary](#) and the [Think Local, Act Personal's Care and Support Jargon Buster](#).

Assertive outreach

A proactive and persistent approach to [outreach](#) that involves repeated contact with people who are initially unable to or unwilling to engage.

Care navigation

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

Health inequalities

Systematic, unfair and avoidable differences across the population and between different groups within society in relation to health and social outcomes. They arise because of the conditions in which people are born, grow, live, work and age. These conditions influence people's opportunities, health and wellbeing.

Homelessness leads

People working in mainstream health and social care services who, as part of their role, lead on homelessness issues within their service. Homelessness leads are designated in areas assessed as not needing a full-time homelessness multidisciplinary team.

Homelessness multidisciplinary team

A multidisciplinary team involves a range of professionals across disciplines as well as agencies working together to assess and support the needs of a person experiencing homelessness.

Inclusion needs

A need to have equal access and opportunities to participate in society and not facing barriers to services, social situations, different spaces and environments; being treated with dignity and not experiencing discrimination or intolerance due to the person's identity. See also [health inequalities](#).

Intermediate care

A range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Intermediate care is given on a time-limited basis, but duration can vary depending on the person's needs.

Low-threshold services

Services that avoid restrictive eligibility criteria and make minimal demands on the client.

Mainstream services

Services designed to be delivered to the general population.

Outreach

Bringing health and care services to people who might not otherwise have access to or engage with existing services, provided in a mobile way in the locations where people are, for example on the street, in temporary accommodation facilities and in day centres. This can be done by mainstream services or dedicated outreach teams.

Peers

People with lived experience of homelessness who are using their experience to support people experiencing homelessness through different means such as direct support, advocacy, research and co-production of services.

People experiencing homelessness

In the context of this guideline, people experiencing homelessness is defined as people aged 16 and over who:

- are sleeping rough (people without homes who sleep outside or somewhere not designed for habitation)
- are temporary residents of hostel, B&B, nightly-paid, privately managed accommodation and other types of temporary accommodation
- use day centres that provide support (such as food, showers, clothing and advice) for people experiencing homelessness
- are obliged to stay temporarily with other people
- are squatting
- are newly homeless.

It also includes people with a history of homelessness (as defined above) who are at high risk of becoming homeless again because of ongoing severe and multiple health and social care needs.

Psychologically informed environment

Service provision and practice that takes into account individuals' psychological and emotional needs, and their experiences of trauma. It includes building organisational awareness of psychological and emotional needs; physical environment and social spaces; staff training and ongoing support; service evaluation and learning; and reflective practice. For more information and resources, see the [Homeless Link's webpage on trauma informed care and psychologically informed environments](#). See also [trauma-informed care](#).

Recovery-oriented language

Language that is person-centred, respectful, non-judgemental and strengths based. It conveys a sense of hope and commitment to the potential of every person and their recovery journey. It includes non-verbal aspects of communication and aims for consistency between verbal language and body language. If recovery is unlikely, this approach might focus on exploring what is important to the person and what living well

means to them.

Reflective practice

A process to:

- reflect on previous practice
- talk about why they made the decisions they made, and why they acted or behaved in particular ways
- talk about their emotional responses to their actions and the actions of others
- engage in continuous learning.

Reflective practice may also provide insight into personal values and beliefs, and help 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's 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, the 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's 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.

Severe and multiple disadvantage

Multiple and overlapping disadvantages that are often persistent and interrelated and affect a person's life. These disadvantages include the experience of homelessness, harmful drug or alcohol use, criminal justice involvement, poor mental health, and the experience of domestic violence and abuse. People experiencing severe and multiple disadvantage have often experienced underlying adverse childhood experiences, poverty, psychological trauma, stigma and discrimination. People with these experiences may have had sporadic and inconsistent contact with services or been serially excluded from services. People who experience severe and multiple disadvantage tend to have much poorer physical and mental health, have higher social care needs, and die at a much younger age than people without severe and multiple disadvantage.

Social care staff

People working in social services and social care providing practical and emotional support to improve people's wellbeing and quality of life. This includes both local authority social workers with legal responsibilities to assess and protect people at risk of harm as well as frontline social care practitioners that may work in residential care, hostels and homelessness services in either the public sector or voluntary and charity sector.

Social determinants of health

Social factors and wider determinants that influence health and wellbeing. These include circumstances in which people are born, grow up, live, work, and age, and the social and economic policies and systems, political agendas, social norms, environmental factors and other wider forces.

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 planning and providing services that involves understanding, recognising and responding to the effects of all types of trauma. It emphasises physical, relational and emotional safety, 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 treatment 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 reviews A and 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 reviews A and 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 1.1.8](#)

Why the committee made the recommendations

There was qualitative evidence that people experiencing homelessness feel that they are offered less or lower quality care than 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. This also aligns with the [NHS Constitution's first key principle](#) of providing comprehensive service available to all, and its 'wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population'.

Co-design and co-delivery of services

Good qualitative evidence showed that people experiencing homelessness want to give feedback on processes and their care, but ways to do this were not always available. Based on their experience, the committee agreed that people often do not feel able to do this because of their experience of stigma and discrimination. However, involving people with lived experience of homelessness in service design is likely to improve services and people's engagement with services. Involving people in service design was also highlighted in the [NICE guideline on people's experience in adult social care services](#), which references the [Local Government and Public Involvement in Health Act 2007](#). The 2007 Act mandates local authorities to provide opportunities for people who use services to be involved in strategic decision making about services. [NICE's guideline on community engagement](#) also gives guidance on community engagement approaches for local

authorities and health bodies.

The committee's experience as well as both qualitative and effectiveness evidence showed that using peers to deliver health and social care services can also be beneficial for people experiencing homelessness. The committee agreed that there are likely benefits for the peers themselves and for the service.

Supporting engagement with services

Good qualitative evidence highlighted that many people experiencing homelessness encounter or perceive stigma, discrimination and lack of understanding from health and social care practitioners. There was also limited evidence showing that many service providers are not aware of the impact that traumatic experiences can have on a person's life and how it can manifest in their behaviour. From their experience, the committee agreed that psychological trauma is common among most people experiencing homelessness, and is particularly prevalent among certain groups, such as women and young people. They also heard from experts who highlighted the importance of 'professional curiosity' in understanding the person's backstory and the use of trauma-informed practices. They agreed to highlight the importance of using approaches that take into account the impact of trauma and consider the person's past experiences as well as their current situation.

There was a lack of evidence on psychologically informed environments and psychological approaches to care, so the committee developed a [research recommendation on the effectiveness and acceptability of clinical psychology-led psychologically informed environments and psychological approaches for people experiencing homelessness](#) and they agreed that research in this area should consider inequalities and collect data that enable the impact on different groups to be studied. The [equality impact assessment](#) provides further information on equalities considerations for this guideline.

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

There was good qualitative evidence highlighting that people reported positive experiences with care providers and increased engagement with services when they were

able to develop a trusting relationship with a provider who paid attention, showed sincere interest and had time available for them. The importance of a genuine, friendly relationship in which the professional listens, remembers, uses humour and shows concern helps to build a trusting relationship, which in turn enables the person to feel safe in the health or social care environment. The committee agreed that this was key to promoting engagement. There was also good qualitative evidence that people experiencing homelessness value non-judgemental communication from professionals that is responsive to people's individual experiences and needs, for example, related to gender, culture, ethnicity and being part of the LGBT+ community. The committee also recognised the importance of service providers addressing the underlying inequalities that people may face, which are underpinned by social determinants of health that shape people's experiences and health and social care needs. The evidence emphasised the importance of staff understanding the impact that trauma may have.

Sustaining engagement with services

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

The qualitative evidence also showed that the length of appointments or contacts in current practice is often inadequate to meet the needs of many people experiencing homelessness, particularly those with severe and multiple disadvantage. Despite some limitations in the evidence, the committee agreed with this and discussed how longer appointment times can give an opportunity to better assess, engage and build trust with people who may otherwise rarely have contact with services, and who are marginalised and have disproportionately worse outcomes. Good qualitative evidence and information from experts emphasised that giving people agency – involving them and promoting shared decision making – helps to improve engagement in care. High-quality evidence from qualitative studies highlighted that focusing on the person's strengths and assets encouraged people experiencing homelessness to use services.

Supporting re-engagement with services

Good evidence from qualitative studies showed that people experiencing homelessness

often experience lack of consistency and continuity from health and social care services, which can lead to disengagement. The evidence also showed that ongoing, sustained support and a service provider's patience and continued attempts to re-engage can improve the person's engagement when they might otherwise be resistant to support. The committee were aware that the Safeguarding Adults Reviews highlighted the prominence of 'self-neglect' in people experiencing homelessness. The committee discussed how some people experiencing homelessness find it difficult to look after their health and personal care because of their environment and circumstances. 'Self-neglect' can also include disengagement with health and social care whether or not the person has capacity. This is made more difficult by barriers to access and engagement with services. This emphasises the importance of actively supporting re-engagement. The committee discussed that re-engagement might not be successful if the person has to start and repeat the process from the beginning of the pathway, instead enabling re-entry from the point they left is more likely to support re-engagement, if appropriate.

How the recommendations might affect services

The recommendations outline principles of good practice that in the committee's view should be happening across all services for people experiencing homelessness. However, practice is variable, and this may represent a change in practice for some services. Most recommendations would not lead to a significant resource impact, but may involve staff training and longer contact times. Any additional costs are likely to be offset by the benefits of improved engagement with care, for example, by accessing care before a crisis and reducing the burden on emergency services.

Economic analysis also suggested that reducing caseloads (and thus increasing time spent with clients) for practitioners working with people experiencing homelessness could be cost effective.

[Return to recommendations](#)

Communication and information

[Recommendations 1.1.9 to 1.1.13](#)

Why the committee made the recommendations

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

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

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

The committee discussed that resources and forms are often written in a complex way and mostly available only in English. They agreed that this is a further barrier for people whose first language is not English. Good qualitative evidence also suggested that low literacy levels among some people experiencing homelessness can add to difficulties in accessing care. The committee agreed that this could include some migrants and people with learning disabilities or acquired brain injury. They therefore emphasised the need to tailor communication and information provision to people's needs and preferences, taking into account a wide range of possible speech, language and communication difficulties.

Good qualitative evidence showed that the presence of an advocate (including a peer advocate) helps people experiencing homelessness to gain confidence and a sense of control over their health and care needs. The committee had confidence in the evidence

and agreed, based on their experience, that advocates (including peer advocates) can play a significant role in supporting people with correspondence and attending appointments, and in bridging the gap between practitioners and people experiencing homelessness. The committee were also aware that NICE is developing a [guideline on advocacy services for adults with health and social care needs](#) (publication expected September 2022).

The committee noted that the advocate could be someone who the person is familiar with, such as a family member or a friend. But they also noted that some people may be entitled to an independent advocate under certain circumstances. For example, the [Care Act 2014](#) mandates that local authorities must arrange an independent advocate to support and represent a person to assist in their involvement in specified social care processes if the person has substantial difficulty in being involved in the process, and if they do not have an appropriate person to support them.

Moderate-quality evidence from qualitative studies showed that people experiencing homelessness felt that there was a lack of help or information about services available to them (such as overall entitlement to care, oral health, maternity services, screening and infectious diseases). This corresponded with the committee's experience, and they agreed that to improve engagement with health and social care services, it is important to give people information, support access, and make sure that they know their rights to health and social care. They considered this particularly relevant for migrant populations who may not be familiar with the local health and social care system and their entitlements, or who may have limited or no recourse to public funds.

How the recommendations might affect services

These recommendations reinforce existing NICE guidelines on communication and information provision for the general population. However, there are some aspects that may need particular attention when working with people experiencing homelessness. There may be a need for some extra staff training on communication, and on the available health and social care services and support for people experiencing homelessness, including legal entitlements for care.

Giving everyone – including staff – the right information about what services are available will help relationship and trust building, and may lead to better access and engagement with services. For example, people may be more likely to access primary care services or specialist services directly instead of relying on emergency services. This can lead to

problems being picked up and dealt with earlier, reducing morbidity and mortality, and associated costs such as for crisis care, and unplanned or emergency care.

Services already use various communication methods to support access to and engagement with services. But tailoring the method to each person's preferences and needs may need some reorganisation of current practice.

Advocate roles could be carried out by a professional or a peer supporter, or sometimes a family member or a friend. There are various advocacy models aimed at facilitating the relationship with service providers, and supporting people to access information and services or attend appointments. Any additional costs could be offset by the beneficial effect on the person's recovery including potential reductions in morbidity and mortality. For example, there is a link between non-attendance at appointments and increased morbidity and mortality in people experiencing homelessness.

[Return to recommendations](#)

Planning and commissioning

[Recommendations 1.2.1 to 1.2.10](#)

Why the committee made the recommendations

Planning integrated multidisciplinary health and social care services

The [rough sleeping strategy](#) by the Ministry of Housing, Communities & Local Government highlights the need for agencies to work together to end rough sleeping and prevent homelessness. Cooperation and integrated working between agencies and partners are also mandated in legal frameworks including the [Care Act 2014](#) and the [National Health Service Act 2006](#).

Based on their experience, the committee discussed that integrated working among commissioners across different sectors is essential to bring all the knowledge and services together to ensure that there is a strategy and funding for coordinated and holistic support for people experiencing homelessness. Joined-up working is also likely to improve long-term outcomes; improve people's experience of services; minimise duplication of work and make services more efficient; improve understanding of the needs of the homeless

population in the local area; and improve practitioners' work by making it easier to collaborate with colleagues.

People experiencing homelessness are to varying degrees disadvantaged and marginalised, and their outcomes are considerably worse than the general population, including having disproportionate rates of premature mortality. The committee discussed the concept of 'proportionate universalism', introduced in [Marmot et al. \(2010\) Fair Society Healthy Lives \(The Marmot Review\)](#), meaning that resourcing and delivering of services are done universally but at a scale and intensity proportionate to the level of need or disadvantage. The committee agreed that more resources and targeted approaches are justified to address the inequalities facing this population.

Local homelessness health and social care needs assessment

The committee agreed that to plan and commission adequate services to meet the needs of the homeless population in a local area, a comprehensive homelessness health and social care needs assessment should be carried out and kept up to date. This assessment will help understand the scale and nature of homelessness, and how existing services could be developed and integrated to better meet the needs of the people experiencing homelessness. The committee agreed that it should involve experts by experience to fully understand the needs, experiences, circumstances and service use of people experiencing homelessness. The committee also agreed that to improve services and to prevent abuse, neglect and death, service planning and design should be informed by Safeguarding Adults Reviews. They heard from an expert who also highlighted this.

Recording housing status

The committee discussed, based on their experience, that data on the needs and service use of people experiencing homelessness can come from housing status in the person's health and care records if this is accurately recorded. [Public Health England's Homelessness: applying 'All Our Health'](#) advises frontline health and care professionals to ask about and record people's housing circumstances. The committee recognised that recording this information can create fear of stigmatisation in people experiencing homelessness. But they agreed that this was outweighed by the benefits of accurate data that can be used to improve services, both for the individual and as a whole, and ensure that there are adequate resources. The data can also be used to help identify and reduce health inequalities.

Developing services

Many people experiencing homelessness have multiple intersecting issues or high support needs, such as physical and mental health issues, drug and alcohol treatment needs and social care needs. High-quality evidence from qualitative studies highlighted the importance of joint working to address complex unmet health and social care needs. The evidence suggested that many services work in silos with minimal coordination and cooperation between agencies. People felt that their issues were often dealt with individually by different providers rather than holistically addressing all of their intersecting needs. The committee heard from experts about adult social care and safeguarding, who similarly highlighted the need for joint commissioning and integrated working across agencies and professions.

The committee agreed, based on their experience and expertise, that commissioners working across larger areas and across sectors could help services collaborate to meet strategic aims, cover varying and intersecting needs, share resources and enable economies of scale. This could be at the level of integrated care systems or place-based systems, with collaboration across an area's health, social care and housing partners in different sectors, as well as with prison, probation and domestic abuse services.

The committee also agreed on the importance of enabling long-term, consistent support regardless of contract lengths so that people experiencing homelessness who may need high levels of support, including long-term medical care, can progress in their recovery journey. They agreed that long-term contracts can provide stability and can support the improvement and extent of services as long as there is flexibility to adapt to changing local needs.

The committee heard from expert witnesses about the importance of supporting service providers and practitioners to exercise their legal duties and powers when working with people experiencing homelessness. The committee agreed that the current systems do not always support public bodies and practitioners to do this, for example the duty to refer based on the [Homelessness Reduction Act 2017](#).

The committee also agreed that commissioners should define and measure outcomes related to homelessness, including health and social care outcomes and service use, to inform local and national homelessness assessments, and help improve and design relevant policies and services.

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

cost-effective way of supporting people experiencing homelessness and delivering services. Based on their knowledge and experience, the committee also agreed that peers are valuable in co-designing services. Involving peers can improve people's engagement with services, leading to better outcomes; improve the quality of services; and reduce pressure on practitioners, as well as having benefits to the peers themselves.

The committee agreed that the particular needs of specific population groups need to be considered. For example, women may have different needs and vulnerabilities compared with men, and young people compared with older people. People with limited or no recourse to public funds have particular disadvantages and risks for poor outcomes because of barriers to accessing care and support. Specialised support for the particular needs of LGBT+ people, disabled people or people with a particular family background or from a particular faith group may be helpful in reaching people and providing appropriate support. The committee agreed to give examples of groups that may need specific consideration, although they recognised the list is not exhaustive. The [equality impact assessment for the guideline](#) provides further information.

The committee discussed how the causes of homelessness are complex. Some people may experience homelessness as a result of disparities in access to or appropriateness of services because of a certain characteristic they have. People may face particular challenges because of their characteristics, such as their age, gender, disability status, family background or being a migrant, including different intersections of these, which may multiply inequalities.

Improving access to and engagement with services

Qualitative evidence of mixed quality from many different studies highlighted various barriers to accessing health and social care, such as transport costs and services being too far away, siloed or in multiple locations. The committee agreed that it is important for commissioners to consider ways to remove barriers to local services to improve access and engagement among people experiencing homelessness.

There was good qualitative evidence that people experiencing homelessness faced challenges registering for GP services and were sometimes refused registration if they did not have an address or ID. Being denied access to GP services can further alienate, cause distrust and prevent already marginalised people from engaging with services. The evidence also corroborated the committee's experience that when people are refused access to GP services, they turn to emergency care services.

The [NHS Primary medical care policy and guidance manual](#) outlines that everyone in England can register with a primary care provider free of charge. This includes people experiencing homelessness, people without a stable address, asylum seekers and refugees. The committee agreed that commissioners and planners need to ensure that there are processes in place to support GP registration, and document, challenge and redress refusals. There is also [NHS England practical resource on improving access for all: reducing inequalities in access to general practice services](#).

Reducing caseloads for practitioners working with people experiencing homelessness would allow them to spend longer with each client. Longer contact time is likely to improve engagement with services, help build a trusted relationship and ultimately lead to improved outcomes and sustained recovery. There would also be likely benefits from improved staff satisfaction and retention, and continuity of care. The committee made a [research recommendation to better understand the effectiveness and cost effectiveness of longer health and social care contacts for people experiencing homelessness](#) and they agreed that research in this area should consider inequalities and collect data that enable the impact on different groups to be studied. The [equality impact assessment](#) provides further information on equalities considerations for this guideline.

How the recommendations might affect services

Although there are legal requirements to collaborate under the [Care Act 2014](#) and the [National Health Service Act 2006](#), health, social care and housing services have different legislative and commissioning frameworks and the committee discussed that collaboration is sometimes challenging and the level of integration varies.

Services working in silos can increase the risk of undiagnosed or misdiagnosed conditions across the mental, physical and disability spectrum, cause morbidity and mortality, and result in substantial costs to services. Commissioners and planners will need to ensure that frameworks are in place to support integrated multidisciplinary health and social care services where this is not already happening. For example, by facilitating coordinated multi-agency and multidisciplinary working, and strengthening information sharing and communication systems.

Improving integrated service provision should lead to improved outcomes, more appropriate use of services, and a lower need for emergency care and hospital admissions, reducing associated costs. Services will need targeted efforts to improve outcomes and to meet the needs of people experiencing homelessness, and

commissioners will need to plan for more funding per person than in mainstream services. However, this should lead to savings later on.

Joint Strategic Needs Assessments are done by public health teams within local authorities, but there is some variation in the extent to which the health and social care needs of people experiencing homelessness are considered, and service users and experts by experience are involved. When done thoroughly and with all the relevant information, including relevant findings from Safeguarding Adults Reviews, it can inform targeted and efficient provision (for example, specialist service provision) and identify opportunities for more integrated services. This will also ensure that services meet local needs, and improve access and engagement. This will reduce morbidity and mortality, and reduce public sector costs associated with homelessness.

Most services have ways to record data on housing status for audit purposes. This would not be a new practice, although some services might not be doing it or do not have processes flexible enough to record it in a meaningful way. Services could improve this by adjusting existing data-recording methods.

Compared with current practice, commissioners may need to look across a larger footprint to develop services. This approach will also enable them to account for mobility and people experiencing homelessness not being tied to a specific place. This may mean commissioning groups coming together to form partnerships.

Involving peers in delivering care or support and co-designing services is already happening in some areas and organisations, particularly in the voluntary and charity sector. It will involve costs in terms of training and support for peers and potential incentives or remunerations; however, involving peers can reduce pressure on practitioners and therefore result in cost savings. There was evidence that it can be cost effective.

Access and engagement with services may not be straightforward in this population, so commissioners will need to ensure multiple ways of enhancing access to care. There are examples of good practice across the country, but practice is variable. Services will have to consider approaches that can be tailored to the specific needs of the person. Currently, because of the lack of flexible services, people often end up in crisis and use expensive emergency services, or do not access services, resulting in disproportionately complex morbidity and premature mortality.

GP registration refusals are relatively common in current practice and commissioners and planners will need to reinforce NHS guidance and support GP practices to ensure that people experiencing homelessness can access GP services.

Finally, economic analysis carried out for the guideline suggested that reducing caseloads for practitioners who work with people experiencing homelessness could be cost effective.

Lower caseloads will mean that services will have to recruit more staff, which might be challenging in some areas. However, availability of trained staff should not be a barrier; for example, services may find it easier to recruit staff to junior roles and provide on-the-job training.

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Models of multidisciplinary service provision

[Recommendations 1.3.1 to 1.3.10](#)

Why the committee made the recommendations

Homelessness multidisciplinary services

The committee discussed that people experiencing homelessness often have overlapping and intersecting care needs, which need the expertise and skills of different professionals to assess, plan and manage care jointly. They may also have needs and challenges that are not typical to the general population, so the committee recognised the value of practitioners with specialist knowledge on homelessness issues.

Good qualitative evidence from various studies described health and care systems as siloed, complex and fragmented, with little coordination between agencies and providers. There was also evidence from qualitative studies that people experiencing homelessness want more individualised care that meets their needs, and hope to develop trusting relationships with service providers.

There was limited effectiveness evidence available on multidisciplinary team approaches to health and social care support for people experiencing homelessness. There was

evidence on the Housing First approach, mainly from Canada, involving intense case management or assertive community treatment by a multidisciplinary team for people with moderate to severe mental health problems experiencing homelessness. This showed a positive impact on housing status and tenancy sustainment. There was also some economic evidence showing that having multidisciplinary homelessness teams resulted in some cost savings and improved outcomes for people experiencing homelessness. Furthermore, the committee heard from experts who emphasised the importance of integrated and collaborative working, and a multidisciplinary approach with clear roles and responsibilities and effective communication and information sharing.

Based on the evidence and their own experience, the committee agreed that the best way to provide health and social care to people experiencing homelessness would be through specialist homelessness multidisciplinary teams. A combination of expertise from a variety of disciplines and agencies would enable holistic and individualised care based on the person's needs.

The committee discussed that a successful joined-up care approach, providing holistic wraparound support based on individual needs would integrate service providers from a range of health and social care settings.

The committee discussed the various experts who could form the multidisciplinary team. The qualitative evidence highlighted that people experiencing homelessness value support from peers who have similar experiences and can be role models in their recovery journey. Some qualitative evidence also reported the benefits of involving people with lived experience of homelessness in shaping and providing care. The committee agreed that experts by experience can bring an important service-user point of view to a multidisciplinary team to help better meet the needs of people experiencing homelessness. The committee discussed that other members of the multidisciplinary team could be an array of different professionals and practitioners spanning different agencies and disciplines, including healthcare, social work, housing, and the voluntary and charity sector. They discussed that voluntary and charity organisation staff often have the closest relationships to the client. The committee were aware that the characteristics of people experiencing homelessness vary across different areas and agreed that it is important to use the local needs assessment to tailor the composition of the team to local needs.

The committee discussed that multidisciplinary teams can provide person-centred, tailored support with personalised case management by a designated person working within the multidisciplinary team, which can improve continuity of care and help build

trusted relationships with service providers that could improve engagement with services and long-term outcomes. Multidisciplinary teams can coordinate care based on the person's needs by providing care themselves or signposting to other services. Having a dedicated team with specialist knowledge can help streamline support and make it more efficient, avoid duplication of work and inappropriate referrals, and improve staff motivation. The committee were confident that there would be benefits for the person being supported, the team members and services in general.

The committee also discussed that the specialist multidisciplinary teams could bring value and expertise in working with other 'inclusion health' groups (groups of people who are traditionally socially excluded) who may be at risk of homelessness and whose needs often overlap considerably with people experiencing homelessness.

Homelessness multidisciplinary teams have a comprehensive understanding of the needs and service use of people experiencing homelessness, so the committee agreed that these teams make a crucial contribution to assessing local needs, improving quality of services, and reviewing complex cases including Safeguarding Adults Reviews.

The committee discussed that working with people experiencing homelessness can be challenging and can have a psychological impact on those providing care. They agreed that homelessness multidisciplinary teams should be given time, in a protected space, to reflect on their practice and experiences to promote continuous learning and professional wellbeing.

Homelessness leads in mainstream services

The committee also recognised that specialist homelessness multidisciplinary teams would not be feasible in areas where levels of homelessness are low. For example, in some areas services might encounter 1 person experiencing homelessness per month. In areas where forming a homelessness multidisciplinary team is not justified, the committee agreed that existing practitioners could act as homelessness leads in mainstream services, for example, in general practice, A&E departments, hospitals, drug and alcohol treatment services, mental health services, palliative care services, sexual assault referral centres, maternity care, disability services and adult and child social services. The homelessness leads would champion, coordinate, advise and collaborate with colleagues and professionals within and across services to enable appropriate provision of care and support for people experiencing homelessness. Partnering with homelessness multidisciplinary teams in nearby areas for advice could further improve care and support

for people experiencing homelessness in these areas.

How the recommendations might affect services

Models of service provision vary in current practice. In some areas with high rates of homelessness, there are no specialist homelessness multidisciplinary teams, or services are often focused on a single aspect of care or are mainly medically led; for example, mental health teams, drug and alcohol treatment services, community-based or hospital-based multidisciplinary teams, or housing-related multidisciplinary teams. Many multidisciplinary teams do not cover the wide range of support that is needed. Services will need to involve practitioners from across multiple agencies to make sure that the team has relevant expertise.

Recommendations on multidisciplinary teams may mean a change in service configuration. However, there may not be a need to employ new staff but to reorganise, collaborate with other agencies and form a team from existing professionals. Forming a multidisciplinary team may entail pulling together a team from different services working with a person experiencing homelessness. Alternatively, it may involve having a permanent integrated multidisciplinary team under single management within a service (that is, a coexisting co-located team), which would represent a more substantial change.

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

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

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The role of peers

Recommendations 1.4.1 to 1.4.4

Why the committee made the recommendations

There was some effectiveness evidence that suggested that peer support to navigate hepatitis C screening and services might help people to engage with services, and this was found to be cost effective. Other effectiveness studies also suggested that peers could increase uptake of tuberculosis screening and hepatitis vaccination to the same degree as professional staff. Although there were some concerns about the quality of the evidence on peer approaches, the committee were confident, based on their experience, that involving peers in delivering care or support and co-designing services is efficient and beneficial, not only for the services and the people experiencing homelessness but also for the peers themselves. They also heard from expert witnesses who highlighted the value of involving people with lived experience in the development of policies, procedures and protocols.

The qualitative evidence also highlighted that people experiencing homelessness value support from peers who have similar experiences and have recovered and grown from that experience. The committee highlighted their experience and knowledge of the beneficial impact of being a peer, describing how peers can progress to become professionals if supported.

Based on the evidence and their expertise, the committee agreed to list ways in which peers may be able to support people experiencing homelessness and how peers can improve services. Peers can take up different roles in terms of intensity, responsibility and tasks, and may gradually progress in these roles. The committee emphasised that it is important to support peers with adequate supervision and governance structures, including confidentiality and data protection. Training needs of peers might include, for example, first aid and mental health first aid, safeguarding, trauma-informed care, advocacy and risk management.

Qualitative evidence highlighted the obstacles and challenges that peers might encounter, including supporting someone with similar issues to their own while trying to maintain their own recovery. The committee agreed that peers should be supported to continue their own recovery journey and development by encouraging them to progress to become professionally employed, which is beneficial in many ways for the person acting as peer

support, the people they are supporting, and services.

The committee also discussed that it is important to consider how to match the peers with people they support. For example, some people may prefer or request peer support from someone with the same cultural or language background, but sometimes this may be a reason for a person to refuse peer support because of the risk of stigma or confidentiality breach.

How the recommendations might affect services

There are existing peer networks, for example, for people recovering from drug or alcohol dependency issues. There are also peers working with people experiencing homelessness in some areas and in some organisations, in the voluntary and charity sector in particular. But the committee agreed that there is the potential to involve more experts by experience in service design and delivery. Peer support has the potential to improve access to and engagement with services, and reduce morbidity and mortality, and associated public sector homelessness costs. There may also be important benefits to peers themselves, leading to better long-term outcomes.

Peers could be recruited through homelessness services or in collaboration with voluntary and charity sector organisations and housing associations. Services will also need to provide support and training for peers as well as incentives or remuneration. Involving peers can reduce pressure on practitioners and can result in cost savings. Organisations may need to adjust their recruitment practices and policies to lower barriers to the employment of peers.

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Supporting access to and engagement with services

[Recommendations 1.5.1 to 1.5.12](#)

Why the committee made the recommendations

People experiencing homelessness are often unable to access health and social care because of barriers at systemic, local and individual levels. Various themes from mixed qualitative evidence highlighted examples, such as strict eligibility criteria, rigidity of

appointment systems, limited opening times, short appointments, long waiting lists, siloed services in multiple locations, cost of transport and experiences of stigma and discrimination. The committee also drew on their own knowledge and experience of these barriers to access.

The committee agreed that an outreach model, in which the services go to the people instead of expecting people to come to them, is a helpful established approach to reaching people who do not access services. There is limited effectiveness evidence on outreach models, although evidence on a London-based outreach service to screen vulnerable people for hepatitis C and offer peer support for getting treatment in secondary care was shown to be cost effective. Moderate-quality evidence from qualitative studies suggested various benefits of outreach services, including increased access to immediate care and increased knowledge of health issues, available services, and healthcare entitlements. The evidence also highlighted that outreach services can be more flexible than traditional healthcare services and that bringing services to people builds a feeling of trust and connection with service providers while reducing the sense of isolation. The committee considered outreach services important to identify people who might otherwise be missed. They had confidence in the evidence and agreed that it corresponded with their experience.

There was good but limited effectiveness evidence that community drop-in services are helpful in reaching people and are preferred by service users. There was also good qualitative evidence that services are often complex, fragmented and difficult to navigate. The committee agreed that providing information and support to navigate care and services can improve people's access to and engagement with health and social care. Based on their knowledge and experience, the committee suggested approaches that could improve access and engagement. For example, low-threshold services that avoid restrictive eligibility criteria and make minimal demands on the client by offering support and care without trying to influence their habits; providing food, vouchers, transport support, internet access or other practical help can incentivise and enable people to engage with care; and providing psychologically informed environments and trauma-informed care can improve engagement with people who often have underlying negative and traumatic experiences.

The rigidity of appointment systems can lead to people being dropped from services if they miss appointments. There was some limited qualitative evidence illustrating the difficulties people experiencing homelessness face when they miss appointments. Some services have policies that prevent people accessing care at that service again or financial

penalties for missing appointments. Based on the committee's experience, this is a major problem for many people experiencing homelessness and they agreed that services should show flexibility and understanding to facilitate engagement. The committee discussed the clear association between missed appointments and premature death and agreed that providing more flexible appointment systems and alternative ways of accessing care is therefore essential in improving outcomes.

High-quality evidence from qualitative studies highlighted that strict eligibility criteria to access healthcare services sometimes forced people into crisis situations before help could be provided, or excluded them from accessing services altogether. Based on the committee's expertise, this is particularly prevalent among people with coexisting mental health problems and drug or alcohol treatment needs, which are common among people experiencing homelessness. Sometimes, people with coexisting mental health problems and learning disability can be excluded from accessing the respective services.

Some services, particularly in social care, may have minimum age criteria that can stop people getting the support they need. Premature aging and frailty, defined by the [British Geriatrics Society](#), the [Royal College of General Practitioner](#), and [Age UK](#) as 'a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves', are common among people experiencing homelessness with [severe and multiple disadvantage](#), so care and support should be based on assessed need, not biological age. Flexibility in the eligibility criteria could prevent the situation from escalating and help people to receive support earlier, leading to better outcomes.

Good qualitative evidence highlighted that some people are unaware of the free or low-cost services available to them, particularly dental care, if relevant paperwork has been processed. The committee discussed their experience that often these forms that enable free access to essential services such as eye care, prescription costs and dental care (such as HC1 and HC2) are not readily available, or are only available electronically. The forms can be challenging to fill in and only available in English.

The committee considered digital exclusion to be a major barrier to accessing health and social care. Qualitative evidence showed that people without access to the internet and those without a phone experienced difficulties in accessing healthcare.

The [NHS Primary medical care policy and guidance manual](#) states that everyone in England can register with a primary care provider free of charge. This includes people experiencing homelessness, people without a stable address, asylum seekers and

refugees. However, according to good qualitative evidence and the committee's experience, many people experiencing homelessness are still refused registration with a GP. Resources are available from the NHS on [improving access for all: reducing inequalities in access to general practice services](#).

The committee were keen to highlight the legal duties of public sector workers as mandated by the [Homelessness Reduction Act 2017](#). In particular, the duty to refer anyone who is identified as being homeless or at risk of homelessness to the local authority. They discussed that despite the legal requirement, this does not always happen in current practice because processes are not in place to do this, and frontline staff lack time and knowledge. An expert also highlighted the need for health and social services to improve legal knowledge among their staff. [Guidance on duty to refer from the Department for Levelling Up, Housing & Communities and Ministry of Housing, Communities & Local Government](#) gives an overview of the legal duty. The [Department for Levelling Up, Housing and Communities' code of guidance](#) advises local authorities on how they should exercise their homelessness functions in accordance with the Homelessness Reduction Act 2017. The committee discussed that every encounter with a person experiencing homelessness could be an opportunity for engagement with care and support. Approaches such as [Making Every Contact Count](#) and [Making Every Adult Matter](#) could be used to facilitate this and help frontline staff better understand the services available for onward referral.

The qualitative evidence highlighted that long waiting times are a barrier to accessing and engaging with health and social care, affecting people experiencing homelessness in particular. The committee agreed that people experiencing homelessness are a priority because their multiple disadvantages put them at an increased risk of deterioration and premature mortality and morbidity. They discussed that long waiting times can be particularly challenging for people experiencing homelessness and can mean that the opportunity to engage with them is missed altogether, for example, if the person moves to another area or forgets about the appointment. They also discussed that people experiencing homelessness may have particular difficulty coping psychologically with long waiting times because of the fundamental feeling of unsafety and exclusion that homelessness causes. Long waiting times could lead to further deterioration of physical and mental health, and could compound feelings of disengagement and exclusion.

How the recommendations might affect services

Current practice is variable. For services that do not have multiple points of access to care or flexible services, these recommendations will represent a change in practice. Services

will need a variety of approaches that can be tailored to specific needs. Currently, because of the lack of flexible services, people are using expensive emergency services or are not accessing services at all, resulting in excess morbidity and mortality, and associated high public sector homelessness costs. For example, inflexible appointment systems increase the risk of missing appointments, and there is a link between missed appointments and premature mortality. Missed appointments also cost the NHS millions of pounds a year; for example, missed GP appointments in the general population cost NHS England around £216 million a year in addition to the disruption for staff and other patients ([Missed GP appointments costing NHS millions, NHS England 2019](#)).

Transport costs are a considerable barrier to access to and engagement with services, and continuity of care. Practice is variable between different areas. People experiencing homelessness often have multiple morbidities, which could make them eligible for a free travel pass, but often do not have one because of bureaucratic challenges. Currently, a clinician (usually a doctor) needs to sign the paperwork for a free travel pass. Services could broaden the list of professionals able to approve applications, which could make free travel easier to access. The cost of providing free travel will be relatively low compared with the cost of missed appointments and the costs relating to unaddressed needs. For example, an annual bus pass in London costs approximately £900 ([Transport for London bus and tram fares](#)), but if a person with a leg ulcer misses multiple appointments, then this may lead to an infection and in some cases amputation, costing the NHS at least £8,000 ([NHS England National cost collection for the NHS](#)), in addition to the impact on the person. Services will need to work collaboratively to agree who will cover travel costs within their local system.

Some mental health or drug and alcohol recovery services will need to modify their eligibility criteria. This may lead to more people accessing services. But there may also be savings from avoiding crisis situations and unplanned care and providing more efficient support, leading to better long-term outcomes.

More practitioner time may be needed to help people with forms and other paperwork. But this can help prevent deterioration and the need for more expensive care, for example, emergency care, in the future.

In recent years, there has been an increase in the use of digital approaches to providing support within the homelessness sector. To avoid this leading to digital exclusion, some services may need to improve access to online health and social care information and support. There may be some costs associated with this, but providing access to digital

services and information can improve engagement with services and avoid the need for costly emergency care.

A significant barrier to accessing health and care services for people experiencing homelessness is that GP practices ask for an address when registering. Recommendations on this reinforce NHS guidance and should result in more people registering with a GP and accessing services that they are eligible for and entitled to. This has the potential for substantial reductions in morbidity and mortality, and public sector costs associated with homelessness.

There is variation in the extent to which frontline staff are aware of their legal duties under the [Homelessness Reduction Act 2017](#), including the duty to refer. Services may need to support their staff in legal literacy and to have the skills and knowledge to identify and support people experiencing homelessness. Training could be delivered in low-cost ways, such as remotely, using pre-recorded sessions, and could coincide with existing training. Both governmental and voluntary organisations have produced materials that are readily available online. The cost for this is therefore not expected to be significant and it could lead to better and more efficient care. Timely and appropriate care can avert the need for expensive crisis care and A&E visits, and reduce other public sector costs associated with homelessness.

Long waiting times for appointments in current practice are a significant barrier for engagement and timely care. Situations can quickly deteriorate, or the person might disengage because their needs are not being met. Shorter waiting times for people experiencing homelessness may avoid a crisis, lower the chances of needing expensive emergency services, and prevent complex morbidity and premature death.

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Outreach services

[Recommendations 1.5.13 to 1.5.17](#)

Why the committee made the recommendations

Qualitative evidence highlighted that people experiencing homelessness often face barriers to accessing services through standard routes, and are often disengaged with health and social care. Outreach is an established way to bring services to people who

may otherwise find it hard to reach them. There is limited effectiveness evidence on outreach models, although evidence on a London-based outreach service to screen vulnerable people for hepatitis C and offer peer support for getting treatment in secondary care was shown to be cost effective.

Moderate-quality evidence from qualitative studies suggested various benefits of outreach services, including increased access to immediate care and increased knowledge of health issues, available services, and healthcare entitlements. The evidence also highlighted that outreach services can be more flexible than traditional healthcare services and that bringing services to people builds a feeling of trust and connection with service providers while reducing the sense of isolation. The committee considered outreach services important to identify people who might otherwise be missed.

Because people experiencing homelessness have a wide range of health and social care needs, the committee agreed that outreach teams should be multidisciplinary and also equipped to respond to needs of people with different, intersecting experiences relating to, for example, gender, ethnicity and being part of the LGBT+ community. Evidence from several economic studies showed that a multidisciplinary approach in general provided value for money in relation to the homeless population. While this was not specific to outreach teams, the committee agreed that given the severe and multiple disadvantage people experiencing homelessness often face, multidisciplinary outreach teams are justified and essential for meaningful response to people's needs.

Good qualitative evidence showed that some people who are resistant to support or who feel overwhelmed by it might feel more motivated if ongoing support is available, including repeated attempts to engage with the person without placing pressure on them. The committee agreed, based on their knowledge and experience, that an 'assertive outreach' approach is useful in improving engagement for those who may be reluctant to engage with services and who would benefit from a high level of support. 'Assertive outreach' is most often used for people with complex mental health needs and drug or alcohol treatment needs. This is in line with the [recommendations about maintaining contact with services in the NICE guideline on coexisting severe mental illness and substance misuse](#). The committee agreed that this approach could also be considered for other people experiencing homelessness who are likely to benefit from health and social care but who are disengaged, for example, because of lack of trust or previous negative experiences.

How the recommendations might affect 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.

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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 others, in line with the [Care Act 2014](#) and the [Mental Health Act 1983](#), and professional codes such as the [Nursing and Midwifery Council Code](#), [General Medical Council's Good medical](#)

practice and Social Work England's Professional standards. The committee were aware of case reviews and Safeguarding Adults Reviews on people experiencing homelessness showing that this risk had been missed, leading to death. This is particularly relevant in the context of homelessness because there is a significant link between homelessness and risk of abuse, neglect and violence, serious mental health problems, self-harm and self-neglect, underpinning the disproportionate rate of premature mortality in this population.

The committee agreed that a comprehensive, holistic health and social care needs assessment within the context of the individual's wider circumstances improves access to health and social care and support that matches the person's needs. They agreed that a multidisciplinary approach is needed to ensure that the full range of health and social care needs are identified, including considering risk and safeguarding issues. Collaborative working also reduces unnecessary duplication and improves communication between professionals working in different services.

The committee were concerned that assessment is commonly perceived by people experiencing homelessness as a process of exclusion. People often have to keep repeating their stories and the assessments can turn into an assessment of eligibility for support rather than a person-centred attempt to understand a person's needs and circumstances. The committee agreed that involving the person in their own assessment process and involving a peer or an advocate could help improve the assessment process. Peers and advocates (who may be peer advocates) can play an important role in bridging the gap between the person experiencing homelessness and professionals. They can make the assessment process feel less formal and therefore more acceptable or accessible to people experiencing homelessness.

The committee were aware that hospital admissions related to homelessness have been increasing. They agreed, based on their knowledge and experience, that hospital admissions are an opportunity for a comprehensive and holistic assessment of a person's needs to enable appropriate personalised care planning that integrates health, social care and housing needs. A hospital stay can be an opportunity to start addressing the often complex and underlying issues that have led people to their situation.

The committee agreed that a comprehensive understanding of the person's physical, mental and social care needs as well as the underlying circumstances of their situation will help when conducting the statutory care and support needs assessment under the Care Act 2014, which sets out local authorities' duties to assess people's needs and their eligibility for publicly funded care and support. The committee noted that the

recommendations on care and support needs assessment and care planning in NICE's guideline on people's experience in adult social care services provides advice on conducting the care and support needs assessment under the Care Act.

The committee were also aware that some people may be entitled to an independent advocate under certain circumstances. For example, the Care Act 2014 mandates that local authorities must appoint an independent advocate to support and represent a person in the local authority-led care, and support needs assessment or safeguarding enquiry if the person has substantial difficulty in being involved in the process, and if they do not have an appropriate person to support them.

The committee pointed out that after the person's needs are established and support planned to meet these needs, many people experience difficulties with ongoing support. Because the needs assessment process can be challenging, the committee agreed that the person's support needs should be reviewed as needed, when their situation changes or if they request it, but not based on standard review periods.

How the recommendations might affect services

Identifying immediate risk of harm to self or others reinforces a statutory and professional duty, and does not represent a change in practice.

A comprehensive assessment of health and social care and support needs involves a multidisciplinary approach, can be time-consuming and needs collaboration between professionals from different agencies. This should be happening across all services. However, practice is variable and these recommendations may represent a change in practice and result in a resource impact for some services.

Hospital admissions are good opportunities to provide a comprehensive and holistic assessment of safeguarding, physical and mental health, drug and alcohol treatment needs, and social care needs for people experiencing homelessness. This does not often happen in current practice and the committee thought that this was a missed opportunity to assess the person's comprehensive needs and start integrated care. The recommendations in this area may mean that services will need to plan for more tests, procedures and practitioner time. This could prolong a hospital stay, although discharge to the community would likely be safer and future admissions could be avoided. Such a proactive approach could have benefits in the long term, such as preventing people from getting into crisis because of unidentified needs, and reducing morbidity and mortality,

and associated homelessness costs.

As a result of the recommendations, more people experiencing homelessness who may benefit from high levels of support may have an assessment of social care needs and go on to engage with services. But an appropriate assessment of the health and social care needs of some of the most marginalised people in society will ensure timely and appropriate care and support for them, with a potential for reduced morbidity, mortality and associated public sector costs.

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Intermediate care

[Recommendation 1.7.1](#)

Why the committee made the recommendation

Intermediate care is a multidisciplinary service that helps people to be as independent as possible and provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. Evidence from several economic studies suggested that it is cost effective and potentially cost saving. The committee agreed that providing such services would help avoid hospital admissions and ensure safe and timely discharge from hospital and transition to the community. Intermediate care can also prevent or shorten expensive inpatient care and provide appropriate care and support to people in need of more intense support than otherwise provided in the community.

How the recommendation might affect services

Intermediate care, including step-down and step-up care, would represent a change in practice because this service is currently rare for people experiencing homelessness. This would need some funding but there is evidence that intermediate care represents value for money. Furthermore, considering the immense human and societal costs of homelessness, providing care that can support recovery and prevent repeat homelessness is likely to be beneficial to society overall. Intermediate care can be delivered in the community, such as in suitable hostels, or in designated facilities.

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Transitions between different settings

Recommendations 1.8.1 to 1.8.4

Why the committee made the recommendations

The committee discussed that people experiencing homelessness can be vulnerable during transition periods. However, testimony by expert witnesses also highlighted that these can also be opportunities for engagement and intervention. The committee agreed that transition periods can be a chance to build foundations for lasting support in the community.

The committee noted that a phased, focused and person-centred approach to transitions is currently unusual. Often the person is discharged or moves between services, settings or areas without thorough planning, follow up or coordination. For example, sometimes the person's homeless status and related needs are identified only at the point of discharge from hospital into the community. Identifying needs and collaboration between professionals and agencies is therefore essential.

Effectiveness evidence comparing 'critical time intervention' (time-limited intensive support during a transition period) with usual care among people experiencing homelessness, including discharge from psychiatric inpatient care and moving from a homeless shelter to the community, showed benefits in terms of mental health service use, housing status and reduced psychiatric re-hospitalisation, although no difference in quality of life was reported. Despite some methodological limitations and mixed results in the evidence, the committee agreed that the general approach and key principles of critical time intervention should form the basis of recommendations on support for key transitions. This is because any transition between settings can be challenging, with a risk of people falling through the gaps, but with appropriate support, it can also be an opportunity for improved engagement and recovery.

The 'critical time intervention' model includes establishing a trusting and enduring relationship, and a gradual decrease in the intensity of support over a fixed period of time. The time period in the studies was 9 months, but the committee agreed that the length of time needed for intense support during transition would depend on the circumstances and needs of the person. The committee agreed that, to make successful transitions, it is fundamental to start support before the move and continue it during and after transition. This needs an effective and coordinated handover across teams and practitioners. Good

qualitative evidence highlighted that staff from all types of services recognised that most care is provided in silos with minimal coordination between agencies and providers. The findings emphasised the need for a more coordinated approach with appropriate information sharing. Good-quality evidence from qualitative studies also emphasised the importance of information sharing between practitioners so that people do not have to repeatedly give the same information. A trusting relationship is also more likely when support is from a single person throughout, or a coordinated team, reducing the need to repeat life stories and any associated trauma. Critical time interventions are seen as a holistic approach to support. The committee wished to reflect this, emphasising the need to link people with other services and the wider community, according to their needs and preferences.

Irregular discharge (self-discharge against medical advice) represents a missed opportunity for services to engage with a person experiencing homelessness and to start integrated care. A common cause of self-discharge is when people experiencing homelessness have a history of problem opioid use and do not have access to the right dose of methadone according to their treatment plan in the community, so they self-discharge to address their withdrawal symptoms.

For some people with drug and alcohol treatment needs, a hospital admission is an opportunity to detox. If people experiencing homelessness return to the streets without appropriate support after detox, they have an increased risk of overdose and a risk that any care plans will fail. It is important that there are procedures to minimise self-discharges and prevent discharges to the street so that risks can be reduced, and discharges are as safe as possible. Reviewing incidents of self-discharge or discharge to the street can improve procedures and care in the future. The [Department of Health and Social Care's Hospital discharge and community support: policy and operating model](#) refers to the [King's College London's support tool and briefing notes on transforming out-of-hospital care for people who are homeless](#), which outlines how safe and timely transfers of care can be delivered.

The committee also highlighted other NICE guidelines that cover important transition periods that may be applicable to people experiencing homelessness.

How the recommendations might affect services

There is wide variation in the support provided during transitions between settings. The recommendations should increase sustained support and lead to a more coordinated

response to needs. This in turn could lead to reduced re-attendance after leaving hospital or breakdown of tenancy, and reduced morbidity and mortality.

Procedures to review cases when a person experiencing homelessness has self-discharged or has been discharged to the street may be a change in practice for some hospitals. But, by learning from these situations and improving practice, there would be an opportunity to prevent irregular discharge in the future and improve outcomes for patients. Having a dedicated homelessness multidisciplinary team or designated homelessness lead working with the discharge team can help strengthen links to community services where people get methadone to ensure they continue to receive the right dose in hospitals. Enhanced connections with social services and local authorities will help link people experiencing homelessness to the right support. This may need additional resources, but reductions in morbidity, mortality and associated costs should offset additional costs in the long run. There was evidence that effective hospital discharge represents value for money.

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Housing with health and social care support

[Recommendations 1.9.1 to 1.9.5](#)

Why the committee made the recommendations

Access to suitable accommodation is a key determinant of health and social care outcomes. The committee discussed, based on their knowledge and experience, that there are various aspects of accommodation that can either hinder or help a person's recovery process and their engagement with health and social care. These might include practical and logistical considerations, such as the distance to health or social care services, accessibility, aids, and appropriate storage for medication.

There was good effectiveness evidence from the Housing First trials that people are more likely to stay housed if their accommodation has wraparound health and social care support. There was also evidence that this approach could be cost effective. The committee's experience of health and social care services designed to support housing was positive, and tenancy sustainment was commonly achieved through this wraparound approach. The committee agreed, based on their knowledge and experience, that the level of support depends on the person's needs, with some people needing specialist onsite

support. These could be people with high levels of need or severe and multiple disadvantage who are vulnerable to abuse and exploitation, young people who have no experience of independent living, people who have experienced domestic abuse, or people with particular care needs who need support in everyday life because of premature aging, acquired brain injury or disability.

The committee discussed the lack of evidence on how to improve needs-based wraparound support for people with severe and multiple disadvantage and premature frailty, particularly those who have experience of rough sleeping. The committee made a research recommendation on the structural and systems factors in health and social care that could help or hinder commissioning and delivery of wraparound support integrated with housing and they agreed that research in this area should consider inequalities and collect data that enable the impact on different groups to be studied. The equality impact assessment provides further information on equalities considerations for this guideline.

Moving into independent accommodation may seem like a positive transition, but based on the committee's experience, this can be one of the most difficult times for people who may have a history of traumatic experiences, have severe and multiple disadvantage, feel profoundly unsafe or have low self-confidence. Such a transition often causes the person to reflect on what has happened to them, which can be triggering and cause re-experiencing of trauma. It can lead to relapses in recovery, including problems with drug or alcohol use. Furthermore, people living in temporary accommodation or on the streets can form bonds with their peers that provide mutual support and a sense of belonging. This may be replaced by a feeling of isolation and loneliness when moving into independent accommodation. Effectiveness evidence on 'critical time interventions' showed that time-limited intense support, gradually lowered over time during transition periods, did not sustain all benefits over time, so the committee agreed that emotional and practical support should be provided for as long as is needed in this situation.

The committee also agreed that an assessment of the risks that could jeopardise the person's recovery, alongside recognition of their strengths, can help recovery, inform appropriate support needs and help people to stay in housing.

How the recommendations might affect services

There is variation in current availability and provision of health and social care support associated with housing. The recommendations aim to reduce variation in practice.

The Housing First model has been used in England to some extent and there is evidence that it represents value for money, but the associated wraparound support is variable and sometimes lacking. To provide wraparound care and support, better collaboration is needed between housing, health and social care services. Services may need to reorganise existing resources, including improving communication between agencies and services and allowing more practitioner time.

Local authorities should already have a range of housing options for differing support needs, although in some areas, accommodation with onsite support might be limited.

Additional costs of providing wraparound support with accommodation, according to needs, are likely to be offset by improved health and social care engagement and outcomes, sustained tenancy, reduced use of expensive emergency services and a reduced return to homelessness and associated costs.

Risk assessment at the start of residency is a low-cost intervention that can potentially mitigate significant harmful outcomes.

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Safeguarding

[Recommendations 1.10.1 to 1.10.7](#)

Why the committee made the recommendations

No effectiveness evidence was identified on the role of adult social work, and safeguarding in particular, in an integrated response to the needs of people experiencing homelessness. The recommendations on safeguarding are based on testimony by experts who were invited by the committee to speak about the role of social work and adult safeguarding.

The experts highlighted the importance of understanding the person's backstory and historical context that led to the current situation, recognising the link between homelessness and self-neglect, the impact of trauma and how risk-taking can be a coping strategy. Because of the value of having a trusting relationship with the person experiencing homelessness, the experts emphasised the importance of having a single key person as a safeguarding lead in an integrated service model.

Section 42 of the Care Act 2014 requires local authorities to make a safeguarding enquiry if an adult with care and support needs is experiencing or at risk of abuse or neglect. The committee agreed that a social worker within a homelessness multidisciplinary team would often be best placed to lead on these enquiries for people experiencing homelessness because of their professional expertise on the assessment and related legal duties and powers.

The experts suggested that safeguarding issues related to homeless populations have historically not been widely considered by Safeguarding Adults Boards. The committee agreed that having a homelessness lead in the Safeguarding Adults Boards could enhance learning and improve practice. The committee also agreed that Safeguarding Adults Boards have an important role in promoting understanding and best practice within local agencies related to safeguarding people experiencing homelessness, including through their statutory strategic plan and annual report and learning from Safeguarding Adults Reviews. By analysing and interrogating safeguarding notifications related to homelessness, the Safeguarding Adults Boards can also enhance their understanding of the appropriateness of local safeguarding arrangements.

Finally, the experts highlighted the need for health and social care staff to understand the legal duties and powers related to safeguarding people experiencing homelessness, so that their welfare could be protected, concerns could be identified and addressed early, and harm mitigated.

How the recommendations might affect services

There are legal duties for safeguarding under the Care Act 2014 and the recommendations in this area only highlight the existing safeguarding responsibilities of service managers and local authorities. Teams involved in active safeguarding cases should already have legal literacy around safeguarding relevant legislation and the intersection of homelessness and multiple disadvantages, but may need more training.

Currently, based on the committee's experience, people experiencing homelessness often fall through the gaps, and safeguarding concerns are not identified and safeguarding notifications are not made. There may be a resource impact for services with practices that are sub-optimal and not aligned with legislation. Safeguarding will ensure that appropriate support plans are in place to manage the risks identified. For example, a person might be supported to move to more suitable accommodation.

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Long-term support

[Recommendations 1.11.1 to 1.11.6](#)

Why the committee made the recommendations

People experiencing homelessness often need support due to severe and multiple disadvantage, including intersecting physical and mental health needs, psychological trauma, drug and alcohol treatment needs, and social care needs. The committee agreed that sustained effort and commitment from services is needed to support their recovery journey, which may often be non-linear.

Good-quality evidence from qualitative studies showed that people experiencing homelessness often experience a lack of consistency and continuity from health and social care services. There was also good qualitative evidence that ongoing, sustained support, and a service provider's patience and continued attempts to offer support, can improve the person's engagement when they might otherwise be resistant to support. Conversely, discontinuity or interruption of care could lead to disengagement with services.

There was plenty of good-quality evidence from qualitative studies emphasising the importance of a trusting and respectful relationship between the person experiencing homelessness and the person supporting them. The evidence showed that continuity of care enabled people to form a relationship with their care provider. The committee agreed, based on their experience, that a trusting relationship is rarely built through a short-term contact but usually needs consistent and sustained contact from 1 main lead or a small team of people who are part of integrated services across agencies.

Good qualitative evidence suggested that people experiencing homelessness often prioritise their immediate needs over receiving care. The committee discussed that addressing immediate needs can be an opportunity to build long-term engagement with services.

From their knowledge and experience, the committee were aware that people experiencing homelessness did not always follow a linear recovery journey and can encounter a relapse or crisis. Therefore, the committee thought it was important that services were flexible in allowing people to easily re-engage with services so that their

situation would not escalate or deteriorate further.

Premature ageing and frailty is common in people experiencing severe and multiple disadvantage and homelessness, and the committee discussed that improvements in their wellbeing can be made if long-term care and support plans take this into account.

The committee also recognised that not all people will recover and risk of premature death is higher in people experiencing homelessness compared with the general population. Palliative care has often not been available for people experiencing homelessness and those who are approaching the end of their lives may remain in for example hostel accommodation without provision of appropriate end of life care that supports the person's preferences.

How the recommendations might affect services

The recovery journey for some people can take a long time, and services need to be persistent, invest in building trust, and recognise that the process will often not be linear. Currently, long-term continued support is quite rare, and funding of services is often not aligned with such an approach. For example, tenancy sustainment teams are often underfunded and only offer time-limited support of varying quality. Offering long-term support could cost more because it may, for example, need lower caseloads, although for many people, the intensity and frequency of support will likely lessen over time. But the value of investing in systems that facilitate longer-term support and sustained care and engagement is likely to outweigh additional costs through, for example, reduced homelessness and morbidity and mortality, and associated public sector costs. Investing in longer-term support will likely help prevent people from returning to homelessness and needing more acute support. Services may need more capacity initially, but longer-term provision of timely help can stabilise people and prevent a crisis, which will be more detrimental for the person and more costly to services.

Currently, people experiencing homelessness have limited access to palliative care services. This should be improved with the introduction of homelessness multidisciplinary teams, coordinated care and improved access to specialist services, including palliative care. Palliative care services already exist, and should become more accessible to people experiencing homelessness.

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Staff support and development

Recommendations 1.12.1 to 1.12.3

Why the committee made the recommendations

Good qualitative evidence showed that healthcare professionals felt ill-equipped and had insufficient knowledge of social determinants of health and homelessness, and the associated health needs for complicated health problems such as addiction and mental health problems. The evidence also showed that people experiencing homelessness felt that service providers did not understand the practicalities of being homeless and their specific needs. The committee discussed that further training and support was needed to strengthen the capacity of health and social care providers to address people's severe and multiple disadvantage and diverse needs.

The qualitative evidence also showed that training would raise awareness and improve provider knowledge in this area, and improve sensitivity and understanding for this population, so that care providers overcome preconceived ideas and judgemental behaviour. Good qualitative evidence showed that most people experiencing homelessness reported experience of discrimination on some level, with many recounting some form of prejudiced behaviour from service providers. The committee discussed that health and care providers should be trained to consider people's preferences rather than making assumptions about their needs and care solely based on their behaviour or appearance, for example. Furthermore, the committee discussed the importance of practitioners understanding and responding to the intersectionality of multiple disadvantages that people experiencing homelessness may face because of their characteristics.

Limited evidence from qualitative studies among service providers also showed that some lack awareness of the impact that trauma has on a young person's life and how it may manifest in their behaviour. The evidence suggested that providers who do not operate from a trauma-informed care approach may inadvertently serve as a barrier.

Experts also highlighted the importance of health and social care professionals' legal literacy and understanding of their duties and powers in relation to homelessness, mental capacity and safeguarding.

The committee were aware that there are various existing training and materials that

organisations could use, such as [e-learning for healthcare resources on tackling homelessness](#), free [online training modules by the Faculty for Homeless and Inclusion Health](#) and [Public Health England's guidance on homelessness: applying 'All Our Health'](#) and further resources in Health Education England's inclusion health education mapping and review.

Experts highlighted the importance of staff support and supervision, which enables reflection on experiences and practices to enable continuous learning for staff and development of both the staff and practices. The committee agreed that reflective practice and supervision can increase staff motivation and wellbeing, quality of care and services.

How the recommendations might affect services

Currently, there is variation in training opportunities for health and social care staff who encounter people experiencing homelessness. Most statutory agencies regularly train their staff, but training on some issues relevant to homelessness, such as legal duties and powers, is not common practice for all services. This extra training could be delivered alongside existing staff training programmes in a variety of low-cost ways, for example, by remotely using pre-recorded sessions, and could coincide within existing training. Because of existing training and materials, there is no expected significant resource impact.

Training to understand the needs of people experiencing homelessness may mean that more people access specialist homelessness services. Training and ongoing support will facilitate joined-up and more connected services, for example, between specialist services and mainstream services, and ensure a holistic approach and a framework of support. Improved knowledge and understanding will improve access and care for people experiencing homelessness. Practitioners will be better placed to give information about available health and social care services, and enable services to meet people's needs before their problems escalate. For example, most people could be legally housed by local authorities and councils if more professionals had a better understanding of homelessness law and guidance.

The recommendations encourage services to include these elements in their training more consistently. They can also influence the development of professional competencies for trainees and future practitioners.

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Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the [NICE topic page on patient and service user care](#).

For full details of the evidence and the guideline committee's discussions, see the [evidence reviews](#). You can also find information about [how the guideline was developed](#), including [details of the committee](#).

NICE has produced [tools and resources to help you put this guideline into practice](#). For general help and advice on putting our guidelines into practice, see [resources to help you put NICE guidance into practice](#).

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