ScotPHN report

Scottish Public Health Network

Restoring the Public Health response to Homelessness in Scotland

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FOREWORD

The NHS across all of Scotland has an important role in improving the health and wellbeing of homeless individuals, children and families and in the prevention of homelessness, which brings with it significant health and social impacts. Through a better understanding of the diverse causes of homelessness and routes into and out of homelessness, public health can lead a collaborative approach to create the right conditions for people to flourish from the early years onwards. For the issue of homelessness, as with so many other 'wicked problems', partnership and prevention are key requirements.

This ScotPHN report brings together the academic evidence and the service experience within Scotland to provide a route map for Public Health to engage fully in the prevention and mitigation of homelessness and its health consequences.

The preparation of this report has been highly consultative and action-oriented, leading to a number of 'early wins' and forging new relationships between health and the wider housing sector. The message drawn from this work was clear: housing (and homelessness) services want a more effective partnership with the NHS and see the key health impacts of good housing for all.

The report sets homelessness in the wider context of social and health inequalities before exploring the interplay of cause and consequence between health and homelessness. New research into multiple exclusion homelessness is demonstrating the importance of transition points across the life course where early service intervention could prevent individuals slipping into severe disadvantage.

The new Joint Integration Bodies offer fresh opportunities for health and housing services to work more closely in both mitigation and prevention. The report suggests a number of means by which this might be achieved.

In developing the report, the role of the 2005 Health and Homelessness Standards was consulted on extensively with stakeholders. While the principles that lie behind these standards are enduring, there is a need to review and embed outcome-focussed standards across a broader range of services working with those who experience complex health disadvantage.

The report documents the progress already achieved as a consequence of the work which went into the report and lists other areas which require further engagement.

Perhaps most importantly of all, it concludes with a review of 'takeaway messages' and sets out a range of opportunities for public health action arising from the report.

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"Preventing homelessness is important to alleviate the misery that homelessness causes"[1]

1. INTRODUCTION

It is timely to revisit the role of the NHS in improving the health of homeless people. It is now 10 years since the Health and Homelessness standards[2] were published by the then Scottish Executive (See Appendix A). The Ministerial foreword to the standards stated that:

> *'we see a key role for the NHS in tackling health inequalities by ensuring services are planned for, designed and delivered in ways that meet the needs of homeless people'.*

The NHS in Scotland continues to have a 'key' role in meeting the needs of homeless people, but the policy context and structures in place for delivery have changed since the standards were produced in 2005. There have also been two committees at the Scottish Parliament that have undertaken inquiries into homelessness recently; the Equal Opportunities Committee published a report: *Having and Keeping a Home: steps to preventing homelessness among young people in 2012.*[3] The Infrastructure and Capital Investment Committee published a report in 2012 on the Scottish Government '2012 homelessness commitment'.[4] Both Committees have followed up on this work in 2014.

Shelter Scotland established a Commission on Housing and Wellbeing[5] in the autumn of 2013. The Commission will report in June 2015 on the importance of housing for general wellbeing in Scotland and will provide recommendations to help improve housing conditions in Scotland and enhance wellbeing. The prevention of homelessness, particularly repeat homelessness, the importance of joint agency working and the role of housing in Health and Social Care Partnerships is highlighted by the Commission. The June launch of the Commission report with the likely media attention is timely in relation to this report which addresses the NHS contribution to that broader agenda of housing and health.

The role of this ScotPHN report is two-fold:

- to revisit the NHS's role in improving the health of homeless people, particularly given the opportunities that health and social care integration offers; and
- to explore the opportunities for the NHS to play a full role in the prevention of homelessness.

The report was commissioned by, and intended for, the Scottish Directors of Public Health. It sets out the approach that has been taken to inform the key messages in the report and the achievements to date which will support local work by Directors of Public Health. Leadership by public health will be vital if the report is to have the intended effect of bringing attention to the NHS's role in preventing homelessness and the associated significant health and social impacts.

The genesis of this report has been different to some ScotPHN reports; though, arguably, it has been one which most fully reflects the wide scope of the national public health network.

The nature of homelessness and its underlying causes has meant that wide engagement across many sectors was prioritised to support subsequent actions arising from the report. Making face to face links and building relationships across sectors and within health has been a key part of the development process and was intended to provide a fertile environment conducive to future work nationally and locally. A list of the organisations and individuals contacted is attached in Appendix B. A number of specific developments at a national level have already been prompted through this engagement process which will support work locally.

Discussions also took place with each health and homelessness lead(s) in territorial Health Boards. A summary of the issues raised is laid out in Appendix C.

This report does not seek to outline every relevant policy as by the very nature of homelessness it touches upon many. Rather it intends to signpost to relevant policies and legislation and highlight what we know from existing research on health and homelessness. Reflective questions are posed to provoke thought and discussion on particular issues. A literature review was undertaken and will be published together with this report on the ScotPHN website where examples of current practice identified through discussions with stakeholders can also be shared.

The report therefore provides an overview of progress and achievements as a consequence of this approach to the topic, openings for further engagement, key takeaway messages and finally the opportunities this presents for public health leadership and engagement.

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2. HEALTH INEQUALITIES

The role of the NHS in tackling health inequalities is a clear priority for NHS Scotland. There have been a number of important policies and reviews in recent years as well as a continuing commitment to address health inequalities across the political spectrum:

- Equally Well, 2008;
- Achieving our Potential: A framework to tackle poverty and income inequality in Scotland, 2008;
- The Early Years Framework, 2008;
- Fair Society, Healthy Lives ('The Marmot Review'), 2010;
- Report of the Ministerial Task Force on Health Inequalities (Equally Well Reviews), 2010, 2013;
- Commission on the future delivery of public services (The Christie Commission), 2010 and Scottish Government's response to Christie, 2011;
- The Child Poverty Strategy for Scotland, 2011;
- Health Inequalities in Scotland, Audit Scotland, 2012;
- Working for Health Equity: The role of Health Professionals, 2013;
- NHS Health Scotland's policy review 2013;
- Children and Young People (Scotland) Act 2014; and
- Report on Health Inequalities, Health and Sport Committee, 2015.

Homelessness is both a consequence and a cause of poverty, social and health inequality. It is also, in many cases, a 'late marker' of severe and complex disadvantage which can be identified across the life course of individuals.[6] The causes of health inequalities are complex. The World Health Organisation recognises the causes to be a result of inequalities in income, power and wealth.[7] Poverty is a pervasive factor for those experiencing homelessness and at risk of homelessness. Homelessness, and particularly repeat homelessness, can often be an extreme form of social exclusion and inequality[8]; the visible iceberg of a much larger issue of complex disadvantage below the waterline. Therefore, all policies which seek to address poverty, inequalities and health inequalities across the life-course have an important contribution to the prevention of homelessness. Raising awareness and understanding about homelessness as a late manifestation of social and health inequity will help to make the life-course approach to its prevention more explicit.

Homelessness is both a consequence and a cause of poverty, social and health inequality. It is also, in many cases, a 'late marker' of severe and complex disadvantage which can be identified across the life course of individuals.

The evidence on health inequalities tells us that action is needed to address social inequalities in order to prevent health inequalities.[9] Current understanding on the causes of health inequalities is shown in Figure 1. A strategy to address homelessness as a significant health inequality will require action across all areas of the determinants of health inequalities; fundamental causes, environmental influences and individual experiences.

Action at the individual level may include equitable access to services and specific out-reach arrangements. For prevention, attention is required at the social and interpersonal aspects (see Fig1 below).[10] However, action is also required further 'upstream' for the prevention of homelessness, such as good parenting, life skills development, education, training and support for young people, and purposeful paid employment for youth and adults alike. Working with community planning partners is therefore important in identifying the right actions to address inequalities and prevention at council level. Demonstrating leadership in community planning is a requirement for NHS Boards in Local Delivery Plans for 2015/16 and the issue of homelessness prevention is a good downstream marker of attention to poverty and the socioeconomic determinants of health.

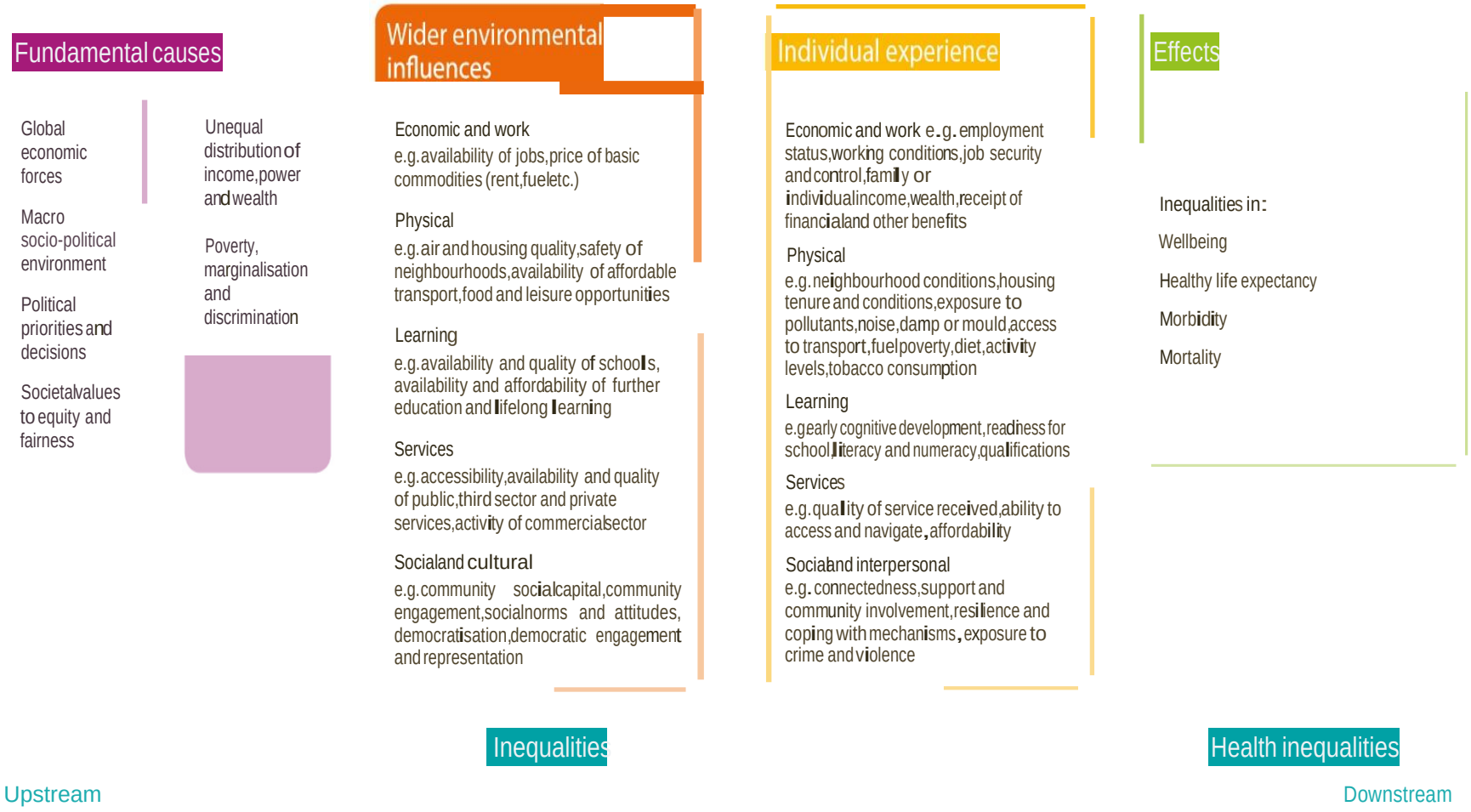
Current guidance for Boards on the health inequalities and prevention priority[11] set out six areas for action:

- Health Inequalities and Prevention;
- Antenatal and Early Years;
- Person-centred care;
- Safe care; and
- Primary Care.

These include a specific action to support the most vulnerable people and communities. Considering the needs of homeless people should therefore be part of annual NHS Boards' Local Delivery Plans, given the particular vulnerabilities of this group.

The issue of homelessness prevention is a good downstream marker of attention to poverty and the socioeconomic determinants of health.

Figure 1: Health Inequalities: theory of causation[10]



3. HEALTH AND HOMELESSNESS

"Tackling and preventing homelessness is a vital part of fighting poverty, but being homeless doesn't mean not having a roof over your head or being out on the street. Only a tiny proportion of homeless people sleep rough. Many stay on friends' floors or with family, sometimes in precarious arrangements. Under the Housing (Scotland) Act 1987, a person should be treated as homeless even if they have accommodation, if it would not be reasonable for the person to continue to occupy it."

Scottish Government

(Source: www.gov.scot/Topics/Built-Environment/Housing/homeless)

Homeless people experience poorer physical and mental health than the general population.[12,13] A 2014 health audit of over 2500 homeless people in England found much higher prevalence of physical, mental and substance misuse issues in the homeless population compared to the general population (see Table 1).[14]

Table 1

Health Issue	Homeless Population	General Population
Long term physical health problems	41%	28%
Diagnosed mental health problems	45%	25%
Taken drugs in the past month	36%	5%

(Source: Homeless Link, Health Audit, 2014)

Homeless people have a much higher risk of death from a range of causes than the general population.[15] A retrospective five year study in Glasgow found that being homeless increases the risk of death from drugs by seven times, trebles the risk from chest conditions and doubles risk from circulatory conditions. Many of the health conditions that homeless people develop in their 40s and 50s are more commonly seen in people decades older. The average age of death for a homeless male person is 47 compared to 77 in the general population.[16] In 2013-14, the average age of death for a Crisis Service user in Edinburgh was 36 years.

The most common health needs of homeless people relate to mental ill-health, alcohol abuse and illicit drug use and dual diagnosis is frequent.[17,18] Violence such as injuries and assaults are also a threat to the physical and psychological health of homeless people.[19,20] Depression and suicides are higher among homeless people compared to the general population. Mental ill health is both a cause and a consequence of homelessness as are alcohol and drug abuse.[21,22] There is also a complex relationship between homelessness and offending with an increase in the risk of homelessness for those who have spent time in prison and a lack of stable

accommodation increasing the risk of (re)offending.[23]

In summary, the research indicates that homeless households experience poorer physical and mental health, which can be exacerbated by continuing homelessness and insecure, poor living conditions. Mortality rates are higher, highlighting the extreme health inequalities experienced by this group.

Homeless people are therefore not enjoying the right to the highest attainable standard of health, a right recognised within the European Convention on Economic, Social and Cultural Rights.[24] The right to health should be equally available, accessible, acceptable and of good quality to people experiencing homelessness.

Poor health is not only a consequence of homelessness but can also be an underlying cause. Scottish Government statistics published in June 2014[25], show that 34% of households assessed as homeless in 2013-14 were assessed as having one or more support needs. This included 13% because of mental health, 14% required support or skills for independent living and 12% required support because of alcohol or drug dependency.

Poor health as a trigger for homelessness is recognised in the Scottish Government's guidance on the prevention of homelessness.[26] It identifies particular groups of the population with health and support needs who may be at high risk of homelessness; people at transition points (looked after children and young people, armed forces, hospital discharge, leaving prison, refugees) and those who have experienced domestic abuse, addictions, poor mental health and family break-ups. Improving outcomes for these particular population groups is identified across a range of policy areas. It presents an opportunity to link action in these areas to the prevention of homelessness at community and local area planning partnerships.

Homelessness also adversely impacts on children's health and wellbeing. Homeless children have shown higher rates of acute and chronic health problems than low income children with homes.[27] Children's development can be damaged and delayed by disruptions to important relationships and the failure to establish or maintain a familiar environment.[28] Homelessness in childhood has been found to be part of most street homeless people's life histories along with school or family problems, indicating the need to support families experiencing homelessness in order to avoid and break such patterns.[29,30] Homeless children are therefore a particularly vulnerable group and unstable accommodation can result in difficulties for homeless families to access services.[31]

Reflective Question:

If 'homelessness' was a protected characteristic like age or gender in terms of Scottish equality legislation, what would change in the NHS service response?

4. MULTIPLE EXCLUSION HOMELESSNESS

"Despite the common sense …, we still categorise people in separate boxes defined by single issues…Each of these labels triggers a different response from statutory and voluntary systems, different attitudes from the public and media, different theoretical approaches from universities, different prescriptions from policy makers."

Julian Cornder, *Chief Executive, LankellyChase Foundation*[32]

A large body of evidence has been building up on 'multiple exclusion homelessness' [33,34,35] and it may be helpful to distinguish this particular form of homelessness from other types.

For some people, homelessness may be a one-off occurrence due to a particular circumstance and which through an application to the local authority can result in the housing need being met. Others may have more complex issues but with the appropriate help can be supported into stable accommodation.

However, for those identified with the most complex issues or 'multiple exclusion homelessness', homelessness can be the result of a number of issues which housing alone will not solve.[36] The complexity of issues faced by those experiencing 'multiple exclusion homelessness', a form of deep social exclusion including homelessness, mental health problems, drug and alcohol dependencies, street culture activities and institutional experiences, raises important questions about how such complexity is best addressed by services and prevented in the future.[37] Research has found that early childhood trauma can often be at the root of 'multiple exclusion homelessness' highlighting the need to recognise this as an early sign of potential routes into multiple exclusion homelessness. Self-harm and suicide attempts are prevalent in adulthood. From such research, recommendations for psychologically informed service environments have emerged for those working with people experiencing multiple exclusion homelessness.

Early childhood trauma can often be at the root of 'multiple exclusion homelessness' highlighting the need to recognise this as an early sign.

Building on this work, a recent report has mapped severe and multiple disadvantage in England.[38] The term 'severe and multiple disadvantage' was used to signify the problems faced by adults involved in homelessness, substance misuse and criminal justice systems in England. It found considerable overlap between these three populations and highlighted the need for greater collaboration between these sectors as professionals are often working with the same people 'viewed through different lenses'.[39] People facing this form of disadvantage suffer much lower quality of life than other poor and vulnerable groups. Poor educational achievement and childhood

trauma puts people at greater risk of severe and multiple disadvantage than others in similar circumstances of deprivation and poverty.

Homelessness is therefore not only a housing issue. As well as the financial costs through the disproportionate use of certain public services, there are also significant social costs which ripple out from the individual experiencing such disadvantage to families and children.

A new and important finding from the research by Fitzpatrick et al[40] for understanding routes into homelessness, is that visible homelessness often happens very late, following contact with non-housing services such as mental health, substance misuse and criminal justice. This finding highlights critical points in a person's journey into multiple exclusion homelessness and the opportunities for services such as mental health and substance misuse to contribute to the prevention of homelessness. Services need to respond to this new evidence with earlier detection of 'at-risk' individuals and families and appropriate prevention pathways.

For some people, homelessness is not just a housing issue but something that is inextricably linked with complex and chaotic life experiences

5. HEALTH AND HOMELESSNESS PATHWAYS

The role of the NHS in improving the health of homeless people, contributing to preventing homelessness and the importance of working with partners to do so is not new for NHS Scotland. The Health and Homelessness standards (Appendix A) were produced in 2005 by the then Scottish Executive Health Department. The standards are strategic rather than clinical and aimed at the corporate level in NHS Boards, emphasising the significance of leadership in tackling health inequalities. The standards recognised that delivery would be in a large part through Community Health Partnerships. With the establishment of new joint integrated boards through the Public Bodies (Joint Working) (Scotland) Act 2014, a review of the opportunities for the NHS and public health's role are timely. Health and social care integration provides a new structure and set of outcomes by which work on health and homelessness can be delivered, with opportunities to work more seamlessly with local authority partners, including housing colleagues.

The standards when published were underpinned by principles which are still relevant today:

- tackling health inequalities;
- involving service users in the development of services;
- the critical importance of partnership working;
- addressing the particular vulnerabilities of children in homeless families;
- reporting arrangements to the Board; and
- considering the needs of homeless people across a range of strategies and plans e.g. Joint Health Improvement Plan, Drug and Alcohol, Mental Health, equality and diversity.

The standards recognised that improving access to services for those experiencing homelessness would benefit a range of marginalised groups.

An important element to the standards when introduced was the performance assessment process. An annual self-assessment to the Scottish Executive Health Department was required of each area Board and any exceptions reported into the annual accountability review process. Health and Homelessness Action Plans were also formalised by the standards as a way to ensure that links were made to other relevant plans, such as Community Planning. The intention behind formalising health and homelessness action plans was also to ensure that there was appropriate reporting within the Board. This performance management approach to health and homelessness is no longer in place.

To inform this report, telephone or face to face interviews were undertaken with Boards to find out about their work on health and homelessness and to gather views regarding the standards. It is generally accepted that the standards at the time were

useful in bringing focus within the NHS to the needs of homeless people. Discussions around the role for standards has led to the proposal that the underpinning principles should be applied across a range of areas and built into existing governance arrangements within Boards, Health and Social Care Partnerships and Community Planning. The principles are not only relevant to those experiencing homelessness but for a range of vulnerable and excluded groups. This is an approach that has been taken by the Faculty for Homeless and Inclusion Health. The Faculty has developed standards[41] for planning, commissioning and providing care for homeless people and other multiply excluded groups (e.g. gypsy travellers, sex workers, vulnerable migrants). The future role of NHS Scotland Health and Homelessness standards within the wider context of this work is proposed in the section headed 'Opportunities for Public Health Action' below.

Reflective Questions:

How are NHS Boards currently assured that the health needs of homeless people are being met?

How are NHS Boards assured that the prevention of homelessness is linked with other plans and partnership working e.g. community planning, local delivery plan, strategies on health inequalities, early years, ADPs, prisoner health?

6. HOMELESSNESS TODAY

A diverse range of people can be affected by homelessness at different times in their lives and for different reasons, including children and families. Homelessness is an issue for both rural and urban areas.

In 2013-14, there were 36,457 homelessness applications to local authorities of which 28,502 were assessed as homeless. The main reasons for applying as homeless in Scotland are that the household was asked to leave accommodation (26%) and that there was a non-violent dispute within the household/relationship breakdown. The statistics also collect the reasons for failing to maintain accommodation and this includes 14% for drug/alcohol dependency, 12% for mental health reasons and 5% for physical health reasons.

In 2013-14 just under a third of applications assessed as homeless were under 25. While applications from the under 25s have been decreasing as a proportional share of all ages, it is still an overrepresented group within the homelessness statistics. In light of this, homelessness amongst young people is a standing agenda item for the Homelessness Prevention and Strategy Group.

Homelessness is a local authority statutory duty. Households who approach a local authority for homelessness assistance are assessed against the legislation, provided with temporary accommodation (there were 10,308 households in temporary accommodation on 30 September 2014, containing 4,586 children) and if they are seen as not having made themselves homeless, are entitled to settled accommodation. This is generally offered in the social rented sector and local authorities have the power to request Registered Social Landlords (RSL) to assist in re-housing the household.

Scotland has a strong homelessness legislative framework, which has meant that from 2012 all people made homeless through no fault of their own have a right to settled accommodation (See Box1).

As well as the right to settled accommodation should a person become homeless, there is an emphasis on the prevention of homelessness through ‘housing options’ and prevention guidance to local authorities from the Scottish Government.[42] The prevention of homelessness can save public finances[43,44] and local authorities have always had a specific requirement to prevent homelessness, recognising that such prevention will reduce pressure on other services such as health in the longer term.

Box 1: Scotland's Homelessness Legislation

The Housing (Scotland) Act 2001 set out a number of requirements for local authorities including a requirement to prepare strategies for preventing homelessness, to ensure advice on homelessness and its prevention is available, and importantly to provide temporary accommodation and advice to anyone believed to be homeless.

The Homelessness etc (Scotland) Act 2003 set out the framework for fundamental changes to the eligibility criteria for homelessness applications. An important change made by the 2003 Act was that the priority need distinction was abolished by 31 December 2012, often referred to as 'the 2012 target'. This means that all people made homeless as a result of no fault of their own will have a right to settled accommodation. Previously, this only applied to certain groups identified as being in priority need, such as families with dependent children.

Housing Options is the current approach in Scotland to providing housing advice to a person with a housing problem who approaches a local authority. Its focus is on early intervention and exploring a variety of options which will best meet the person's needs. The intention is to avoid a housing crisis and a person or family becoming homeless so relies on working with the person to discuss what is needed, such as debt advice, family mediation, mental health services and the like. Five Housing Options Hubs have been established by Scottish Government, covering all 32 local authorities, to provide support in developing the Housing Options approach through sharing practice and commissioning joint training and research.

There has been a steady drop in homelessness applications in Scotland since 2010 and this has been attributed to the emphasis on prevention through the housing options approach. Housing Options as an approach is relatively new and there continues to be dialogue with the Scottish Housing Regulator (SHR) about improving its delivery. In its report[45] into the approach, the SHR recommended a number of areas where it believed improvements could be made, suggesting that diverting people from a homelessness application through housing options was not always appropriate and could lead to an under-reporting of statutory homelessness. The report did however find good practice and the Hubs are developing a training toolkit to support a more consistent approach. In order to report on the work being done through housing options and prevention, the Scottish Government now collects mandatory data on housing options (PREVENT 1) and is developing national guidance on housing options with its partners.

Reflective Question:

How are health services linked to these Housing Options Hubs and local housing options arrangements to provide the necessary public health and healthcare service advice?

7. THE ROLE OF THE NHS IN PREVENTING HOMELESSNESS

"Many people in society, as part of everyday life, face experiences, or triggers that could lead to homelessness… the evidence backs this up and reinforces our view that we should make every contact count - giving local services the incentives and flexibility they need to work together to intervene earlier to tackle these underlying problems and to ensure that those at risk of homelessness get access to integrated and responsive services - preventing a common life experience from turning into a housing crisis."

"With millions of patient contacts a day, from doctors, nurses and midwives, and far beyond, there is real potential for health services to do more to help identify those at risk of and to prevent homelessness by referring them on to the appropriate service to address their needs."

Making Every Contact Count: A joint approach to preventing homelessness[46]

Preventing homelessness and the risk of homelessness through much earlier intervention and prevention activity is an area where the NHS can contribute greatly. Given what we know about the causes of homelessness, the health of homeless people and the contact with services that some people have prior to a homelessness presentation at a local authority, the prevention of homelessness cannot be led by housing alone.

This is recognised in 'Making every contact count' published by Whitehall's Department for Communities and Local Government in 2012. The report aims to ensure that every contact local agencies make with vulnerable people and families really counts.

The Institute of Health Equity's 2013 report 'Working for Health Equity' lays out clearly how health professionals have an important role to play in tackling the social determinants of health.[47] The current review of the Health Promoting Health Service will embed these principles. It provides an important inequalities-focussed context for health services, particularly the acute sector, to consider a person's housing circumstances, and deliver the holistic approach necessary to find sustainable solutions for people at risk of or currently experiencing homelessness.

The work of NHS Boards and partners in mitigating the impact of welfare reform is also closely aligned to work to prevent homelessness and such approaches can and should be joined up. Interventions to mitigate the impact of welfare reform[48] such as staff training and awareness, financial assessments and signposting and partnership working all offer opportunities to identify people at risk of homelessness. Anecdotal evidence is mounting that welfare reform has led to an increase in rough sleeping and this requires to be formally evidenced and addressed.

8. HEALTH AND SOCIAL CARE INTEGRATION

"Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting…"

"We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission."

Scottish Government 2020 Vision[49]

NHS Scotland's Quality Strategy (2010) sets out a commitment for an NHS that is person-centred, efficient and effective. The context for taking forward the Quality Strategy is set out in the 2020 Vision:

This vision is for everyone; it is equally relevant in meeting the needs of those most marginalised from services, including people affected by homelessness. The Public Bodies (Joint Working) (Scotland) Act 2014 provides the legislative framework for the delivery of integrated health and social care services. Integrated arrangements will have to include at least adult health and social care. Other services such as children's health and social care, criminal justice and housing, can also be included in integrated arrangements, if there is local agreement to do so.

This integration provides an important change in context to the delivery of services for people affected by homelessness.

Strategic Commissioning has been seen as a key component supporting Integration. Strategic Commissioning has been described by the Scottish Government as:

"…the mechanism via which the new integrated partnerships will deliver better care and support for people, and make better use of the significant resources we invest in health and social care provision... strategic commissioning… needs to deliver better outcomes, particularly for people with multi-morbidities and in terms of improving preventative and anticipatory care, with less inappropriate use of institutional care and better support in communities. Its impact will be measured against the statutory national outcomes for health and wellbeing and the indicators that underpin them."[50]

Co-production is an important principle to guide the strategic commissioning process and is recognised to be central in delivering more effective preventative and anticipatory interventions. Listening to the experiences and needs of people affected by homelessness is identified in the existing health and homelessness standards. Health Inequalities Impact Assessment[51] provides a systematic way to ensure the experiences and needs of homeless people are considered when planning mainstream services and developing policy.

There are nine national health and wellbeing outcomes, set out in the Act which provides the strategic framework for the delivery of health and social care (Appendix D). One of the outcomes – Outcome 5 – focusses on how Partnerships will contribute to reducing health inequalities. The accompanying advice note for joint strategic needs analysis, which is the basis for the commissioning process, provides a relevant mechanism to address homelessness at a partnership level.

The 2005 Health and Homelessness Standards recognised the role of the NHS in working with partners to prevent homelessness. Now is the time for NHS Boards and Health and Social Care Partnerships to review their contribution to both meeting the health needs of those experiencing homelessness and in homelessness prevention.

Reflective Question:

How are the health needs of homeless people being assessed as part of the strategic commissioning process and within locality planning?

9. HOUSING AND HEALTH AND SOCIAL CARE INTEGRATION

"The housing sector already makes a very significant contribution to national outcomes on health and social well-being… the integration of adult health and social care is recognised as bringing opportunities to strengthen the connections between housing and health and social care… to support the shift to prevention and to incorporate (and if necessary review) current arrangements for housing support and homelessness services." [52]

Housing has an important part to play in Health and Social Care Partnerships delivering their outcomes.

Most areas of housing services, including homelessness services, will not be within the scope of Partnerships. While some functions must be delegated, such as assisting with the provision of housing adaptations, other functions may be delegated with local agreements such as homelessness services and housing support.

There remains an opportunity through integration to maximise the connections between housing, health and social care to ensure those individuals and families affected by homelessness are supported by all of the necessary agencies.

Reflective Question:

What are the opportunities for public health leadership to maximise connections between housing functions and Health and Social Care Partnerships?

10. PROGRESS AND ACHIEVEMENTS THUS FAR

This ScotPHN review of health and homelessness sought from the beginning to 'prepare the ground' for the intended new focus on the NHS's contribution to impact on the health inequality faced by the homeless community. The process involved gathering data through meetings with academics, GPs, local and national homeless agencies, council, third sector and advocacy groups across the country. Highlighting patterns of hospital usage from work to link homelessness and hospital data in Fife has provided visibility of this work with Scottish Government, COSLA, Association of Local Authority Chief Housing Officers (ALACHO), Health Scotland, NHS Education Scotland and other national housing bodies. This has proved very fruitful as many new and much appreciated connections have now been formed between the 'housing and homelessness' world and the NHS. The decision for NHS Health Scotland to delegate a programme manager alongside the Consultant in Public Health Medicine for the duration of the report research and drafting has worked well as the knowledge and connections are now embedded into Health Scotland.

Key achievements arising out of this collaborative approach have been:

- The Homelessness Prevention and Strategy Group which includes the Minister, COSLA, ALACHO, Scottish Federation Housing Associations and SOLACE now has a health representative on the group and health is now a component part of their work plan;

- A 2 day conference on Homelessness and Exclusion Health held in London was live streamed to audiences in Edinburgh and Glasgow where local discussions were able to apply the learning to the Scottish setting and explore further engagement with Alcohol and Drug Partnerships, mental health services and Police Scotland's violence reduction approaches;

- Presentations to the National meeting of the Housing Hubs, ALACHO, and workshops at Shelter Conference and IRISS[a] have led to invitations for local engagement in service changes;

- Following a presentation to the National Homelessness Statistics Users Group a proposal has now gone to the Chief Statistician requesting resource for a national approach to link council homelessness data with ISD health data and thus create a national picture of health care access and outcomes by the statutory homeless sector;

[a] Institute for Research and Innovation in Social Sciences held a workshop to share findings and inform next steps in their Homelessness Pathways and Prevention project. Information available at: http://www.iriss.org.uk/project/homelessness-pathways-and-prevention

- Positive links have been made between the recommendations from this work and the learning arising from the Shelter Scotland hosted Commission on Housing and Wellbeing due to report in June 2015;

- There is agreement to embed the issue of homelessness into the redevelopment of the Health Promoting Health Service (HPHS) Chief Executive Letter (CEL) for 16/17 and an interim addition of a relevant indicator into the 15/16 HPHS Guidance. This fits well with the intention of the HPHS to focus more on the social determinants of health and health inequalities across both primary and secondary care;

- Housing will be included in the forthcoming Scottish Government framework for health and justice for offenders in the community;

- Health is now invited to help shape the relevant sections (including one specifically on health matters) for a new training toolkit to be commissioned by the Housing Hubs and used as part of the 'preventative' housing options approach being taken across Scotland; and

- The National Health & Homelessness Steering Group (facilitated by NHS Health Scotland) has been closely engaged during this work and is intent on re-energising its role based on the outcome of this report.

11. OPPORTUNITIES FOR FURTHER ENGAGEMENT

In addition to the work already underway, other areas for further discussions have been identified and initial conversations begun. It is hoped that these can be built upon both locally at Board level and nationally by NHS Health Scotland.

- Initial connections have been made with how Police Scotland, through its public health approach to violence reduction and its contact with offenders and their families, can link learning with that of others engaged in homelessness prevention.

- Recent research on 'multiple exclusion homelessness' and discussions with Deep End GPs, the Edinburgh Deprivation Group and learning from the Royal College of Nursing's Nursing at the Edge programme has highlighted the need for a psychological-informed practice approach by front line staff from all professional disciplines.

- An initial discussion with the Scottish Prison Service (SPS) about a 'revolving door' cohort of frequent re-offenders who will often also become homeless has taken place. Further work is needed to explore the possibility of preventative activity between Police Scotland, SPS, housing, criminal justice, social work and health to reduce this system failure for these individuals.

- Front-line practitioners emphasised the importance of early years experiences, childhood poverty and neglect and the role of the educational sector. More conversations will need to take place between homelessness services, the Early Years Collaborative and Education departments to explore this further.

- Options have been raised for forming a Scottish group addressing 'Inclusion Health' based around the work currently under way by the Faculty of Homelessness and Inclusion Health and their proposed standards for commissioners and service providers.[53]

12. KEY LEARNING AND TAKEAWAY MESSAGES

- The recent research by Fitzpatrick[54] and others has brought a new rigour to the understanding of those at the margins of social disadvantage (multiple exclusion homelessness). Not only does the data clearly demonstrate the overlap between homelessness, mental ill-health, substance misuse and offending behaviour but also how homelessness is a late feature of an observable life trajectory which opens opportunities for earlier intervention by a number of agencies including health.

- The importance of 'home' and a secure nurturing environment as a key component of wellbeing for individuals, families and children– the loss of which leads to levels of extreme health inequality. This links to the value of strategic public health engagement with housing partnerships.

- The manner in which housing and homelessness services are focusing on prevention and are seeking health service partnerships to enable clients to avoid the harms associated with homelessness.

- The current opportunities for health to support housing service contributions within the new Health and Social Care Partnerships.

- The value of joint training between health and housing front line staff and the sharing of homelessness and healthcare data.

- The opportunity to embed homelessness prevention and mitigation into early years, education, work with looked after children, mental health, substance misuse, community safety and employability workstreams.

- The requirement for new models of care including 'psychologically-informed practice' and 'housing first' approaches for those experiencing repeat homelessness. As prevention approaches though housing options resolves housing needs for many, those with more complex needs are becoming a higher proportion of homelessness applications.

- The rise in youth homelessness and the increased level of mental distress in those affected.

13. OPPORTUNITIES FOR PUBLIC HEALTH ACTION

Local public health actions include:

1. NHS Boards should consider the inclusion of homelessness prevention and mitigation actions within new or existing Health Inequalities Strategies and their LDP returns under the sections relating to community planning, health inequalities, person-centred care and integration.

2. Directors of Public Health (DsPH) should consider how their Boards actively support the role of housing and homelessness services within their Community Planning Partnerships and Health and Social Care Partnerships (HSCPs) as contributing to population wellbeing and resilience.

3. Local Public Health systems should include the health needs of homeless people, homeless children and families as part of HSCP strategic commissioning processes and locality planning.

4. The DsPH group should request NHS Health Scotland to formulate a work plan based on these findings and initial actions which will embed the needs of the homeless community into wider actions to tackle health inequality.

5. The DsPH should consider the value of releasing resource from the wider Public Health specialist workforce to support regional or national health and homelessness expertise for ongoing engagement and partnership working with housing and linked public and third sector agencies alongside NHS Health Scotland actions.

6. The existing Health & Homelessness Standards should be refreshed and re-branded with a set of measurable indicators and principles that can be applied across a range of services and with relevance to other groups vulnerable to poor health outcomes. This could be supported and led by a revised 'health and homelessness' group, currently facilitated by NHS Health Scotland (Appendix E). Local monitoring arrangements should be explored, for example, the potential to be undertaken by the third sector with the inclusion of reviewers with lived experience of homelessness.

7. DPHs should consider the value in a DPH helping to shape a refreshed health and homelessness group to support the delivery of local work and influence Health's role on the Homelessness Prevention and Strategy Group.

Scottish Government action requiring DPH support for local action include:

8. The embedding of housing-related measures into the future health inequalities focussed Health Promoting Health Service (HPHS) and the intention to drive forward the importance of the links between 'home' and health via the existing Ministerial oversight of the HPHS activity.

9. The value of shared data between housing and health at Board level in order to demonstrate and monitor the healthcare access and health outcomes of the homeless population. The potential to cost the health care needs of this population from this data could be explored.

NHS Health Scotland actions which should be carried forward within their work plan (see action 4 above) include:

10. Ongoing secretariat support for the National Health and Homelessness Group (currently steering group) and its stronger links to the Homelessness Prevention & Strategy Group.

11. A 2015 launch event for the implications of this report and an annual event to update HSCPs, and NHS Boards on recent research, delivery of actions and emerging best practice in the prevention of homelessness and the housing-health interface.

12. With support from Scottish Government Heath and Housing Directorates Health Scotland seek to embed homelessness prevention and mitigation into relevant policy and delivery mechanisms for: Health Promoting Health Service, Community Justice, Mental Health, Financial Inclusion and Welfare Reform Mitigation, Substance Misuse, Early Years, Children and Young People, Fuel Poverty, Place Standard, the public health approach to violence reduction and public health workforce development.

13. As part of strategic support to HSCPs on health inequalities, explore the value from the integration of housing and homelessness services into the new partnerships.

14. Request the National Health and Homelessness Group to assess the value of applying the Faculty of Homelessness & Inclusion's Service Standards to Scotland.[55]

14. APPENDICES

Appendix A: Health and Homelessness Standards

Standard 1 The Board's governance systems provide a framework in which improved health outcomes for homeless people are planned, delivered and sustained.

Standard 2 The Board takes an active role, in partnership with relevant agencies, to prevent and alleviate homelessness.

Standard 3 The Board demonstrates an understanding of the profile and health needs of homeless people across the area.

Standard 4 The Board takes action to ensure homeless people have equitable access to the full range of health services.

Standard 5 The Board's services respond positively to the health needs of homeless people.

Standard 6 The Board is effectively implementing the health and homelessness action plan.

Appendix B: Stakeholder Engagement – December 2014 – May 2015

We discussed health and homelessness with a range of people in sectors including academia, the voluntary sector, local and national homelessness agencies, councils, NHS and Scottish Government. A list of organisations that we discussed this work with is set out below:

NHS Boards

NHS Ayrshire and Arran, NHS Borders, NHS Forth Valley, NHS Fife, NHS Greater Glasgow and Clyde (including Community Health Partnerships in Renfrewshire, West Dunbartonshire and Inverclyde), NHS Grampian, NHS Highland, NHS Lanarkshire, NHS Lothian, NHS Orkney, NHS Shetland, NHS Tayside, NHS Western Isles, NHS Dumfries and Galloway and NHS Education for Scotland.

Voluntary Sector

Shelter Scotland, Homeless Action Scotland, Cyrenians, Aberdeen Foyer, Scottish Churches Housing Action, Bethany Trust, Glasgow Homelessness Network, IRISS (Institute for Research and Innovation in Social Sciences), Rock Trust, Joseph Rowntree Foundation, Housing Support Enabling Unit

Local Authorities

South Lanarkshire Council, Renfrewshire Council, Dumfries & Galloway Council, ALACHO (Association of Local Authority Chief Housing Officers), COSLA, Improvement Service.

Academics

Professor Suzanne Fitzpatrick, Herriot Watt University
Professor Isobel Anderson, Stirling University

GPs

Dr Andrea Williamson and Dr Kerry Milligan, Glasgow Homelessness Practice
Dr John Budd, Edinburgh Access Practice

Scottish Government

Joint Improvement Team
Housing Support and Homelessness Team
Public Health Division

Appendix C: What have NHS Boards told us?

Interviews with each identified health and homelessness lead in area health boards took place between January and April 2015. The framework used during the discussion is included along with a list of those who participated.

The discussions have been organised into the following themes:

- Strategy;
- Performance Management;
- Health and Homelessness Standards;
- Health and Social Care Integration; and
- National Support.

Strategy

There are no specific Health Board strategies on health and homelessness. Instead, NHS Boards are contributing partners to local authority led homelessness strategies and action plans. There are various models, for example, Health and Homelessness Action Plans for each local authority area in NHS Greater Glasgow and Clyde, a Health and Homelessness multi-agency group, chaired by NHS Fife and which reports through the Community Planning Partnership. Boards recognise the multi-agency approach to addressing the health needs of homeless people and to preventing homelessness.

Many Boards have highlighted that homelessness issues are embedded across a range of strategies and plans, for instance, anti-poverty strategies, children's plans, mental health. This work did not appraise these strategies to identify how homelessness was being considered. Given the guidance to NHS Boards for 2015-16 Local Delivery Plans to include action to support the most vulnerable people and communities, it may be that issues around homelessness and its prevention is within these plans.

One theme that emerged from discussion with Boards was that homelessness should be part of Board, Health and Social Care Partnership and Community Planning Partnership strategies to address inequalities and health inequalities. An example from NHS Lanarkshire is the Board's recently approved Health Inequalities Action Plan which identifies homelessness within work to support vulnerable populations.

Performance Management

There is no formal reporting specifically on health and homelessness to NHS Boards or to Scottish Government, as was previously the case when the health and homelessness standards were published in 2005. For some Boards, this work is reported through community planning partnership work to address health inequalities

or is being incorporated into other work, for instance as a factor in work around looked after children.

There was general agreement from Boards that action plans specifically on health and homelessness would not necessarily achieve improved outcomes. Questions were raised about what the current expectations are from Scottish Government on health and homelessness. Boards are keen that any performance management should add value and measure progress towards the outcomes that we are seeking to achieve. There was recognition that the disappearance of performance management around health and homelessness has meant that its profile within Boards has diminished.

Health and Homelessness Standards

All Boards recognised that the standards served a useful purpose when they were published in 2005. They were successful in putting a spotlight on the particular issues around homelessness, the role of the NHS and providing direction to develop work in this area. Most Boards consider the standards to be dated and in need of review. Issues raised around the standards included:

- redrafting to be more outcome-focused and measurable;
- dated and in need of revision in terms of health and social care integration; and
- relevant for many groups vulnerable to poor health and opportunity to link with broader work on health inequalities, without losing the focus on homelessness.

Health and Social Care Integration

All Boards recognised the opportunities that the integration of health and social care offers to work on homelessness prevention and the health of homeless people. It is viewed as a good opportunity to have a debate about the role of housing, issues around homelessness and its prevention. It is also seen as an opportunity for a holistic approach to meeting needs, which is required in tackling homelessness.

National Support

NHS Health Scotland current facilitates a health and homelessness steering group and virtual network. Both the steering group and the network were established to provide a forum for sharing information. A Health and Homelessness event also took place in 2011, facilitated through NHS Health Scotland. As part of the discussions with Boards, views on the current model of support and what is needed was raised. The opportunity to share practice across Scotland in different ways is welcome from Boards. Views from those on the steering group are that its remit should be revisited as it could be utilised much more effectively. The opportunity to maintain a focus on homelessness and as a public health issue, linked with broader work on tackling health inequalities is welcomed.

Appendix D: National Health and Wellbeing Outcomes, Scottish Government

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

By working with individuals and local communities, Integration Authorities will support people to achieve the following outcomes:

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community

Outcome 3: People who use health and social care services have positive experiences of those services, and have their dignity respected

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Outcome 5: Health and social care services contribute to reducing health inequalities

Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well- being

Outcome 7: People using health and social care services are safe from harm

Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services

An associated Core Suite of Integration Indicators has been developed in partnership with NHS Scotland, COSLA and the third and independent sectors, drawing together measures that are appropriate for the whole system under integration.

www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

Appendix E: Health and Homelessness Steering Group

Membership of health and homelessness steering group, facilitated by NHS Health Scotland:

Elaine Caldow, NHS Ayrshire and Arran
Ann Forsyth, NHS Greater Glasgow and Clyde
Yvonne Friel, NHS Health Scotland
Pauline Craig, NHS Health Scotland
Katy Hetherington, NHS Health Scotland
Neil Hamlet, NHS Fife
Jim Hayton, ALACHO
Matthew Howarth, Scottish Government
Robert Aldridge, Homeless Action Scotland
Naureen Ahmad, Scottish Government
Ruth Robin, Shelter
Sue Irvine, Dumfries & Galloway Citizens Advice
Val Holtom, South Lanarkshire Council

Appendix F: ScotPHN Report Steering Group

The following were approached to meet with the report authors to discuss the findings and shape the approach to the report:

Linda de Caestecker, Director of Public Health, NHS GG&C
Jim McCormick, Joseph Rowntree Foundation
Claire Frew, Glasgow Homelessness Network
Marion Gibb, Scottish Government Homelessness Team
Jim Hayton, ALACHO
Pauline Craig, NHS Health Scotland

Phil Mackie,ScotPHN
Ann Conacher, ScotPHN

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ScotPHN report

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