



# Health and Homelessness **standards**





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## Ministerial Foreword

The Scottish Executive is very pleased to publish our *Health and Homelessness Standards* for NHS Boards. They are at the centre of our commitment to improve the health of homeless people.

Homeless people are among the most disadvantaged in our society, with poorer health and lower life expectancy than those who lead more settled lives. This is something we are determined to change and 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.

Good progress has been made in developing and delivering Health and Homelessness Action Plans in response to the *Health and Homelessness Guidance* (September 2001). The Guidance was endorsed by the Minister for Health and Community Care and Minister for Social Justice as a reflection of the Scottish Executive's joined-up approach to tackling homelessness. Our commitment remains firm and the Health and Homelessness Standards will require NHS Boards to re-state and further refine their commitment to meeting the health needs of homeless people.

Improving the health of homeless people requires long-term solutions and the Health and Homelessness Standards provide the structure for this approach. These have been produced through an inclusive process involving many individuals and organisations that work with homeless people. They are based on the experience of assessing the delivery of Health and Homelessness Action Plans and the lessons we have learned from this process about the most effective ways of working. These are not clinical standards; they are for the corporate level of NHS Boards and the performance of Boards against these Standards will be closely monitored through the NHS Performance Assessment Framework.

These Standards are a key component of the Scottish Executive's holistic approach to preventing and alleviating homelessness. We have in place the most progressive homelessness legislative and policy framework in Europe, and whilst we recognise that this creates a challenging agenda for change, the Executive is determined that by 2012 everyone in Scotland who is homeless will have the right to a home, and that the necessary support and health care people need to realise their potential will be in place.

Closing the opportunity gap – tackling poverty and disadvantage and promoting economic inclusion – is an over-arching aim of the Scottish Executive. The Health and Homelessness Standards support this aim and we will ensure that all NHS Boards meet these challenging requirements.

ANDY KERR MSP  
Minister for Health & Community Care

MALCOLM CHISHOLM MSP  
Minister for Communities



## Acknowledgements

The Health and Homelessness Standards have been produced through an inclusive process involving many individuals and organisations in Scotland and beyond. The Scottish Executive therefore wishes to thank all who responded to the consultation, NHS Lothian and NHS Grampian for testing the Standards and the organisations who contributed information on their innovative services and ways of working. In particular the Scottish Council for Single Homeless has played a central role in developing the Standards.

Thanks also are extended to all of those who have led on the delivery of Health and Homelessness Action Plans in NHS Boards and also to Edinburgh Cyrenians for providing some of the photographs in this publication.

The Scottish Executive also wishes to gratefully acknowledge the work of the Health and Homelessness Steering Group whose members have given their considerable experience and time to drive forward the vision to improve the lives of homeless people.



**Section one**  
Introduction





The Health and Homelessness Standards are the Scottish Executive's next step towards improving the health of homeless people in Scotland. They build on the considerable progress which has been made in delivering the aims of the *Health and Homelessness Guidance* (Scottish Executive, 2001) and resulting Health and Homelessness Action Plans. They are not, however, clinical standards as existing clinical standards, for example for heart disease, asthma, etc., also apply to health care for those who are homeless. Rather, these Standards are strategic and aimed at the corporate level of NHS Boards in recognition of the critical importance of strong leadership in tackling health inequalities.

The Standards are intended to be challenging as it is only by increasing the drive to improve homeless people's health that there will be a real and lasting change for these vulnerable individuals. The Scottish Executive accepts that it will take some time before all NHS Boards will meet all aspects of these Standards but will seek, through the performance assessment process, clear evidence of progress. Health improvement and tackling health inequalities will be priorities for discussion at Accountability Review meetings and the Health and Homelessness Standards will form part of such discussions. In recognition of this challenging agenda support to meet the Standards will be provided by the Scottish Executive Health Department and NHS Health Scotland.

Whilst NHS Boards will hold the strategic responsibility for the Standards it is expected that delivery will in the main be through Community Health Partnerships (CHPs). CHPs will need to consider and plan for the needs of homeless people and so the onus will be on NHS Boards to ensure that there is appropriate accountability in place to ensure continuous improvement. The health improvement and health inequalities guidance for CHPs (forthcoming, Scottish Executive) will be helpful in meeting these requirements.

The Health and Homelessness Standards sit within the broader holistic Scottish Executive framework to prevent and alleviate homelessness. The totality of this approach is challenging for all of those working with homeless people. Consequently it is crucial that good partnerships are in place to support complementary work across the NHS, Local Authorities and the voluntary sector. Delivering the Health and Homelessness Standards should sit within such a framework and will also include taking forward the health recommendations made by the Homelessness Task Force, which can be found at Annex A.

The Standards apply to all groups of homeless people. To assist in understanding the heterogeneous nature of homelessness, the Homelessness Task Force definition of homelessness can be found at Annex B. It is vital to note that in addition to the significant issues for single people, children and families who are homeless are very vulnerable and may have specific health needs. Therefore, in addressing the Performance Requirements, NHS Boards will need to ensure that they take into account such differing needs. This will require excellent strategic linkages, for example including homeless issues in Children's Services Plans, which in turn will ensure appropriate responses from maternity services and screening, surveillance and immunisation for homeless children.

The Standards also relate to the Scottish Executive's equality and diversity approach and should assist NHS Boards in using the Equality and Diversity Impact Assessment Toolkit.

The Health and Homelessness Standards will be implemented by NHS Boards from April 2005 onwards. The performance assessment process is outlined in Section 5.





**Section two**  
Background



## The Development of the Standards

Since the *Health and Homelessness Guidance* was published by the Scottish Executive in September 2001, the resulting activity and implementation of Health and Homelessness Action Plans has been the subject of some considerable scrutiny. The Health and Homelessness Steering Group (membership can be found at Annex C) formally assessed the progress made by all NHS Boards through a programme of Progress and Assessment Visits which commenced in January 2003. Each visit was organised to include the Health and Homelessness Co-ordinator and at least one member of the Health and Homelessness Steering Group. Over 40 such visits took place between January 2003 and March 2005 in addition to many more informal meetings with NHS Boards.

As a result of this intense process it has been possible to ascertain the crucial elements which determine effectiveness in addressing the health and health care needs of homeless people in Scotland. These have been analysed to ascertain the approaches that work and also those that are perceived to have fundamental weaknesses.

The process for taking this learning and turning it into these Standards has involved representatives from NHSScotland, the Scottish Executive Health Department, the Health and Homelessness Steering Group, members of the Homelessness Monitoring Group, the voluntary sector and Local Authorities as well as relevant individuals from out-with Scotland. This group has had the opportunity to comment on the Standards as they have developed and provided constructive feedback which was taken into account within the Standard Statements and Performance Requirements as well as in the remainder of the publication.

Once the Standards were sufficiently developed NHS Lothian and NHS Grampian tested out the individual Standards through a desk-based exercise. Once again the feedback assisted in the refining of this piece of work.

As a result of this inclusive process it has been possible to ensure that the Standards are firmly rooted in the learning from the performance assessment processes and the insight and experience of those working with homeless people. Therefore, whilst the Health and Homelessness Standards are challenging, they are also achievable.

## Background to the Individual Standards

**Standard 1** has been developed through observing the different corporate approaches to health and homelessness planning. There has been considerable variation in Boards' responses to the requirements of the *Health and Homelessness Guidance* (Scottish Executive, 2001) with the most significant of these being corporate support. The reports of the Health and Homelessness Steering Group show very clearly that where at a senior level there is a focus on this policy area then activity flows smoothly and the individuals tasked with delivering Action Plans are supported within a strong strategic framework. To reflect this there is a change to the accountability arrangements for health and homelessness which previously required each Board to choose their own lead officer; the Standards move to a position where this lead must be an official at Director level or above.

Strategic links are also seen as vitally important and where such links have been established there is evidence of the complex and diverse needs of homeless people being mainstreamed through wider planning processes. This was flagged as an issue in the *Health and Homelessness Guidance* and the Standards build on this way of working.



In addressing corporate buy-in and strategic links resources can flow towards meeting these Standards. Resources will be subject to each Board's prioritisation processes and are also broader than simply funding; experience shows that effective implementation of Action Plans is most sustainable when the individuals tasked with leading the work are also appropriately supported and resourced to ensure capacity to deliver.

**Standard 2** focuses on the partnership approach to health and homelessness. Tackling homelessness cuts across the statutory and voluntary sectors and no one knows more about what works than homeless people themselves. Experience has shown that where there is in place a multi-agency group steering the delivery of the Health and Homelessness Action Plan then activity is focused and outcome-driven. These working relationships will also support Local Authorities in meeting the aims and objectives of their Homelessness Strategies.

The challenges of cross-boundary working are also recognised, so for those Boards that share Local Authority boundaries there must be good joint working and congruence of aims. Emphasis is also placed on the importance of effectively engaging with homeless people, an issue which will be followed through in the assessment process.

**Standard 3** covers the need for good information and evidence on health and homelessness. The *Health and Homelessness Guidance* (Scottish Executive, 2001) required all NHS Boards to carry out needs assessments and the Health and Homelessness Standards build on this base. The health needs of homeless people are affected by a range of changing factors; hence the importance of ensuring information is current, and this has particular relevance as the Homelessness etc (Scotland) Act 2003 is fully implemented.

The information base can be achieved in a number of ways, so NHS Boards can tailor their approach to local circumstances including using mainstream feedback systems. In so doing, frontline staff will be assisted in their effectiveness by having the necessary information on homelessness in the local area, as a common barrier to effectiveness is a lack of insight into the nature of homelessness.

**Standard 4** covers the important area of access to health services. In common with those who lead more settled lives, homeless people need to know how, where and when to access health services. However, the ways in which services respond may need more flexibility than has perhaps always been the case. Standard 4 therefore identifies some of the common barriers and specifies actions NHS Boards will need to consider if these are to be addressed.

Through the delivery of Health and Homelessness Action Plans it has been evident when such actions are taken then services become more responsive, so there is a consequent benefit for the wider population. In particular this Standard covers the usefulness of Single Shared Assessments as an appropriate way of working.

**Standard 5** addresses improving service responses. In some areas of predominantly urban Scotland, specialist services are providing excellent services for those who are homeless. However, specialist services must not be the only option for homeless people, so this Standard has move on and mainstream responses at its core. There is also no expectation that all NHS Boards will develop specialist services, hence the focus on the mainstream.

Appropriate patient planning is also emphasised to reduce the prevalence of people being discharged into homeless circumstances, the incidence of



which remains unacceptably high. Staff training is critical to ensuring appropriate service responses, though the content and level of training and awareness raising should be determined by local circumstances. Such training should include all relevant staff, including reception and administrative personnel.

**Standard 6** formalises the use of Health and Homelessness Action Plans as the main planning tool. This Standard reflects the best approaches to health and homelessness planning and stresses the importance of making good strategic links to other relevant plans and processes. Whilst the Action Plan is in many ways an administrative tool, it is important that it is delivered and monitored in order that key issues which affect the health of homeless people are not lost.



**Section three**  
Health and Homelessness:  
The Key Issues





## Homelessness in Scotland

Homelessness affects people throughout Scotland including in both rural and urban areas. In 2003-04, 54,829 households made homelessness applications to Scottish Local Authorities, of whom 38,659 were found to be homeless (Scottish Executive, 2004). The scale of homelessness has grown significantly since the beginning of the 1990s; in the years 1992-93 the number of homeless applicants was 42,822 of whom 30,100 were found to be homeless.

The Scottish Household Survey (NFO System Three and MORI 2002) found that across Scotland 3% of adults reported having experienced homelessness in the past which gives some indication of the level of hidden homelessness.

## Defining homelessness

There have been many different attempts to define homelessness in research and there is also a definition contained in legislation in the Housing (Scotland) Act 1987 (HMSO, 1987). However, for the purposes of these Standards the definition adopted by the Scottish Executive's Homelessness Task Force should be used. This can be found in Annex B.

The Homelessness Task Force was set up by the Scottish Executive in 1999 "to review the nature and causes of homelessness in Scotland; to examine current practice in dealing with cases of homelessness; and to make recommendations on how homelessness in Scotland can best be prevented, and, where it does occur, tackled effectively". (Scottish Executive, 2002).

The purpose of the Task Force was to find ways to achieve a step reduction in the incidence of homelessness in Scotland. The Task Force recognised that tackling homelessness effectively meant not only addressing housing policy issues; in

many cases homelessness is the result of wider needs not being met.

An important principle underlying the conclusions of the Task Force was that a "one size fits all" approach would not work. The Task Force concluded: ". . . all the varying needs of people affected by homelessness must be addressed individually, effectively and flexibly. If they are not, purely housing solutions are unlikely to be sustainable". (Scottish Executive, 2002). The Health and Homelessness Standards form a key element in achieving this holistic approach.

As well as those who literally have no roof, the Task Force's definition includes people living in emergency or temporary accommodation, people living in hospital or other institutions because they have nowhere else to stay, those in accommodation which is overcrowded and a danger to health, people who risk violence by living in their accommodation and households who have to share accommodation on a long term basis in unreasonable circumstances, or in other substandard or unsuitable accommodation.

It also therefore includes people who are at risk of becoming homeless, and hidden homeless households, such as those "sofa surfing" – moving from one house to another every few days.

## Who is homeless in Scotland?

Homelessness affects a wide diversity of households with a range of needs. It can affect those who have suffered a disaster (such as a fire or flood), people with debt problems, people with unresolved health or addiction problems, those who have experienced abuse, family breakdown and a whole range of other circumstances. Very often a homeless person may be affected simultaneously by a number of different but inter-related issues.



Homelessness affects families with children, childless couples, same sex couples, single people (both men and women), single parents, all ethnic groups including gypsy travellers and refugees, and all age groups. Statistics from 2003-04 (Scottish Executive, 2004) show that just under 25% of those found to be homeless were single people aged under 25, around 23% were households with children, and just under 40% were single people between the ages of 25 and retirement age.

All of these groups will have specific needs both in terms of their homelessness and in their access to health services. The policies and practices NHS Boards adopt in developing their equality and diversity approach will need to take account of the heterogeneous nature of homelessness.

The immediate causes of homelessness vary greatly. Across Scotland as a whole, the two most significant reasons for homelessness are friends or relatives no longer being able to accommodate the household, 35%, and family or relationship breakdown (which may or may not involve violence or abuse) 22% (Scottish Executive, 2004). However, there are many other reasons. These may include debt, leaving institutions such as hospitals and prisons without appropriate accommodation and support being in place, leaving the care of a Local Authority, mental or physical health problems and many others. Often there will be a combination of issues which have to be addressed, as clearly illustrated in needs assessment research by NHS Argyll and Clyde (NHS Argyll and Clyde, 2002).

It is important, therefore, to recognise that reasons for homelessness will vary across Scotland and each Board area will need to understand the profile of the local homeless population in order to appropriately address their health needs.

Because of the diversity of the homeless population, responses to the health and the related requirements of homeless people need to be tailored to the individual household. Some people may benefit from specialist services, whilst most will simply require equitable access to mainstream services. Finding a sustainable solution to a household's homelessness is likely to involve different agencies working together to resolve all of the key issues.

### The health needs of homeless people

The health needs of homeless people have been recognised within Scottish health policy as part of the broad goal of reducing health inequalities. The White Paper, *Our National Health: a plan for action, a plan for change* (Scottish Executive, 2000), highlighted the need to improve the health of homeless people. This commitment was built upon in *Improving Health in Scotland: the Challenge* (Scottish Executive, 2003) and in the White Paper *Partnership for Care* (Scottish Executive, 2003).

Poor health is not only a consequence of homelessness but can also help to precipitate it. More generally there is a greater risk of premature death and morbidity amongst the homeless population than amongst the population at large.

There are a wide range of health problems which are more prevalent amongst homeless people than the wider population. These include chronic conditions as well as anxiety, stress, self-harm, other mental health problems and infectious diseases. A significant minority of homeless people are dependent on drugs or alcohol often alongside mental health problems and other multiple needs. A study of homeless people in Aberdeen (Love, 2002) found that only 22% of homeless people in Aberdeen considered their health to be "good"





compared to an average of 77% of the general population.

A study by the Office of National Statistics of homeless people in Glasgow (Kershaw, Singleton and Meltzer, 2000) found that:

- 73% had experienced one or more neurotic symptom in the past week and 44% were assessed as having a neurotic disorder.
- Over half experienced levels of hazardous drinking.
- 65% had a longstanding illness.
- 29% had attempted suicide.
- 18% had self-harmed.

The final two figures were substantially higher amongst young people.

It is important to recognise that health problems are not confined to those sleeping rough. People living in temporary accommodation, with friends or in hostels have little stability, often have to share kitchens and bathrooms and have little privacy or security. They may also experience problems relating to damp or overcrowded conditions. Research also shows that homeless families in rural areas may spend longer in temporary accommodation than those in urban areas (Fitzpatrick, Pleace and Jones, 2005). Some of the health problems arising from such circumstances include an increased risk of dermatological problems, musculoskeletal problems, poor obstetric outcomes and a range of mental health problems.

The effect on children in homeless families living in temporary accommodation can be serious. There are many detrimental effects on the physical and emotional development of children living in unsettled or overcrowded accommodation with little room to play or do homework. Studies have shown children in these circumstances to be prone to behavioural

disturbance, have higher levels of illness and infection, have poor sleep patterns and are more prone to accidental injury (Quilgars and Pleace, 2003).

Homeless young people may also neglect their health needs unless they become debilitating (Quilgars and Pleace, 2003). They may also be reluctant to approach health services because they expect a hostile response.

Health visitor contact can be extremely important and may be the most frequent point of contact, especially for homeless families. However, there can be a perception amongst some homeless people that the health visitor can be judgemental of their circumstances (Fitzpatrick *et al*, 2005).

It can be more difficult for homeless people to sustain continuity of care, to meet appointments made a long time in advance, or to participate in health improvement and health promotion activities, such as healthy eating and physical activity. Maintaining contact with key workers such as the family GP, social workers, dentists and lawyers can be difficult if the household is accommodated temporarily some distance away from such support networks.

Research suggests that flexibility in health services for homeless people results in high levels of satisfaction (Quilgars and Pleace, 2003). It further indicates that joint working, especially between housing, care and support providers, is extremely important. However it is important that access to health services should not be conditional upon a household also making contact with other services or participating in other resettlement activities.



## The Scottish Executive's response

The Scottish Executive's Homelessness Task Force recommended a holistic and joined up approach to tackling homelessness in Scotland. Part of the Executive's response has been a new legislative framework, which will give every homeless person a right to a home after 2012. (Housing (Scotland) Act 2001 and Homelessness etc. (Scotland) Act 2003, HMSO).

This will mean that a broader range of homeless people will be housed by Local Authorities and, if accommodation is to be sustained, health, social and emotional needs will also have to be addressed. A fundamental principle is that no-one should have to sleep rough. This means that there should be a safety net even for people with the most complex needs, which is likely to necessitate joint working across a range of agencies.

Linked to this framework was the *Health and Homelessness Guidance* (Scottish Executive, 2001) which required each Health Board to develop a Health and Homelessness Action Plan in co-operation with relevant partners. Every Local Authority is also required to have in place and implement a Homelessness Strategy, incorporating the Health and Homelessness Action Plan.

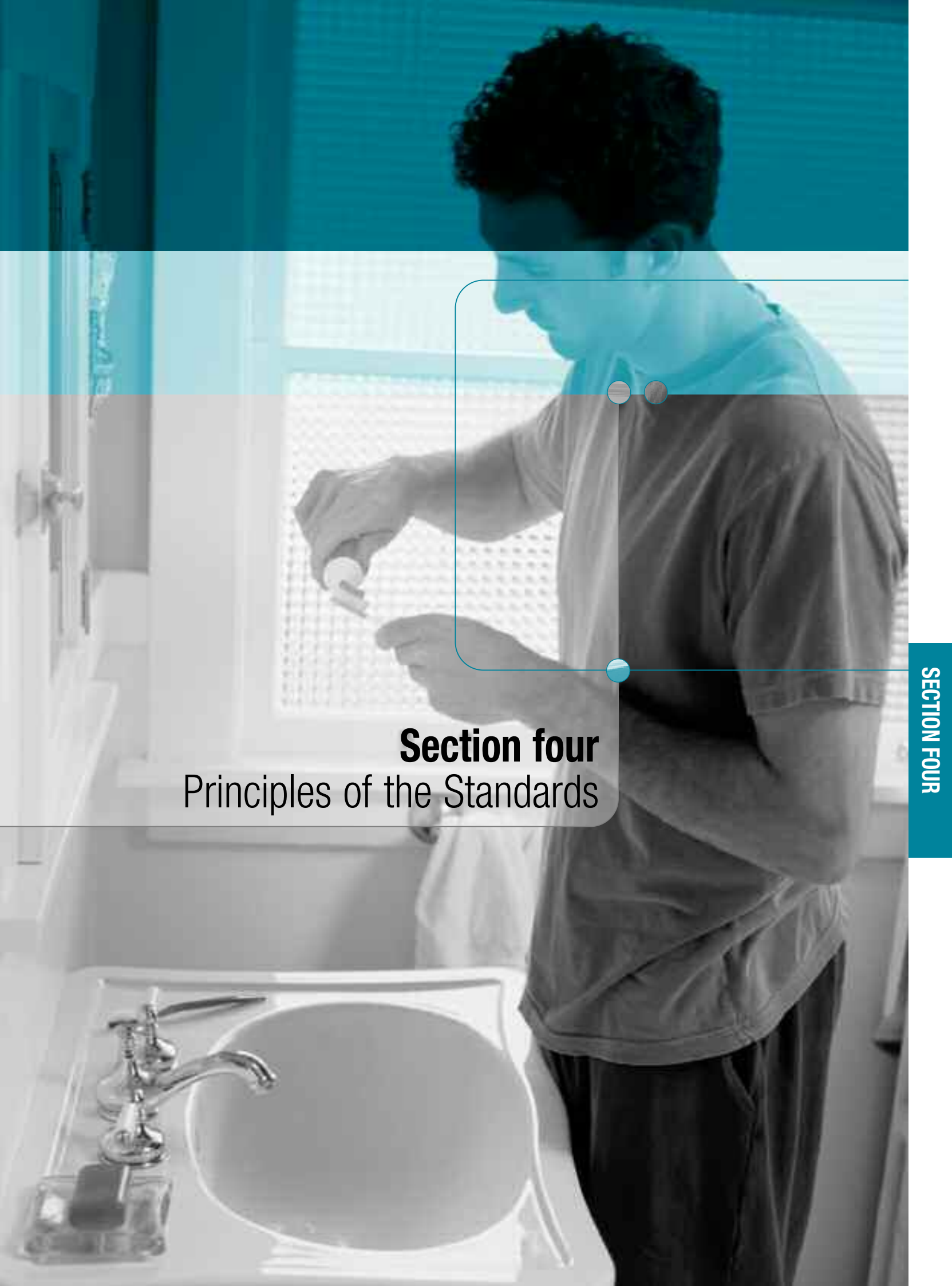
The initial Action Plans included a profile of the local homeless population and assessments of their health and health care needs. Plans were also required to demonstrate an understanding of the network of health care services that support homeless people in the area, combined with an assessment of the accessibility of services alongside an assessment of which services are, and are not, used by homeless people.

The Action Plans included implementation plans for improving services to meet the needs of homeless people, and they formed part of the NHS Board's Local Health Plan. Much has been learned from the initial Action Plans and the Standards have built upon the lessons learned.

Underpinning the framework of legislation and guidance is a new culture with an emphasis on trying to prevent homelessness where this is possible, and if homelessness does occur, to tackle the whole of a household's problems so that solutions become sustainable in the long term.

The emphasis in this new culture is to move away from a "gate-keeping" role in relation to services, towards one of seeking to meet individuals' needs. It involves proactive involvement from whichever agency the homeless person first approaches to help ensure that all the needs are assessed and addressed as effectively as possible. This includes both hard issues such as ensuring effective information sharing protocols are in place, and softer issues such as ensuring that attitudes towards homeless people encourage the use of services.

The Health and Homelessness Standards are therefore an important tool to assist NHS Boards to work in partnership to ensure that all of their activities take into account the health needs of homeless people, and to ensure that there is a commitment to helping prevent homelessness and contributing to sustainable solutions.



## **Section four** Principles of the Standards



In order to assist in the application of the Standards this section outlines some of the underlying principles which should be taken into consideration by NHS Boards and partners.

The Health and Homelessness Standards are designed to assist NHS Boards to continuously improve their services to homeless people and those at risk of homelessness. They build on the development of service responses achieved through the implementation of Health and Homelessness Action Plans. Each of the individual Standards is of equal weight and importance. Each Standard represents one element of a whole and they will be considered both individually and collectively in assessing overall performance.

The Standards also reflect the Scottish Executive's determination that tackling health inequalities, and the health needs of homeless people in particular, should be embedded in Boards' strategies and services in the long term.

The voice of service users is very important to the development of services and strategies across the NHS. Boards should ensure that homeless service users participate in the development of services; their views should not only be heard in relation to specific services for homeless people, but also, proportionately, in the development of all services.

In considering health and wellbeing services NHS Boards should address the whole range of services provided. This will include primary and secondary care services covering both physical and mental health, the services of allied health professionals, and important services linked to wellbeing and the health improvement agenda such as health promotion, healthy eating, smoking cessation and physical activity.

More widely, NHS Boards should recognise that the improvements they make in both access to, and

delivery of, services for homeless people will benefit a range of marginalised groups; likewise service improvements for other hard to reach groups will also bring benefits for homeless people. Boards should also be clear that homelessness involves an intensive set of compound risks to health and wellbeing which make it much harder for homeless people, compared to the general population, to maintain good health in the sense of physical, mental and social well-being.

Children in homeless families are particularly vulnerable. NHS Boards should therefore ensure effective and timely access to services such as maternity services, child health screening, surveillance and immunisation, and should also take account of the impact of homelessness or living in temporary accommodation on the mental health, self esteem and emotional development of children in these circumstances.

In all cases delivering the Health and Homelessness Standards will involve working with partners in related fields (e.g. housing, social work and the voluntary sector) to address the whole needs of households, in order to reduce health inequalities and promote well-being.

NHS Boards will have an increasing role to play in inspection and performance management in relation to Community Health Partnerships as the primary means of delivering Boards' strategic priorities. The Health and Homelessness Standards should therefore assist Boards in developing appropriate reporting mechanisms. In considering overall performance measures, NHS Boards will have in place a number of existing reporting mechanisms. It is expected therefore that Boards will ensure that, where appropriate, existing systems can provide, or be adjusted to provide, a suitable level of evidence to enable reporting against the performance requirements in these Standards.



## Service responses

Some Boards will have in place specialist services for homeless people, others will not, depending on local circumstances, and the Standards do not require the creation of further specialist responses unless these are identified at the local level as being the effective response. However, all Boards must provide mainstream services to homeless people and should be able to identify that such services are appropriate and accessible for those who are homeless.

In areas where specialist services are established, Boards may wish to pose questions of such services and invite responses which include SMART objectives against which they are measured. Some of the principles of quality services to consider should include:

**Accessibility:** In what way is the service more accessible to homeless people than alternatives?

**Effectiveness:** What does the service aim to achieve, and is it succeeding?

**Acceptability:** Do service users and staff find the service acceptable?

**Efficiency:** What does the service deliver and what resources are used?

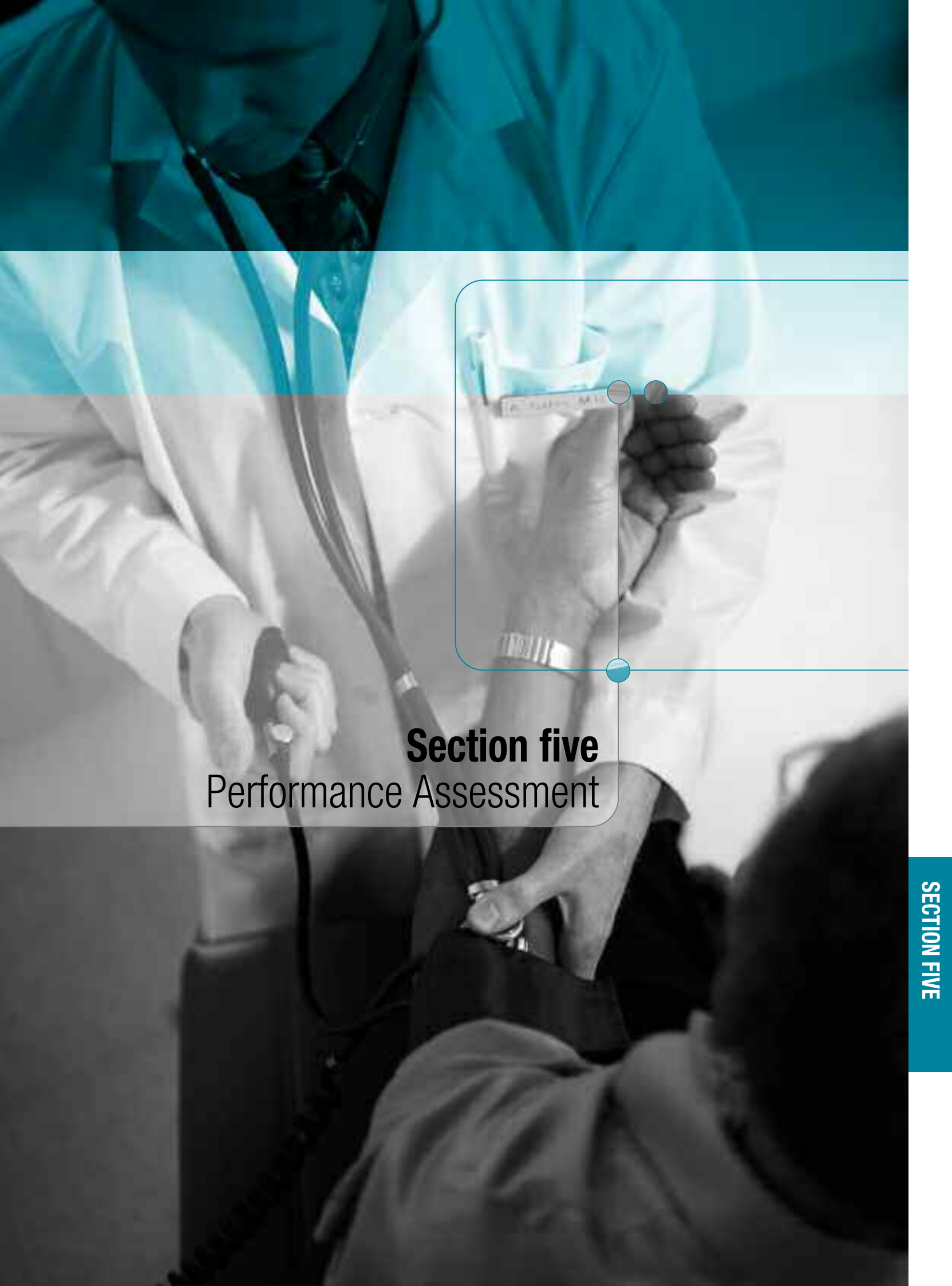
**Clinical governance:** What arrangements are in place to make services accountable for continuously improving the quality of their services and safeguarding high standards of care?

## Policy Proofing

The household composition and health-related needs of homeless households are so diverse that Boards should policy proof all strategies to take account of their needs. Whilst in some strategies homeless people may comprise one of the most significant groups to be addressed, in others their relevance may be more peripheral, though still important. Clearly Boards will need to ensure that homeless people's needs are addressed in a wide range of strategies and plans, for example the Local Health Plan including the Joint Health Improvement Plan, the Equality and Diversity Strategy, Health Inequalities Strategy, Community Plans, Drug and Alcohol Plans, Mental Health frameworks and Community Health Partnership plans.

However, this list is not exhaustive. NHS Boards must ensure that all strategies and plans are policy proofed to ensure that they take account, proportionately, of the needs of homeless households.





**Section five**  
Performance Assessment



Health and homelessness has been featured in NHSScotland's Performance Assessment Framework since 2001. As the policy has matured so has the measurement of performance which evolved to include the delivery of the Homelessness Task Force's health recommendations.

The method of performance assessment up until March 2005 relied heavily upon Performance and Assessment Visits (see Section 2, Background) including feedback from partner organisations supporting the delivery of Health and Homelessness Action Plans. This was a useful approach as it provided the Scottish Executive Health Department with good quality information on progress, and on barriers to delivery. This is also now the basis for the Health and Homelessness Standards.

With the new and enhanced framework the assessment process is changing. **The Standards will come into effect from April 2005 and meeting these is expected to form the Performance Assessment Framework indicator.** Performance against the Standards will be evaluated by an annual self-assessment return. In addition there will be independent scrutiny of the self-assessment returns in order to provide a further degree of analysis. The outcomes will be reviewed by the Health Department and exceptions reported in to the Accountability Review process. This is the principal forum for feeding back performance issues to NHS Boards on an annual basis and is led by the Minister, or Deputy Minister, for Health and Community Care.

Further information on the Performance Assessment Framework can be found at [www.paf.scot.nhs.uk/pafi](http://www.paf.scot.nhs.uk/pafi)





**Section six**  
Standard Statements and  
Performance Requirements



## Standard 1

**THE BOARD'S GOVERNANCE SYSTEMS PROVIDE A FRAMEWORK IN WHICH IMPROVED HEALTH OUTCOMES FOR HOMELESS PEOPLE ARE PLANNED, DELIVERED AND SUSTAINED.**

### Objective

The objective of this Standard is to enable Boards to demonstrate corporate buy-in and support for the policy, and to ensure that implementation is being driven at senior management level.

### Why this Standard?

It is vital that health and homelessness planning is embedded in the Board's corporate thinking, and that this is integral to its duty to continuously improve services. Experience has shown that the most effective approach to this policy is where an official at Director level or above has responsibility for guaranteeing that the Board is fully aware of the strategic approach to improving the health of homeless people. In so doing it can be ensured that related activities are appropriately resourced (not simply in financial terms, but also personnel and support), and that health and homelessness is considered in strategies such as substance misuse, health inequalities, Public Focus Patient Involvement, mental health, children's services, domestic violence and health improvement. Good practice suggests that effective joint working at Director level across agencies is beneficial.

As Community Health Partnerships will inform and deliver much of the health and homelessness activity it is critical that accountability procedures with CHPs include service delivery to homeless people. CHPs need to pro-actively inform all service planning for homeless people and agree the appropriate models of care to be delivered locally.

Health and homelessness is also an aspect of overall health inequalities strategies. Action to secure better health outcomes for homeless people is a component of the overall strategy to reduce health inequalities by securing a faster rate of improvement for those who are the most disadvantaged.

### Performance Requirements

- 1.1 The Board can evidence that responsibility for health and homelessness is taken at Director level or above.
- 1.2 The health needs of homeless people are incorporated into the Board's Health Inequalities Strategy and all other relevant strategic planning frameworks, which also reflect the common aims of the Health and Homelessness Action Plan.
- 1.3 In the financial planning framework, and in other matters relating to resources, the Board can demonstrate that it has taken account of the priorities agreed in the Health and Homelessness Action Plan.
- 1.4 The Board is able to fully report against the health and homelessness Performance Assessment Framework indicator and other relevant health inequalities indicators.
- 1.5 The Board has in place appropriate involvement and accountability procedures to enable it to ensure that Community Health Partnerships are effective in planning and delivering the health and homelessness priorities, linked to the Health Inequalities Strategy.
- 1.6 The Board regularly reviews its health and homelessness activities to continuously improve services.



## Standard 2

**THE BOARD TAKES AN ACTIVE ROLE, IN PARTNERSHIP WITH RELEVANT AGENCIES, TO PREVENT AND ALLEVIATE HOMELESSNESS.**

### Objective

The objective of this Standard is to demonstrate that NHS Boards are working with, and learning from, those agencies that also have important roles in the lives of homeless people.

### Why this Standard?

Health and homelessness activity is part of the holistic approach to preventing and alleviating homelessness promoted by the Scottish Executive. Local Authorities' Homelessness Strategies also form part of this framework. NHS Boards are expected to lead activity on health and homelessness in their area but not to undertake all activities themselves, though frontline health care workers have an important role in preventing homelessness. Boards should be proactive and work as part of a multi-agency partnership where all partners are involved in planning and delivering services. Boards are also expected to involve homeless people in helping to shape services. Effective partnership activity will ensure that Homelessness Strategies and Health and Homelessness Action Plans are complementary and reflect common themes and priorities. This will also ensure that Community Planning Partnerships and Community Health Partnerships take account of this activity in their planning processes.

### Performance Requirements

- 2.1 The Board plays a leading role in a partnership group comprising voluntary and statutory sector partners, focussed around Community Health Partnerships, which drives the Board's activities in relation to health and homelessness.
- 2.2 The Board supports partnership working by ensuring that such an approach is appropriately resourced.
- 2.3 Service users are a key partner in the Board's health and homelessness activities, and more widely are fully involved and consulted.
- 2.4 The Board supports partner organisations in the voluntary, statutory and private sectors to improve the health of homeless people.
- 2.5 The Board's partnership activity ensures that the Health and Homelessness Action Plan and Homelessness Strategies are complementary, reflecting common issues and aims, and reflecting Community Health Partnerships' local service plans.
- 2.6 The Board is effectively engaged in the implementation and delivery of the Local Authority(ies) Homelessness Strategy(ies).
- 2.7 Where a Board covers more than one Local Authority activities relate to all Local Authorities in the area. In addition, where a Board shares Local Authorities with other NHS Boards there is evidence of joined up working to meet the needs of homeless people.



### Standard 3

**THE BOARD DEMONSTRATES AN UNDERSTANDING OF THE PROFILE AND HEALTH NEEDS OF HOMELESS PEOPLE ACROSS THE AREA.**

#### Objective

The objective of this Standard is for NHS Boards to develop and maintain an evolving body of knowledge in the health and homelessness area. This knowledge will help to ensure that services evolve in ways that will be most responsive to the health needs of homeless people, which may change over time.

#### Why this Standard?

In preparing their initial Health and Homelessness Action Plans, NHS Boards were required to assess the profile and needs of homeless people in the area. It is important that Boards maintain an up-to-date evidence base on the health needs of the homeless population. The evidence must remain current as new homelessness legislation is implemented, Health and Homelessness Action Plans rolled out, and in the light of the social and economic changes that will occur. It is vital to use a range of means of identifying needs, including reports relating to critical incidents involving homeless people, and service users' views. Awareness of the profile and needs should not be concentrated at Board level, but all relevant personnel, especially those in front line services, should be trained to ensure they deliver services to homeless people effectively and equitably.

#### Performance Requirements

- 3.1 The Board has assessed the health needs of homeless people and, working with Community Health Partnerships, regularly reviews this information and uses it to shape services.
- 3.2 The Board makes active use of service user views in shaping its services.
- 3.3 The Board uses critical incident reporting and complaints procedures to inform policy and practice towards homeless people.
- 3.4 The Board maintains an up-to-date knowledge base on health and homelessness issues, including relevant research, which informs its services and Health and Homelessness Action Plan.
- 3.5 The Board, in partnership, ensures that staff at the front line of service delivery have the relevant competencies to work effectively with homeless people and supports them in acquiring further competencies as required.



## Standard 4

**THE BOARD TAKES ACTION TO ENSURE HOMELESS PEOPLE HAVE EQUITABLE ACCESS TO THE FULL RANGE OF HEALTH SERVICES.**

### Objective

The objective of this Standard is to break down the barriers which prevent homeless people from having their health needs met. Barriers may be structural, policy based or attitudinal.

### Why this Standard?

Homeless people have more difficulty in accessing services than the general population. In order to gain access to services homeless people must first know that they exist, have details about the services and know how to access them. Local NHS service providers should be aware of the needs of homeless people in their area in order to ensure services are accessible and meeting those needs. For example, homeless people may be living in temporary accommodation away from their local community, with a distance to travel.

Understanding which services are used or not used by homeless people may lead Boards to consider whether these are accessible to homeless people or to remodel services to overcome such problems. Barriers may be structural (for example an inflexible appointments system), policy based (for example that a homeless person must have a permanent address to access a service), or may be related to attitudes towards homeless people. Mainstream services should be systematically audited to ensure they are designed in ways which improve reach for the most disadvantaged groups and which identify and overcome barriers.

## Performance Requirements

- 4.1 The Board ensures the information needs of homeless people are assessed in order to ensure access to services and an appropriate response for those who need to use them.
- 4.2 The Board ensures partner agencies have appropriate information on access to health services for homeless people.
- 4.3 The Board ensures that being alcohol- or drug-free is not a prerequisite of accessing services.
- 4.4 The Board provides information to primary care and acute sector practitioners about homelessness in their area.
- 4.5 In ensuring equitable access to all its services the Board takes account of the needs and lifestyles of homeless people, including literacy and numeracy.
- 4.6 The Board monitors and evaluates which services are used/not used by homeless people and uses this information to refine and improve services.
- 4.7 The Board ensures that the attitudes of those providing health and well-being services for homeless people do not create barriers to accessing services.
- 4.8 In the development of Single Shared Assessments the needs of homeless people are taken into account.





## Standard 5

### THE BOARD'S SERVICES RESPOND POSITIVELY TO THE HEALTH NEEDS OF HOMELESS PEOPLE.

#### Objective

The objective of this Standard is to assist NHS Boards to understand the ways in which services can operate with the greatest positive impact on the health of homeless people.

#### Why this Standard?

Homeless people are entitled to receive the same range of health and well-being services as the general population, though their circumstances may make it more difficult to participate equally in a range of health-related programmes, or to receive the continuity of care experienced by the housed population. Specialist services may be appropriate for homeless people for a period of time, but the existence of such services should not mean that everyone who is homeless is automatically channelled through this route; the aim must be to incorporate homeless people within mainstream services and to ensure these services are designed in ways which meets their needs.

It can also be very difficult for homeless people to plan and wait for services (such as detoxification) so it is important that Boards take lifestyles into consideration and where appropriate consider fast tracking into services. Admission and discharge procedures should also take account of the patient's housing status and ensure that no one with a planned discharge leaves to a homeless situation. This holistic approach to combating homelessness means that health workers should be equipped to sign-post homeless people to other appropriate agencies to prevent a continuation of their unsettled lives.

#### Performance Requirements

- 5.1 The Board can evidence that homeless people are able to use the full range of health and wellbeing services, and can report on outcomes.
- 5.2 Where waiting lists for health services exist, the Board takes account of the needs and lifestyles of homeless people in determining priorities.
- 5.3 Where specialist health services for homeless people exist, the Board can demonstrate that moving on to mainstream services is integral to their activities.
- 5.4 Where specialist health services exist, the Board can demonstrate that homeless people are not restricted to such services.
- 5.5 The Board's procedures ensure that no one who is subject to a planned discharge is discharged into a situation of homelessness. This will necessitate good joint working with other agencies.
- 5.6 The Board ensures homeless people receive appropriate continuity of care which takes account of their circumstances.
- 5.7 The Board can demonstrate that relevant front-line staff have the skills and knowledge to assist homeless people and are trained accordingly.



## Standard 6

### THE BOARD IS EFFECTIVELY IMPLEMENTING THE HEALTH AND HOMELESSNESS ACTION PLAN.

#### Objective

The objective of this Standard is to formalise the ongoing use of the Health and Homelessness Action Plan as the main planning tool for local health and homelessness activity.

#### Why this Standard?

Health and Homelessness Action Plans are the driving force behind health and homelessness activities for the Board. They should form part of the Board's Health Inequalities Action Plan in its Local Health Plan, and feed into Community Planning Partnership Health Inequalities Strategies, expressed in Joint Health Improvement Plans. Community Health Partnerships will be responsible for the delivery of much of the activity so Boards must be able to account for their progress against the Plan. The Action Plan must be an up-to-date document, regularly reviewed and monitored to ensure it remains relevant. It must not exist or be implemented in isolation, and appropriate resources will be required. The Plan also forms part of the broader framework to combat homelessness in Scotland; as such it relates to the recommendations of the Homelessness Task Force, and to the Health and Homelessness Guidance (Scottish Executive, 2001). The Action Plan should also be congruent with the Health Inequalities Action Plan.

#### Performance Requirements

- 6.1 The Board can demonstrate that the Action Plan is revised and updated on at least an annual basis.
- 6.2 The Action Plan is driven, delivered and monitored through a multi-agency steering group.
- 6.3 There is a clear reporting structure within the Board for the monitoring of the Action Plan.
- 6.4 The Action Plan is both deliverable and measurable and is built around SMART objectives.
- 6.5 The Action Plan has a level of resources appropriate to its aims.
- 6.6 The Action Plan reflects the principles of the Health and Homelessness Guidance.
- 6.7 The Action Plan addresses the health recommendations of the Homelessness Task Force.
- 6.8 The Action Plan is reflected in the Local Health Plan and the Joint Health Improvement Plan.
- 6.9 The Board has mechanisms in place to ensure Community Health Partnerships are delivering the Action Plan.





**Section seven**  
Delivering the Standards  
– practice and innovations



## Practice and Innovations

This section of the Health and Homelessness Standards gives examples of services, practices and innovations that have developed through the delivery of Health and Homelessness Action Plans, in accordance with the *Health and Homelessness Guidance* (Scottish Executive, 2001). The examples are illustrative and are not necessarily intended for duplication, although elements from each can be distilled for local use. For further information on each example please use the local contact.

## Standard 1: Corporate Approach

### NHS Lothian

NHS Lothian has developed a series of approaches to ensure there is a sound corporate approach to developing and implementing the Health and Homelessness Action Plan. This approach has ensured the effective delivery of the Health and Homelessness Action Plan.

The first element was to ensure Board level commitment. From the earliest stages the Chairman took an interest in health and homelessness issues and sought to ensure that this was a central area in NHS Lothian's thinking around reducing health inequalities and improving health. The degree to which health and homelessness is a feature of the working of the Board is reflected in the way that health and homelessness is one of the issues included in the Chief Executive's regular reports to the Board.

The second element is ensuring that health and homelessness is part of the overall planning processes of the Board. The Pan-Lothian Health and Homelessness Planning Group has direct relationships into the planning mechanisms for health improvement, for mental health and wellbeing and the Drug and Alcohol Action Teams. These direct links provide not only access to the funding streams associated with the three programme areas, but also mean that corporate planning in these areas take the issues of homelessness and its consequences as part of their work.

The final element is performance management. The Scottish Executive Health Department has undertaken performance management of the Health and Homelessness Action Plan and its delivery. NHS Lothian agreed that there should be an annual formal meeting, as part of the Accountability



Review, between members of the Health and Homelessness Steering Group and the two Directors with responsibility for the delivery of the Action Plan, the Director of Public Health, with responsibility for health improvement, and the Director of Partnerships, covering mental health and well-being and the work of the Drug and Alcohol Action Teams. This forum also provided a further means of linking the Board directly into the delivery of the Health and Homelessness Action Plan.

For further information please contact NHS Lothian on 0131 536 9000.

## Standard 2: Preventing and Alleviating Homelessness

### Scottish Executive

In recognition of the need to involve service users in influencing policy development, the Scottish Executive Health Department commissioned The Lemon Tree in Aberdeen to work with homeless people to explore their experiences of health services. This was to inform discussions at the Health and Homelessness Conference held in Dundee on 20 and 21 May 2004. As part of this process The Lemon Tree made a short film to provide a further opportunity for homeless people to have their voices heard.

A DVD copy of the film is included in this publication for use as an educational tool, for example in training front line health workers, or general awareness raising within the public health workforce. Viewers will see that the homeless people who participated in the making of the film shared very personal experiences and so this should be taken into consideration when broadcasting.

Please note that the copyright for the film belongs to The Lemon Tree ([www.lemontree.org](http://www.lemontree.org)) and that any use in other than in an educational capacity

must be with the explicit agreement of The Lemon Tree. The company can be contacted on 01224 647999 or by emailing [info@lemontree.org](mailto:info@lemontree.org)

## Standard 2: Preventing and Alleviating Homelessness

### NHS Lothian

Ensuring the involvement of service users in the planning and implementation of health care services is a priority for all NHS systems in Scotland. This includes those who are homeless. In NHS Lothian, the aim has been to include homeless people, and those who work with them, as routine stakeholders in patient involvement and consultations. So, for example, when the first NHS Lothian Local Health Plan was developed, a focus group of young homeless people was brought together to let the Board know what they thought of the Plan and how it would affect them.

More recently, NHS Lothian has simultaneously consulted on its acute care services, its mental health and well-being services and its hospital services for older people. This consultation, *Improving care: investing in change* (NHS Lothian, 2004), recognised that homeless people needed to have a significant voice in such processes. As well as the usual consultation channel, an open meeting for groups involved in working with and for homeless people was organised to reflect on the proposals and to comment. The overall approach was broadly welcomed.

One final area of specific user involvement is also worth noting. Health and homelessness conferences have been organised by the Scottish Executive Health Department and the Scottish Council for Single Homeless. In 2004, NHS Lothian offered its subsidised place at this conference to a service user from one of the local health and homelessness groups. A formerly homeless person, who was



working with one of the local projects in Edinburgh on a voluntary basis, was able to attend and provide other conference participants with a very clear insight into what was needed and wanted.

For further information please contact NHS Lothian on 0131 536 9000.

## Standard 3: Understanding Needs

### NHS Argyll and Clyde

During the development of NHS Argyll and Clyde's initial Health and Homelessness Action Plan, alongside the Board's five Local Authority partners, the requirement for a local Health and Homelessness Needs Assessment was acknowledged. With the funding in place to progress a structured interview for use with local homeless people was devised and pilot tested. After revision and approval by the Local Ethics of Research Committee, interviewers were recruited and trained.

A total of 119 participants were interviewed with each interview lasting 45 minutes. The results were analysed, and were broadly similar to those in published work, with high proportions affected by family relationships breakdown, physical and mental health problems, and addictions.

However, when the results were re-analysed for the proportions of this group with one or more issues, the complexity of problems faced by homeless people became more obvious. In summary, 76% of this sample had three, four or five other significant difficulties in addition to being homeless.

One challenge in the process, not unique to the Argyll and Clyde area, was that of identifying hidden homeless people; hence the needs assessment had a focus on those who had presented to Local Authorities as statutorily homeless.

An important conclusion of the analysis is to emphasise the necessity of the various agencies working together timeously in order to resolve all of the problems presented by homeless people. In addition there are implications for joint training and working, and resourcing this with time, expertise, staff and money.

For further information the needs assessment can be found at:

[www.nhsac.scot.nhs.uk/publications/healthandhome.pdf](http://www.nhsac.scot.nhs.uk/publications/healthandhome.pdf) or by contacting NHS Argyll and Clyde on 0141 842 7200. Further reading on health needs assessments can be found in the References section at the end of this publication.

## Standard 3: Understanding Needs

### NHS Greater Glasgow

In 2004 NHS Greater Glasgow commissioned the Glasgow Homelessness Network (GHN) to undertake research to improve knowledge of the experiences of women who are vulnerable to homelessness and rough sleeping who use Primary and Acute Health Services.

The initial pilot involved three projects that collected data from their female clients over a 9-month period. The data were captured and collated via the addition of a health module to GHN's existing Common Monitoring System currently used by Rough Sleepers Initiative projects. This allows for the collection of information on women's experiences of health services and their levels of satisfaction with the service provided, as well as allowing for the analysis of these data against various data profiles of this population.

The need for the pilot was established in response to concerns being raised about anecdotal evidence of statistically small populations of homeless women



who were dissatisfied with the services they had received. It was felt that these women had particular histories and characteristics and the pilot was developed to test whether such health information on this particular group of women could be identified.

This innovative pilot will allow for a better understanding of the needs and experiences of homeless women as well as facilitating the identification and measurement of any other sub-population. On the basis of the viability of this system being established the NHS Board hopes to be able to build on the pilot and further develop this facility. This would allow for the early identification of women in comparatively small populations and the development of appropriate protocols to improve their experiences of health services. It will also inform other opportunities for service development, delivery and improvement to be identified.

For further information please contact the Glasgow Homelessness Network, [www.ghn.org.uk](http://www.ghn.org.uk), [info@ghn.org.uk](mailto:info@ghn.org.uk) or 0141 302 2760.

## Standard 4: Access to Health Services

### NHS Highland

The Streetwise Directory began as an update of a basic information leaflet within the Inverness area, but developed into a project which involved a comprehensive mapping exercise and a questionnaire delivered across Highland. The process also included locality seminars as well as a Highland launch.

The main partners involved in pulling this project together included NHS Highland, Inverness Council for Single Homeless and Highland Council. The remit of the project was to carry out a mapping of the main services for homeless people so that the Directory would not only assist service providers in

signposting homeless people to appropriate services, but also help to form a network of providers that had previously not existed.

The services that are included in the Directory are not simply health services or housing services; they are based on a wider interpretation of the kind of services that homeless people may wish to access, including leisure and educational opportunities. The Directory helps homeless people to access health services by giving homeless service providers information about the health services that are available, but more importantly relevant information about the ways in which services can be accessed. The Directory is produced in both hard copy and as a website that allows it to be updated rapidly, and contains both Highland wide and localised information across the Highlands.

There have also been a number of local events held involving all agencies to introduce the Directory and to help people make the best use of it. In this way it has been much more than just a way of providing information; it is a tool to bring agencies together with the aim of providing better access to information and ultimately improved access to services themselves.

The Directory can be accessed at: [www.streetwise-highland.org](http://www.streetwise-highland.org) or by contacting NHS Highland on 01463 717123.

## Standard 4: Access to Health Services

### NHS Greater Glasgow

NHS Greater Glasgow Primary Care Division, in partnership with Glasgow City Council Social Work Department and the voluntary sector, have developed a range of services to respond to the health care needs of homeless people. Health





services operate on an outreach basis which allows patients to be seen in the clinic of their choice; this maximises attendance and in turn ensures greater treatment compliance. However, in order to provide specific clinical work it was recognised that suitable premises were needed.

Premises on Hunter Street in Glasgow were identified as a base for delivering health services to homeless people as well as providing an office for various health and social work teams. The service opened in April 2004 and has added choice to the existing outreach health services, an enhancement to health provision, and a stepping stone in the patient's journey back to mainstream primary care.

On assessment by the health service, if a patient is already on a General Practitioner's list and has been accessing mainstream primary care health services then the patient has their immediate and necessary treatment dealt with; they are then encouraged to re-engage with their registered GP. The patient's GP will then have all details of the consultation sent to them for inclusion in the patient's notes.

If a homeless person is not registered with a GP, or is not engaging with them, then the patient will join the Hunter Street practice and at the appropriate time the specialist GP will assist the patient in finding a suitable mainstream practice to join.

Addictions problems within the homeless population are high so services have also developed to meet this need. However, the Homelessness Addiction Team works tirelessly with mainstream addiction services and GPs to re-engage patients with local services through agreed protocols.

The Physical Health Team (district nursing service) and affiliated sexual health team provide nursing care to homeless people on behalf of their own GP as well as the specialist GP. There is also liaison

with sexual health mainstream services in order to keep patients fully linked into the mainstream. Similarly the mental health service actively re-engages patients with Community Mental Health Teams by agreed protocols and handover.

The Hostel Resettlement Team is comprised of both health and social work staff and works specifically with patients in the hostels that are due for closure as part of the re-provisioning of accommodation services for homeless people in Glasgow. This ensures that residents within these settings are provided with a comprehensive assessment, which allows them to move on to the most appropriate accommodation in a planned way, whilst ensuring linkages into mainstream health provision.

For further information please contact NHS Greater Glasgow on 0141 201 4444.

## Standard 4: Access to Health Services

### NHS Dumfries and Galloway

Within the NHS Dumfries and Galloway area Local Rural Partnerships, an arm of the Community Planning structure, bring together representatives from local businesses, education services, housing services, primary care services and the full range of voluntary sector providers to address the specific needs of their rural communities.

Public Health Practitioners have been identified as the locality leads for the development of services which cater for the health needs of homeless people, and they also sit on their Local Rural Partnership. As a result they are able to both raise awareness about the specific health needs of homeless people and influence the development of services in such a way as to cater for these needs.





By this use of existing structures the needs of the homeless population and the response from the community is coordinated from the outset. This is also a particularly useful approach in an area such as Dumfries and Galloway which has a diverse mix of small- and medium-sized communities within a large rural area. By localising the approach to improving the health of homeless people a greater understanding of the issues can be developed by local people.

For further information please contact NHS Dumfries and Galloway on 01387 272700.

## Standard 5: Service Responses

### NHS Ayrshire and Arran

CLHASP, the Children's Learning, Health, Support and Play Initiative, aims to integrate education, health, play and leisure services for children in homeless accommodation in East Ayrshire, and is funded through the Changing Children's Service fund. It is based on the recognition that services were failing to meet many of the health and social needs of homeless children, initially in hostel accommodation but subsequently in temporary furnished flats.

The initiative provides children and families with a range of services that include:

- An initial health and social care assessment by a named health visitor or school nurse when families present as homeless.
- Link social worker.
- Play equipment in both hostels, including computers.
- Crèche facilities and sessional play workers in hostels and in Yipworld.com, a local youth facility with whom there is a service level agreement for play and leisure.
- Free access to local leisure facilities.

- Welcome play packs.
- Home safety equipment.
- Support workers to assist parents and children in establishing a routine that enables children to prepare for and attend nursery, school and locally based leisure facilities.
- Transport to allow children to continue to attend their existing school, nursery or other pre-five facility.

Other developments that have taken place include the appointment of a part-time co-ordinator; the extension of health visiting/school nursing service to two other hostels and homeless flats; cooking skills training for support workers and provision of classes for parents and older children; links with local community pharmacies for provision of direct care; agreement for a dedicated health visitor.

An external evaluation has assessed the impact of the service and findings demonstrate that:

- There has been good uptake of all aspects of the service.
- It provides a needed service in a flexible and user friendly manner.
- It supports the play and care needs of children at a stressful time.
- It has led to the development of new forms of integrated provision.
- It has enthused the staff and added to their personal and professional learning.

For further information on CLHASP please contact Lead Public Health Practitioner, East Ayrshire LHCC, on 01563 538849 or the Homeless Strategy and Services Manager, East Ayrshire Council on 01563 576986.



## Standard 5: Service Responses

### NHS Fife

Making Connections is a pilot multi-agency training programme that aims to develop the health related knowledge and skills of frontline staff from Fife Council, NHS Fife and the voluntary sector to better meet the needs of homeless people. It is based on the premise that the quality of advice, guidance and support homeless people receive, from whatever quarter, depends largely on the knowledge, experience and importantly attitudes of staff. The initiative is a joint objective within the Health and Homelessness Action Plan and Fife Homeless Strategy. It is also jointly funded.

The programme is comprised of four modules, run three times on a locality basis in order to encourage multi-agency networks to develop between staff. Informed by a needs assessment, the modules cover:

- Maximising your potential – a personal development opportunity for staff, looking at motivation, self-awareness and self-management techniques.
- Mental health – including reviewing attitudes, presenting symptoms and behaviours, management strategies and local NHS services.
- Substance misuse – including drug use and its effects, the law, tenancy agreements/policies, dealing with aggression and local services.
- Health and Homelessness – a concluding module on partnership working for homelessness, community planning, health and homelessness/sustainable tenancies and reflective learning.

Each programme has 20 participants drawn from housing, the Fife Local Office network, criminal justice, primary care services and voluntary sector projects. Trainers are almost all local professionals with training expertise. In this way costs are minimised and the local perspective is maintained.

For further information please contact NHS Fife on 01592 712472.

## Standard 5: Service Responses

### NHS Lothian

Based on its long experience, Edinburgh Cyrenians recognises that health and well-being is a critical component in an effective strategy for tackling homelessness and poverty. Their strategy includes a mix of innovative projects and creating pathways to mainstream services and community resources.

The Health Improvement Service provides specific interventions targeted at the particular health needs associated with homelessness. Current initiatives include healthy eating, drug use management and promoting exercise and relaxation. It also gives a health improvement dimension to all other provision; for example, hostel staff are supported in a role of practical health promoters, supporting residents to eat well, to exercise and generally to make healthy choices.

In 1999 lack of access to an adequate diet and the multiple benefits of good food were identified as priorities through consultation with service users; this was backed up by research that revealed that 70% of long-term homeless people showed symptoms of malnutrition. The charity has gone on to develop a health improvement programme aimed at transforming food access and food use for homeless people in Lothian whilst being “a hand up, not a hand out”.

The Good Food in Tackling Homelessness programme involves four elements:

- Accessing large quantities of high quality food for distribution to supplement the food supplies of local hostels and centres to improve the choice, nutritional value and enjoyment of meals. 350 tonnes of quality checked surplus fresh food is



distributed to 40 projects adding variety, nutritional value and enjoyment to approximately 150,000 meals.

- Involving large numbers of homeless or formerly homeless people in running the scheme, thereby improving social engagement and employability. This includes 12,000 hours of volunteer help each year with approximately 75% provided by people who are or were homeless. These volunteers are given assistance to benefit from volunteering, support in whether to remain alcohol and drug free and away from homelessness or progressing to training and employment.
- Providing educational and personal development opportunities around the use of good food to promote healthy choices. Cooking at Home – a specialist small group learning model – works directly with 50 people and assists local services to establish ongoing cookery classes of their own whereby service users will be enabled to learn about the safe, healthy and enjoyable use of food in improving their quality of life.
- Promoting the creative use of good food in tackling homelessness to the hostels and centres receiving food donations.

For further information please contact Edinburgh Cyrenians, 0131 475 2354 or [www.cyrenians.org.uk/](http://www.cyrenians.org.uk/), [admin@cyrenians.org.uk](mailto:admin@cyrenians.org.uk).

## Standard 5: Service Responses

### NHS Tayside

Central Healthcare is a nurse-led service, funded through what was the Personal Medical Services Scheme, and is for vulnerable and hard to reach groups in Perth and Kinross.

The service targets the health needs of these groups focusing in particular on homeless people,

women and children living with or escaping from domestic abuse, looked after and accommodated children and young people, looked after young people leaving care, gypsy travellers and prisoners facing homelessness on discharge from local prisons.

The service seeks to address both current and projected future social inclusion and healthcare issues, and focuses on reversing the exclusion of disadvantaged groups by managing their care pathway back into mainstream primary care.

Central Healthcare was established in early 2003 and has introduced a number of new ways of working which concentrate on offering a unique service targeted towards disadvantaged groups. This is underpinned by collaborative working with mainstream primary care, secondary care, the Local Authority and voluntary organisations using approaches which cut across traditional boundaries to ensure that care is patient rather than organisation/agency led.

The service works particularly closely with local primary care teams and will support individuals and families who meet the service's criteria, regardless of whether they are registered with a local General Practitioner or with the Central Healthcare Medical Practice.

Individuals and families who choose to register with Central Healthcare are supported through a time in their lives when their homelessness is further exacerbated by a number of problems leading to complex needs and difficult life circumstances.

When an individual or family's circumstances become more stable and more permanent accommodation is found, the Central Healthcare team work with the individual/family and local primary care teams towards permanent registration



with ongoing support for an agreed period of time, which can range from 6 weeks to 6 months. This ensures a smooth transition for the individual/family and additional support for the primary healthcare team who will provide ongoing care.

For further information please contact NHS Tayside on 01382 818 479.

## Standard 6: The Health and Homelessness Action Plan

### NHS Highland

There are a number of key ways in which the NHS Highland's Health and Homelessness Action Plan is implemented. Within the NHS itself there is a working group that was responsible for pulling together the Action Plan; this then reformed into a monitoring and implementation group. Key people involved include many of the main health services such as mental health and drug and alcohol services, as well as locality representation from each of the areas of Highland. There are also representatives from the Highland Council and voluntary sector organisations. The Action Plan was endorsed by the NHS Board and many of the actions are translated into other appropriate service strategies in order to be taken forward.

There is also a multi-agency working group which completed the Highland Homelessness Strategy of which the Health and Homelessness Action Plan is a component part. The partners include Highland Council, Northern Constabulary, NHS Highland, voluntary sector organisations, Scottish Prison Service, Landlords' Association and service users. This Strategy has also been adopted and endorsed by the main partners.

Finally, through the Community Planning structure, the Wellbeing Alliance, the Joint Health

Improvement Plan carries forward into the Community Plan an emphasis on health improvement and tackling health inequalities, which includes homeless people as a priority group.

In this way, actions are taken forward through a number of processes and have ownership from both the NHS and other appropriate partners at both strategic and local level.

For further information please contact NHS Highland on 01463 717123.

## Standard 6: The Health and Homelessness Action Plan

### NHS Tayside

In response to national guidance, the aim of NHS Tayside's Health and Homelessness Action Plan is to provide an outline for addressing service improvement together with a suggested implementation programme. Initially the NHS lead officer met with each Local Authority homelessness steering group to establish views and current work across all agencies. Building on this work, a series of three workshops were then held as a joint exercise between NHS Tayside and the three Local Authorities covering the area. The process consisted of four parts:

1. The establishment of a steering group consisting of the NHS lead officer, NHS planning and key service managers, and lead practitioners from each Local Authority and Local Health Care Cooperative (LHCC).
2. An assessment of baseline information in respect of housing and health and the identification of key issues from the local homelessness strategy groups.
3. Three workshops were held in February 2002 across Tayside. These workshops consisted of a series of presentations and discussion centred on



group work and answering and commenting on key questions formulated from the Health and Homelessness Guidance. Invitations were extended to a wide range of agencies including voluntary sector organisations, the Scottish Prison Service, Tayside Police, Local Authorities, housing and social work services and community planning, NHS primary and secondary care, lead managers and development officers from each of the Local Health Care Cooperatives and lead officers within the NHS Board and Public Health with responsibility for planning and strategy development.

4. The identification of key themes and issues in terms of health and homelessness, service provision and service development.

This work then provided a key platform to formulate the Action Plan which was divided into the following areas:

- a) An introduction to the policy context, a Tayside profile and the history to health and homelessness in Tayside.
- b) Current processes with the key people involved in planning and service provision.
- c) A breakdown of key issues and action plans divided into issues specific to each Local Authority/LHCC area, reported in three separate sections, and issues that are Tayside wide and which need to be considered on this basis.
- d) Conclusions, recommendations and suggestions on a way forward.

## Corporate Structure

An initial and key priority was the need to clarify direction and leadership for health and homelessness within health services and across all agencies to achieve a strategic overview for homelessness planning and service development in

Tayside. To address these issues, discussions started in each Local Authority/LHCC area and in reviewing all current homelessness groups, structures and membership. Following interagency consultation and discussion, an interagency steering group was formed consisting of the lead Local Authority representative from each area, and from NHS Tayside the lead health and homelessness officer, a planning representative, Assistant Director of Finance, secondary care representative, public health/health promotion representative and a public health officer.

The terms of reference for the group were initially to:

- Provide a strategic forum to oversee and plan health services in relation to homeless people for NHS Tayside, in partnership with other agencies.
- Agree, clarify and detail priorities for action.
- Quantify resource implications.
- Ensure agreement and cohesive and shared actions on priorities across Tayside and between agencies.
- Oversee and support the development, implementation, monitoring and evaluation of the Tayside Health and Homelessness Action Plan and Local Action Plans.
- Develop a financial framework for health and homelessness in Tayside.
- Dovetail local plans with overarching Tayside wide plans.

## Links

It was agreed that Local Authority representatives and the NHS lead officer would represent all local voluntary organisations, prison services, etc. Clear links were also in place via the lead officer with the NHS Board's Senior Management Team, Health Improvement Committee, Drug and Alcohol Teams, Health Inequalities and local mental health heads of service and performance assessment. Local health and homelessness groups were set up in each



locality linking into the Local Authorities' homelessness strategy groups to pull together all nursing and health disciplines, Drug and Alcohol Action Teams, etc.

To progress service developments, priorities and issues are put forward by the steering group to a prioritisation panel discussion forum within NHS Tayside. The Board is then able to clearly discuss and reflect on key homeless issues and where these sit within the prioritisation process for NHS Tayside. Examples of priorities routed through this channel include:

- Proposals for training and development.
- Personal Medical Services and nurse-led services.
- Key workers for health promotion and drug and alcohol services.

For further information please contact NHS Tayside on 01382 818 479.





**Section eight**  
Annexes and References



The Homelessness Task Force, in its final report *Homelessness: An Action Plan for Prevention and Effective Response* (Scottish Executive 2002), made a number of recommendations which were intended to have a positive impact on the health of homeless people. Some of these are aimed at the statutory sector as a whole, others directly at the NHS and others are for the attention of the Scottish Executive. The recommendations are listed below for ease of reference and numbered as they appear in the report, cross referenced by the paragraph in which they appear where additional contextual information may be found.

The delivery of the health recommendations will be monitored through the self-assessment reporting framework for the Health and Homelessness Standards.

## Recommendations

(26) Those responsible for prisoners, looked after children, **long-stay hospital patients** and the armed forces should develop high quality housing and homelessness advice services with support from Communities Scotland. Standards for these advice services should be set and monitored within the appropriate regulatory regime for each type of institution. Local Authorities should ensure that appropriate linkages are being made between services in institutions and services in the community (paragraph 62).

(33) All service providers, statutory and voluntary, should ensure that they are promoting values, attitudes and behaviour which deliver responsive and personalised services. They should ensure that staff are supported and trained in serving people affected by homelessness. Training should cover, as appropriate, the definition of homelessness, risk assessment techniques to help “first-to-know” agencies respond effectively, joint working with

other agencies, support packages, consultation techniques and how to help and empower people experiencing homelessness to find appropriate solutions. Joint training approaches should be pursued. The training programmes run by the Scottish Training on Alcohol and Drug Abuse (STRADA) partnership should include coverage on serving homeless people (paragraphs 76-77).

(42) A high priority should be placed upon monitoring of quality and delivery of Health and Homelessness Action Plans. The Health Department’s Primary Care Modernisation Group should set out how the primary care needs of homeless people would best be met (paragraph 99(i)).

(43) All Local Authorities should record information about the GP registration of all those who register as homeless, and should offer information about local health services to homeless people rehoused out-with their existing GP area (paragraph 99(ii)).

(44) NHS Boards should ensure their strategic planning embraces the current and future service needs of homeless people. Drug and Alcohol Action Teams should include, in their planning priorities, the service requirements of homeless people relating to substance misuse. Monitoring of the effectiveness of such processes should be undertaken through the Scottish Executive’s assessment of Local Health Plans and Corporate Action Plans on Substance Misuse (paragraph 99(ii)).

(45) NHS Boards should ensure that all children in homeless families are able to access the full range of universal health services for children; and the Health and Homelessness Co-ordinator should monitor this action (paragraph 99(iii)).



(46) NHS Boards should address the provision of mental health services to homeless people to minimise the barriers to access. Being free from substance-misuse should not be an automatic precondition for access to services (paragraph 99(iv)).

(47) Actions within the national drugs and alcohol plans which will prevent addictions contributing to homelessness and which will tackle substance misuse amongst homeless people should be given high priority. The recommendations of the Glasgow Street Homelessness Team in relation to the development and provision of drug and alcohol services to hostel dwellers should be more widely applied. Local action to tackle substance misuse and homelessness in parallel should be developed through homelessness strategies and Drug and Alcohol Action Team plans. The results of Scottish Executive work on effective interventions in tackling substance misuse should be disseminated to support commissioners and purchasers of services and service providers in both homelessness and drugs and alcohol agencies (paragraph 99(v)).

(48) In the case of primary care services, specialist provision should be seen as transitional for all but a small number of homeless people. It should provide planned support over a reasonable period of time until individuals are re-housed and settled with access to their local GP practice and primary health care team. The general approach should be to support homeless people to maintain their current health networks or to establish new regular contact with mainstream health services (paragraph 99(vii)).

(49) The Health and Homelessness Co-ordinator, whose remit includes setting standards for homelessness training programmes, should support training on homelessness for health professionals and ancillary staff (paragraph 99 (viii)).

(52) Public sector employers should also examine ways of creating and expanding work opportunities for homeless people. New public sector initiatives should strive to employ homeless people in the provision of their services (paragraph 108).



The Homelessness Task Force identified a range of housing situations that defined the meaning of homelessness for the purposes of their work. This definition embraces the following categories, which are not mutually exclusive, but all have been specified in the interests of clarity. **It is this definition that should be used in applying the Health and Homelessness Standards.**

1. Persons defined in current legislation as homeless persons and persons threatened with homelessness, i.e. those:

- Without any accommodation in which they can live with their families.
- Who cannot gain access to their accommodation or would risk domestic violence by living there.
- Whose accommodation is “unreasonable”, or is overcrowded and a danger to health.
- Whose accommodation is a caravan or boat and they have nowhere to park it.

2. Those persons experiencing one or more of the following situations, even if these situations are not covered by the legislation:

- Roofless: those persons without shelter of any kind. This includes people who are sleeping rough, victims of fire and flood, and newly-arrived immigrants.
- Houseless: those persons living in emergency and temporary accommodation provided for homeless people. Examples of such accommodation are night shelters, hostels and refuges.
- Households residing in accommodation, such as Bed & Breakfast premises, which is unsuitable as long-stay accommodation because they have no where else to stay.
- Those persons staying in institutions only because they have nowhere else to stay.

- Insecure accommodation: those persons in accommodation that is insecure in reality rather than simply, or necessarily, held on an impermanent tenure. This group includes:
  - Tenants or owner-occupiers likely to be evicted (whether lawfully or unlawfully).
  - Persons with no legal rights or permission to remain in accommodation, such as squatters or young people asked to leave the family home.
  - Persons with only a short-term permission to stay, such as those moving around friends’ and relatives’ houses with no stable base.
  - Involuntary Sharing of Housing in Unreasonable Circumstances: those persons who are involuntarily sharing accommodation with another household on a long-term basis in housing circumstances deemed to be unreasonable.

The Task Force’s full report can be found at [www.scotland.gov.uk/library3/society/htff-00.asp](http://www.scotland.gov.uk/library3/society/htff-00.asp)



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