Working together to effectively implement the Health and Homelessness Standards

Report of a Learning and Support Seminar

held on 25 June 2007

NHS Health Scotland

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1. Introduction

1.1 The Standards

Improving the health of Scotland's homeless people requires long-term solutions and a multi-agency, co-ordinated approach. To enable NHS Boards to more fully play their role in the development of these long-term solutions and be valued for their actions, the Scottish Executive launched six challenging but achievable Health and Homelessness Standards in March 2005, for immediate implementation by all geographic NHS Boards across Scotland. They should underpin NHS Boards' Health and Homelessness Action Plans. A summary of the Standards is given in Appendix 1.

Produced through an inclusive process involving many individuals and organisations that work with homeless people across Scotland, these non-clinical standards are based on this collective expertise as well as the Scottish Executive's experience of assessing the delivery of Health and Homelessness Action Plans and the lessons learned as a result.

The Health and Homelessness Standards are principally aimed at the Corporate Teams within NHS Boards, in recognition of the critical importance of strong leadership in tackling health inequalities. While NHS Boards hold the strategic responsibility for their implementation, delivery should largely be through the activities of Community Health Partnerships (CHPs), involving both NHS and other partners.

1.2 The seminar

The seminar on 'Working together to effectively implement the Health and Homelessness Standards' was held on 25 June 2007. A copy of the programme is included at appendix 1.

NHS Health Scotland, in partnership with the Scottish Council for Single Homeless, wished to provide a national networking and learning seminar for all NHS Boards and CHPs to ensure the continued and effective implementation of the Standards. NHS Boards and Community Health Partnership representatives were encouraged to extend this invitation to their Community Planning Partners.

This event was aimed at:

- NHS Board Lead Directors for Health and Homelessness
- NHS Board Health and Homelessness Leads
- Community Health Partnership General Managers
- Community Planning Partners

41 people came together from across Scotland (including three on a video link from Orkney) to share learning, identify barriers to implementation and identify what support needs remain unmet in order for Boards to more effectively

deliver on this agenda and achieve and sustain full implementation of the Standards locally. The focus of the seminar was local strategic planning and the delivery of services. It was also used to explore the networking needs of local strategists to ensure dissemination of learning and successful approaches to support the implementation of the Standards.

This event was intended to help participants to:

- actively engage with colleagues across Scotland who are involved in the delivery of the health and homelessness standards
- share areas of good practice and learning between and within local areas
- value health and homelessness work as a contribution to reducing health inequalities
- promote the continued embedding of health and homelessness activities in strategic planning and reporting
- explore health board and CHP needs in progressing and influencing this agenda further
- explore opportunities for effective joint working and future networking
- be updated on current national activities.

1.3 This report

This report was commissioned by NHS Health Scotland. It is based upon:

- The presentations of key speakers, and the questions and answers that followed;
- Notes taken in each of the four workshops, and of discussions throughout the day; and
- Written comments from the Orkney participants.

It brings together the main issues and support needs that were identified and wherever possible the examples of implementation or barriers to implementation of the Standards. A brief summary of some of the main emerging issues is provided in the final section of the report.

2. Key themes and messages from speakers

2.1 Welcome and introduction

Emma Witney, Head of Healthy Settings Team, NHS Health Scotland opened the seminar, which was a result of discussions with the Homelessness Monitoring Group.

Invitations were focused, being aimed primarily at geographical NHS Board strategists and planners of health and homelessness services and Community Health Partnerships (CHPs), with some of their partners from Community Planning Partnerships (CPPs), to acknowledge their important role in this work.

The seminar was an opportunity for delegates to establish dialogue across Scotland on health and homelessness and to listen and learn from each other.

The Healthy Settings Team, and specifically its Community and Voluntary Sector Programme, was taking the lead on this agenda for NHS Health Scotland. Emma thanked Lizanne Conway and Heather Apsley for their hard work in organising the event. Colleagues from the Team's Health Service programme were also involved in the seminar. However homelessness was also a concern for other Health Scotland Teams – Children and Young People's Health and Healthy Topics.

The influence of past and current work undertaken by Health Scotland on health and homelessness was acknowledged - especially Gary Wilson's work on youth homelessness and health. This had led to research by Blake Stevenson Ltd into *Young, single homeless people: their perceptions of health and use of health promotion activities*[1]*.*

Also acknowledged were the contributions of the national Food, Health & Homelessness Programme, based within Community Food & Health (Scotland) and of Sue Irving, now the Director of Business Development at Aberdeen Cyrenians but previously Health and Homelessness Co-ordinator at the Scottish Executive.

Delegates were also informed of the National Health and Homelessness Conference, co-planned with the Scottish Council for Single Homeless, which will be held in Edinburgh on 26 September 2007.

2.2 Embedding the Health & Homelessness Standards

Paul Gray, Director of Primary Care & Community Care, Scottish Executive. Delegates were thanked for their hard work towards implementation of the national Standards to date. This was the first health board seminar on health

[1] NHS Health Scotland, 2006 http://www.healthscotland.com/documents/481.aspx

and homelessness since the Standards were launched in March 2005 and therefore as much as possible had to be concentrated into the day taking into account work still to be done.

Achievements in Health & Homelessness

Scotland has the most progressive legislative and policy framework on homelessness in Europe. This is recognised at home (UK) and abroad. By 2012, everyone in Scotland who is homeless will have the right to a home, and the necessary support and healthcare people need to realise their potential should also be in place.

Current initiatives build upon a long period of commitment. The health needs of homeless people have been recognised within Scottish health policy as part of the broad agenda to reduce health inequalities.

A ‘people’ focus is central and right. Homeless people should be able to expect to receive a proper standard of service, and the national Standards provide the framework to do this. There is also a ‘business case’ for addressing health and homelessness. If people get into a downward spiral of which homelessness forms part, the cost to services is great. Helping people to live worthwhile and fulfilling lives is better both for the individuals and for Scotland.

Every health board has developed and are implementing Health and Homelessness Action Plans.

It is important to measure what we are doing, to assess its success. Programmes that have proper management and measurement of outcomes tend to be the ones that go well. The 'one year on' survey of the implementation of the Standards conducted last year set out to provide a baseline for this.

One-Year-On Survey – Where can we do more?

The outputs from the survey act as a guide to see where we can do more.

Nationally, the overall compliance level was around 78%. Eight boards reported overall compliance greater than the national average with five of these reporting compliance of 90% or over.

However, there was a great deal of variability within and across the Standards at both national and board levels.

Further work is required across the vast majority of boards, in particular to:

- embed health and homeless planning in corporate thinking,
- make strong and effective linkages with other strategies,
- understand and profile the health needs of homeless people,

- ensure equitable access across health services, and
- ensure that services respond positively.

Key activities central to the Standards where we could do more include:

- Boards should **regularly review their Health and Homelessness Action Plans** and other related strategies to determine what more can be done to strengthen performance against the standards. Action Plans should be kept relevant, particularly to the operational aspects of the Standards.

- Boards should **work effectively with partners**, particularly local authorities. It is a great opportunity for health and social care services to recognise their common values and value each other's work and develop a common understanding and achieve common goals.

- We must demonstrate that homeless people **are able to use the full range of health and well-being services**. The aim must be to incorporate homeless people within mainstream services and to ensure these services are designed in ways which meets their needs.

- Relevant frontline staff **must have the appropriate skills and knowledge**. They should be trained to ensure that they deliver services to homeless people effectively and equitably. In addition, front line staff should be equipped to signpost homeless people to other appropriate agencies to prevent a continuation of their unsettled lives.

- CHPs need to be **proactive in influencing all service planning for homeless people** and agree the appropriate models of care to be delivered locally.

Working together towards full compliance of the Standards

The 'one-year-on' survey results **should be reviewed locally** to check how local needs are being met. Boards will have already made further progress on implementing standards since the survey was carried out. However it is important that each NHS board continues to review performance locally and pursue improvement action.

Strengthen performance against the operational aspects of the Standards. Planning and partnership working at a strategic level needs to translate into positive action at an operational level.

Take advantage of networking opportunities like today's workshops to identify ways of working more effectively and what support needs remain unmet. Be honest about what hasn't worked.

Reflect on the Progress Reports (which were due on 2 July) and explore solutions for those aspects of the Standards that present the most challenges.

Health and Homelessness will be covered in the **2007 Annual Accountability Reviews**. It is important that boards are able to demonstrate that they have set local plans and goals for improvement.

Paul Gray concluded with reinforcing the importance of the seminar, which was to share experiences and learning, establish contacts with other boards with more experience in this field and establish networking and learning opportunities.

The health and homelessness agenda is of immense importance. It is about delivery to a key group of people who deserve better.

2.3 Partnership working to prevent and alleviate homelessness

Robert Aldridge, Director, Scottish Council for Single Homeless (SCSH), (and member of the Homelessness Monitoring Group).

Introduction

Acknowledgement was given to the good progress that had been made up to and including the introduction of the Standards, and the progress is still being made in many areas of Scotland, but not all. The concern was that the agenda did not lose momentum.

This seminar would identify the real obstacles and feed in to the much broader Conference in September. Both are important in maintaining this momentum.

Measuring the baseline and outcomes was important, but more work is needed to get behind the survey activity results to test action on the ground.

Partnership Working

It was now five years since the then Minister for Social Justice, Margaret Curran stated the vision:

> "In 10 years time, we can look forward to a Scotland in which every homeless person has a basic right to somewhere decent to live, and receives all the appropriate support and healthcare they need to sustain their home."

This comes to the heart of why partnership working is needed. It is not about policy or legislation alone, but a change in culture towards a joined up response.

How can this change be achieved?

- the new legislative framework is important
- the supply of housing must be adequate
- support needs to be offered

- we need to move towards individually tailored solutions, not pigeon hole people into 'client groups'
- this needs partnership working across disciplines; the difficulty of this must not be underestimated; there are limits to people's professional capacity, and practical issues such as Data Protection
- Homelessness Strategies and Health & Homelessness Action Plans must be integrated together; in some areas the two are already being dealt with together.

We must develop a framework that offers all of:

- prevention
- crisis intervention
- sustainable solutions.

Partnership working must be aimed at delivering holistic, individually tailored responses to people's problems. The reaction of the first service that a person contacts can determine the outcome of their experience. We must not just look at people using the first label that we attach to them. Joint training, especially for front line and reception staff, is important, to help them to understand each other's jobs and who they could signpost people to.

All sectors need to contribute: health boards, local authorities, the voluntary sector, and Drug and Alcohol Action Teams (DAATs), who are the 'fourth leg', but currently not a firm one. Their response has been patchy and in some cases unacceptable. A review is under way. A Homelessness and Substance Misuse Working Group has been set up to reconcile the 'housing first' and 'treatment first' approaches, and to look at how to measure what is success.

The International Stage

In Scotland we are pioneers in this work. We have an opportunity to be world trend-setters. The European network of homelessness organisations is looking at the Scottish model to see if it can work, and at a conference in the USA that Robert Aldridge had attended recently, people were amazed that Scotland had such structures in place. If we get it right for homeless people, we will have got it right for a broad range of hard to reach groups and those with multiple problems affected by health inequalities.

Networking

There should already be local networks in every area. Local authority homelessness strategy forums should include representation from health, and from homeless people. Multi-agency forums should be in place around the Health and Homelessness Action Plans.

Nationally there were fewer opportunities for networking. SCSH already leads a forum for local authority lead homelessness officers, and Robert said he was interested in developing one for health and homelessness lead officers.

The previous network for health and homelessness projects might also be revived.

Conclusions

- Homelessness work must be embedded in the mainstream activities of health boards
- Joint and partnership working must be a permanent feature
- People affected by homelessness must be included in all consultations and plans.
- Mainstreaming must involve prevention and sustainability, not simply specialist homelessness services. The aim is essentially that as few people as possible should go through the crisis of homelessness.

We are at a point where we can make a real difference, and must find our way through the obstacles. The Health and Homelessness Conference (details on www.scsh.org.uk) on 26 September 2007 would provide another opportunity to learn about the good practice on the ground and the output from today's seminar would directly feed into planning for the national conference.

2.4 Questions and answers

The panel of speakers took questions from the floor.

Should we review the Standards nationally? They do not reflect the new focus on Community Health Partnerships (CHPs) as delivery agents.

Robert Aldridge acknowledged that the Standards should be revisited as they were introduced at a time before CHPs had been fully embedded in the new structure of the NHS. Changes had also been made to the performance management arrangements at the centre with the introduction of H.E.A.T.

Paul Gray was not opposed to this suggestion but would want to act if this was the general feeling, particularly if feedback from Boards showed that they were forced into a repetitive presentation of the situation in different CHPs.

There is a gap in developing practice as well as policy. Health Scotland should have a key role.

Emma Witney said that they hoped that the workshops would look at support needs which Health Scotland would look at and try to address, with the Scottish Executive.

Robert Aldridge expected the September conference to identify good practice.

Paul Gray wanted to guard against developing very tightly defined specialist practice just for homelessness; he also wanted people to develop good practice that works for their own areas, not just 'best practice'.

Could work on health and homelessness be used as a pathfinder for work with other vulnerable groups?

Paul Gray agreed in principle, but urged that care must be taken not to give the message that the focus was being taken off homelessness.

The work of my DAAT has overlaps with health and homelessness activity and there are local links, but these are not rigorous. There seems to be no specific guidance for DAATs.

Robert Aldridge agreed that there was not sufficient guidance to make it plain that DAATs are a crucial element in the framework.

Currently performance is self-reported, but policy and practice can be different. Are there any plans to talk more systematically to the people affected about their views, and offer national support for this?

Paul Gray said that this would have to form part of an overall evaluation. Service users' views are crucial, and the most difficult aspect to capture.

Robert Aldridge agreed that most areas have found this difficult. Many service users have been consulted about specific services. If we get things right, homelessness should only be a very short experience, which makes it difficult to build up people's capacity to be involved. Good practice in involvement needs to be built into the way projects work.

The design of the current Standards invites senior managers to press people at lower level to give things a positive spin. CHPs should not be purely regarded as an arm of the NHS. Homeless people are one of many groups with multiple and complex needs – could the Standards be a paradigm for how we move forward to meet these?

Robert Aldridge agreed that these points summed things up.

Paul Gray wanted action if the Standards were found to encourage dishonest reporting. He agreed that the words 'Community', 'Health' and 'Partnership' were all of equal value. CHPs are not just the creatures of Health Boards (nor do CPPs only relate to local authorities).

3. Workshop discussions

3.1 Purpose of workshops

Four workshops were held for delegates to exchange information and ideas on two main areas:

1. Their experience of implementing the Standards locally.

   - What had worked well?
   - Had they experienced any barriers?
   - Why have some found it difficult to progress certain aspects of the Standards?
   - What progress is being made in each Board area on health and homelessness?
   - What learning from each area could be shared with colleagues?

2. The support that is needed for successful implementation of the Standards:

   - within Health Boards
   - within Community Health Partnerships,

   and how this could be provided at a local or a national level. Some groups discussed as a separate matter what actions they would now wish to take forward in their areas and what they would want to see happen next nationally. These views are presented alongside those on support needs.

The following sections capture the workshop discussions and are presented according to the main themes.

Finally each group presented four key points for action to the whole group. These points are listed in section 4.

3.2 Issues about progress and learning to date

Overall

The Standards generally were felt to have a positive impact and provide a focus for work. They provide a high level checklist against which local health and homelessness action plans can be developed; they hold health boards to account and highlight the expectation that they should deliver on this agenda. There was evidence of more joint working across a range of areas as a result and 'enabled the Community Health and Care Partnerships to take ownership of the issue'.

The process of improvement had already been underway, but the Standards were a contributory factor. They helped people to get resources for health and

homelessness work. It was also helpful for performance against the Standards to be part of the Accountability Review process.

However, because the Standards are high level in nature, they can be a bit vague and it is difficult at times to project from them what implementation of a Standard would actually look like.

Integrated Planning and Partnership Working

There was a lot of commonality of things that had worked well across health board areas including: communications, partnership working, and bringing people together to highlight issues. However, the lack of understanding of other people's roles was still a barrier in delivering the Standards.

The ability to use the Standards to gain a better understanding of the challenges to each sector (Health Boards, local government, the voluntary sector) was highlighted, which has assisted learning.

Examples of good practice included:

- a joint NHS and local authority post for health and homelessness in the Borders (though with a focus on operational rather than strategic issues)

- strong partnership working and integration of plans was considered to be a real strength in Lothian: NHS Lothian hopes to have an updated single plan, which incorporates the health and homelessness standards, by the end of the year. Its homelessness planning group is Council-led with representation from health, Police and the voluntary sector.

Some delegates, whilst echoing the importance of effective partnership working for the successful implementation of the Standards, cited the lack of partnership approaches, especially the lack of information sharing and co-ordination of activities, as being the biggest barrier in making progress.

Local authorities and health boards needed to work in partnership to ensure that the needs of any children involved are paramount.

Some felt that this agenda was not perceived as important enough, and that even with partners 'signing up' to the Standards, there were still not enough levers available to make sure that they had an active influence on partners. This was highlighted in the following examples:

- A draft protocol for a homeless service was developed across two NHS Boards. An approach to service delivery had been identified, but engaging broader support within the NHS workforce for implementation had proved challenging, due to competing priorities within the NHS.

- ‘all the usual suspects’ were involved in delivery of an action plan, but great difficulty was experienced in engaging other essential partners, e.g. in mental health services and the DAAT. Others also identified a lack of clarity about the role of other strategic partners such as DAATs, and the need for guidance to them.

- One area reported that getting a local health and homelessness group together had been their biggest struggle. The same people turned up all the time, but it was difficult to involve other partners, who appeared to expect others to take responsibility.

- Problems had been encountered in involving primary care services if activities were not part of the General Medical Service contract or Quality and Outcomes Framework.

- Some delegates felt that the Standards did not seem to carry as much weight as other strategic priorities.

- Others said there is a need to emphasise that, since the CHP is the main delivery vehicle, it is also the key organisation with regard to planning, engaging partners and reporting.

Specific relationships

Several learning points related to variations in the involvement of specific agencies and sectors.

- Ayrshire and Arran highlighted the good progress made in their Hospital Discharge Strategy Group. The Group’s original focus was on meeting the needs of the older population, but it now sees the benefit of ensuring that its strategy is also appropriate for homeless people and is working to achieve this. The Standards had led to someone at senior level taking responsibility for championing this agenda.

- One area reported progress with housing officers visiting hospitals, and also outstanding co-operation from one particular prison; better links with other prisons, including private prisons, were beginning to develop.

- Some delegates felt that links to drug and alcohol services were becoming more effective. For example prisons were now not supposed to give methadone treatment unless the homelessness team could arrange for a continued service post-discharge. Though links were not 100% successful, there was now less risk of ex-prisoners being ‘dumped’ on the team without warning.

- One area is putting together a Health and Homelessness directory for voluntary organisations, which will help them with signposting people to services.

- One delegate felt that the Care Programme Approach to mental health is a good initiative, involving all agencies, and would like to build on it.

- Another area had looked at innovative ways of getting people into temporary accommodation, and no longer had people 'jammed in the system'.

Barriers

- One group felt that a major barrier to progress was the ability to deal with situations where people have multiple issues, but only one of them, e.g. housing, can be dealt with because other services can say that they are 'not serious enough' and/or 'not within our remit' .

- In one health board area the reaction has varied greatly between CHPs – some teams saw engagement in the homelessness issue as overdue, others saw the invitation to be involved as 'more bureaucracy'.

- The relationship most often identified as a barrier was that with drug services. Drug related issues can be an area of weakness - one area acknowledged that they had found it difficult to get homelessness onto the agenda of DAATs, but were now beginning to see more involvement from them.

Specialist or mainstream services?

The Standards emphasise that the ultimate aim of specialist services should be reintroducing people to mainstream services.

There was agreement that 'homelessness needs to be mainstreamed and not kept in one silo'. When specialist services are established, the agenda is often left to that team or individual only, who are often left isolated or perceived as a peripheral service, and the impact on mainstream services is minimal.

Many saw the development of specialist services as a more successful aspect of current work than the link to mainstream services. 'Specialist services should be a means to an end, but we are not sure this is working', one group reported.

Delegates felt that most of the progress made had been in the creation of specialist teams, but that these had not really begun to influence mainstream services, or guide people back to them. Others felt that an influence could already be seen.

One area reported that there was a 70-80% increase in services available compared to four years ago, but that engaging and training staff in mainstream services remained difficult. At present having a specialist team was positive because it meant that that homeless people avoided having to

deal with the inappropriate perceptions of receptionists and others in mainstream services.

One delegate felt that although the aim of the specialist team was to move people into mainstream services, it was better for that team to give them continuity of care, if the alternative was to be passed around between services.

Health and homelessness in relation to other complex needs

Some saw the definition of homelessness as a real difficulty for implementation, because of its breadth - it could range from people sleeping on friends' sofas to those living on the streets. The implications of meeting needs could be very different according to each presenting person. Prevention issues are particularly difficult to identify, particularly as people may be reluctant to reveal that they are at risk of losing their tenure.

Participants acknowledged that the Standards were very helpful in getting homelessness on everyone's agenda as an important issue. However several groups explored the idea that health and homelessness should be tackled as part of a spectrum of complex needs, rather than a separate issue. The ideas discussed included the following:

- The health and homelessness work could be a 'pathfinder' for work with other vulnerable groups.

- Incorporating the homelessness agenda within an inequalities strategy helps gain more 'buy in'. Standard 1.2 performance requirement emphasises that the health needs of homeless people should be incorporated in Boards' Inequalities Strategies and other relevant strategic planning frameworks.

- If an area does not have a very visible roofless population, it can be hard to get attention for the homelessness agenda. If homelessness is considered within the broader terms of addressing multiple and complex needs, this might engage the wider services which need to be involved, such as mental health and addiction services.

- Services perhaps spend too much time on personal causes of problems and not on the structural ones, which are mainly the root causes.

- In some areas, because staff attitudinal issues towards homeless people have been recognised, they are now redefining this population as 'vulnerable people with complex needs' rather than 'homeless' in an attempt to remove labels and to get everyone to take ownership across various teams.

- In Glasgow, the specialist team is being dispersed across the CHCPs and will work with 'vulnerable people with complex needs'. People at

local level are being encouraged to recognise that homeless people are vulnerable people who come from their own communities and should not just be dealt with in the city centre.

Remote and Rural areas

Preventing and tackling health and homelessness issues becomes even more challenging for boards that do not have a concentrated homelessness population.

- The homeless population that NHS Highland deals with, for example, is now more widely spread than ever since the incorporation of parts of NHS Argyll and Clyde, and is at times hidden. While building strong partnerships was central to the approach of all boards represented, remote and rural boards described some additional challenges they faced when implementing the Standards.
- Ayrshire's geography and its scattered homeless population meant that it, like most other boards outside the central belt, struggled to co-locate services, despite having built strong partnership working between sectors.
- The Orkney participants also felt that the nationally understood profile of homelessness does not always reflect the remote and rural or islands perspective. They asked for recognition that this client group could receive services as part of an equality of access to generic services rather than insisting on the availability of specialist services.

Recognition of the different challenges facing Boards across Scotland would be welcomed in the annual self-assessment process for the Standards.

Delegates reported that homelessness is now higher on the agenda in rural areas. However, there is still a lack of a basic understanding that the issue is relevant in some rural communities. Practitioners have stereotypes, and there is a lack of specialist resources and skills. But there are also advantages: personal contacts between a smaller number of service providers may be stronger.

Fit with performance management frameworks

Workshops were particularly encouraged to consider how the Standards fit into the Joint Health Improvement Plans (JHIPs), or other Performance Management Frameworks.

- One area reported that at least some of the Standards were seen as fitting, and that staff tried to ensure that they were included in the Performance Management Framework.

- A delegate felt that the Standards fit in well with their JHIP and the work of their CPP. They have combined health and homelessness into one strategy group which is working well. Homelessness and health is given a high priority as a result of being included in the JHIP.

- A CHP representative commented that the health and homelessness standards had been incorporated into the local development plans in each of the 5 Glasgow CHCPs. Although it took a lot of work to achieve this structure, the delegate felt that it was now quite well embedded.

- Another delegate noted that homelessness is increasingly appearing in different strands of the various strategies and that this helps to lever finance from a range of sources. However it was acknowledged keeping it high on the agenda can be difficult due to competing priorities.

Monitoring

More general issues about monitoring health and homelessness were raised from many areas.

- One group was concerned that the 'one-year-on' survey simply reflects boards' own perceptions of progress. It is difficult to tell how well things are being implemented on the front line, since the survey is usually completed by one person who may not have an accurate view of this.

- One participant said that the process which has led to estimating a 78% compliance rate was a cause for concern, as they felt much more action was still required than this implies. Some felt constrained by the 'yes' and 'no' answer options. They felt there was no room for an 'in part' answer and suggested that a system involving 'red, amber, and green' answer options would be beneficial.

- At local level, the need to develop systems that produce measurable outcomes was seen as a learning point, and the fact that people and organisations often do not know how well they are doing was seen as a barrier to progress. Knowing the baseline for and composition of the client group is necessary for service re-design. People need information at this level before they can begin to address the implications in the detail implied by the Standards.

- One workshop saw the lack of a standard understanding of who the clients were as a barrier to progress. Housing, Social Work, Health and others all had different IT systems and were huge enterprises that found it difficult to change their systems to focus consistently on one relatively small part of their caseloads.

- Basic processes of gathering information may be lacking. People are not clear how to recognise vulnerability whilst avoiding labelling. It was difficult to move beyond a generic policy of 'treating everyone according to their known needs'. Homeless people do not necessarily declare their status to local GPs; staff in primary care claimed that they

would only know if someone was homeless if their address was a hostel or Homeless Unit. People could therefore continue to attend primary care services without anyone knowing that they were homeless, but their access to care was still diminished. Similarly, Accident and Emergency services would not ask if a person is homeless.

Learning and Awareness

- Some groups identified education as 'a big need'. It was stated that learning and development for staff around working with homeless clients is not currently built into routine training or induction.

- More generally, several people were concerned about levels of awareness of homelessness. One area for future focus in Glasgow would be developing and changing staff attitudes to dealing with the homeless population. Others agreed that there is an attitudinal issue. Front line staff could have an inappropriate attitude to homeless people. It was suggested that there was a need to raise their awareness as part of broader learning. Members of one group described a 'severe stigmatization problem amongst health care staff' in relation to the homeless population.

- It was also noted that people 'on the front line' often don't know who to contact or direct an individual to if dealing with a need that is not directly 'homelessness'. Understanding of each other's roles could be improved.

- Private landlords were also said to be a group where awareness of health and homelessness issues should be raised.

Involvement

The issue of service user involvement attracted little discussion in the workshops.

- One example of good practice was a booklet 'Your guide for service users in Moray', which was funded through the local health improvement budget and developed with partners and service users.

3.3 Issues about support needs and actions required

Many discussions highlighted the differences in perceptions between staff at operational and strategic levels. But, although asked to distinguish between the support that is needed for successful implementation of the Standards at health board and CHP level, at least one group felt unable to do so. Many of the issues discussed were presented in ways that do not always make it clear what support is required from a national level for the actions described.

Training

Needs identified included:

- opportunities for learning and exposure to homelessness issues within health and social care professions both before and after registration

- including this issue in national training programmes for front line staff.

- a mechanism to share learning in order to come together and share practice. There was a recognition that this could prove more difficult in rural areas where more generic posts, rather than health and homelessness lead officers, were responsible.

- joint training for all frontline staff within agencies that may be the first point of contact for a homeless person seeking help and support. Receptionists within health centres, housing offices, benefits agencies, hospitals, clinics, dental surgeries were all described as being possible recipients of such training.

- training that includes practical guidance about how to help the person most supportively, but also covers the importance of being non-judgmental.

- wider and ongoing training for all health and social care staff working with the homeless population to help overcome any stigma and prejudice that may exist when a person presents as homeless

- a specific need to support GPs to become more engaged, to help homeless people get registered or reregistered with GP practices.

Networking

There was a lot of support for increased networking opportunities at many levels. The support requested included:

- sharing of good practice and information with a forum or resource to support this

- 'we would find it useful to meet as a group to discuss planning and implementation'

- opportunities to share practice (both operational and strategic) between board areas through networking opportunities such as events, e-group and learning days

- dedicated support at a national level to co-ordinate communication between Boards about health and homelessness

- a follow-up seminar

- a projects network, which would enable rural areas without specialist services to look at how to translate practice to their settings.

- ensuring that events at a national level etc actually 'go somewhere'

- looking at a different level of staff than those present at this event. It had been aimed mostly at a strategic level, though some operational staff were also in attendance.

However the limits on people's threshold of capacity to get to different meetings were also recognised.

- One group agreed that an e-network or reference group would be better than a shared internet page. Such a network could share snapshots of what is already going on in different areas. It was suggested that a closed e-network for Health Board and CHP leads could be facilitated by SCSH.
- A SCSH representative explained that they already provide this service for local government officers. Participants agreed that this kind of network would require resources at both ends to make it work. Users would 'buy into it' at different times and it could be used to build relationships with similar areas.

Co-ordination and sharing of information

- Communication between such professionals is usually uncoordinated. As a person experiencing or at risk from becoming homeless is likely to have multiple needs, s/he may be in contact with a number of agencies at any one time.

- More needs to be done to ensure that information is better shared between agencies as a matter of automatic practice to maximize the likelihood of a positive outcome for an individual. Mechanisms needed to be developed to ensure this happens consistently across and between sectors if the health outcomes for the homeless population are to improve.

The need for single shared assessment and for learning from other sectors that use this approach was discussed.

- Need to widen the community of people who are interested in exchanging information, for example in DAATs and other groupings involved in JHIPs.

- There was a particular need for a programme for people with severe and ongoing Mental Health problems. Stirling has piloted a system allowing the Community Psychiatric Nurse working with a person in hospital to identify a housing problem and approach housing agencies.

Learning from practice

A need to identify and disseminate knowledge within Health Boards of what works and provides positive outcomes for people was identified. There is a need for someone to keep an eye on how this work is developing. Feedback is always just one small bit of someone's remit in each board area, therefore it is important to appoint a lead person for this.

Results from the 'one-year-on' survey were difficult to explain to people locally what it meant. There was a feeling that the successful implementation is a different task from raising awareness of the Standards and getting partners to give them as high a priority as desired.

Recording of information

It was argued that there is a need to record on NHS records (and presumably elsewhere) the status of a patient's current address in order to more easily identify whether a person should be considered homeless or at risk of being homeless e.g. someone 'using the couch' at a friends house.

Organisation and leadership

Needs identified included:

- a dedicated person or post within each Board area to progress the Standards
- clarity on who is going to co-ordinate the evaluation of each of the Standards
- a key person at a local level to help understand the system or, probably better, a group of people to ensure continuity
- recognition at a national level for what is being done, including the things that people are officially required to do
- a key named individual in the Scottish Executive to provide support.

Clarity of policy

Health Boards needed to have a clear agreed policy line on whether they were adopting a specialist or generic approach to health and homelessness services. In some areas there is currently tension. If a specialist approach is adopted but priorities change then funding is withdrawn and the post disappears. There is a tendency to rely on specialist teams where they exist, which places too much pressure on them, so more resources are needed. If someone is in temporary accommodation, mainstream services will say 'the homelessness team will take them'.

To achieve clarity, homelessness must be kept on the agenda at health board level. Funding must be allocated, research must be done, and understanding of what works must be developed. Learning and practice must be cascaded down from health boards.

Resources and funding

One group identified a lack of dedicated and recurrent funding and resources for health and homelessness services. This often weakened partnerships and hindered progress with the implementation of the Standards. Everyone in the group considered this issue to be a priority for the Scottish Executive to respond to.

Another group specifically identified the need for more direct support and funding directed at CHP level.

Prevention of homelessness

Several groups called for more focus on the prevention of homelessness. The approaches identified included work at several different levels:

- awareness raising: with local private landlords about their potential role in local homelessness; informing and engaging GPs, school health practitioners, health visitors etc

- shared assessments highlighting the multiple and complex needs of individuals and families at risk; one group specifically identified the need for support for IT capacity to implement the shared assessment process

- better co-operation with prisons

- more joined up discharge planning from hospitals and care homes

- highlighting and identifying vulnerable groups within primary care,

- more targeted support to help prevent groups most at risk such as care leavers, people in long stay hospital care, ex-military and ex-offenders from becoming homeless; such programmes would need to be tailored to the needs of the group, but should include independent living skills such as building confidence and decision making, coping skills, literacy support, cooking skills and life skills such as budgeting and filling out application forms

- more programmes to support former homeless people such as hostel dwellers reintegrate into the community and develop similar independent living skills in order to help sustain a tenancy; lessons from Glasgow's hostel closure programme will be useful in developing this practical knowledge base of resources and practical support

- more suitable housing and a better housing supply; the Scottish Executive needs to provide more resources and give authority to councils to allow this happen.

Revision of Standards and guidance

One Group supported the updating of the Standards and associated guidance in light of the creation of CHPs and changes within local government. More pressure on Boards to enforce progress on this agenda would be welcomed.

It was suggested that it would be good to do a review of JHIP and CHP guidance soon, but it was noted that there is only one person working, one half–day per week, on this topic in the Scottish Executive

Revision of reporting system

All welcomed better central evaluation of progress but many felt that the annual self-assessment process was not an accurate or adequate mechanism to do this. Some participants felt that the methodology for measuring relative performance between boards is not adequate. There was agreement that honest feedback is essential in the surveys although it is currently hard to discover if this is equally provided across the returns.

A common difficulty described by participants was the need to answer either ‘yes’ or ‘no’ to the questions within the annual self-assessment. Given the diversity of the homeless population within any Board area and the varying degrees of success in reaching all of a Board’s homeless population at any time, an option such as ‘work in progress’ would be welcomed by Boards. One group felt this might facilitate more accurate reporting. It would allow some recognition of the work underway, but would also highlight that full compliance had yet to be reached. Some boards and CHPs find it difficult to show how they have progressed over the year.

Another group called for reporting mechanisms which allow more space for narrative to capture details and the reasons for lower performance.

Compliance checking was also thought important as a means to follow up self assessment reports. Some basic changes could be made immediately to assist this, such as requiring the self-assessment report to be signed off by all key agencies within the board area, including the local authorities, the CPP and the CHPs.

4. Summing up

4.1 Key points from workshops

Kay Barton, Head of Health Improvement at the Scottish Executive, invited each workshop to report the four key points that it had identified for action.

These identified some common themes:

Partnership working

- Partnerships must be supported and encouraged
- Sectors must keep talking to each other and co-ordinate their activities.
- Engagement with other partners (e.g. local authority partners) is a key challenge, and provision of guidance for this and identification of key strategic priorities for these partners is essential. Partners will not engage if they don't see it as a priority for them to do so.

Training

- Frontline staff from different agencies should all receive training together, so that they appreciate each other's roles and the issues they have to deal with.
- Learning about and experience of service delivery to homeless groups should be part of pre- and post- registration training for all health and social care staff.

Networking

- Networking is important. Rural and urban areas are very different but can learn from each other.
- A forum to share good practice and advice is needed.

Communications with Executive

- Greater clarity is needed in the guidance on the Standards.
- Returns to surveys should allow more detailed answers – 'maybe', not just 'yes' or 'no'.
- There should be a designated person or team in the Scottish Executive who can be contacted to deal with problems.
- Best practice should be shared at national level, possibly through a national guide.

.Evidence
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- Things are being progressed but we can't provide the evidence of this.

- The IT infrastructure to promote single shared assessments for this client group needs support. This development is required for services as a whole, and not necessarily as an exclusive requirement of the homelessness agenda.

- There should be more recognition of the work that people working in the field of health and homelessness have done and positive feedback given.

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Mainstreaming
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- Homelessness should be considered within a broader agenda of meeting people's multiple and complex needs, which go beyond health. Guidance should be given to wider strategic groups such as community safety partnerships

- Sustained investment is needed, not funding from different sources with different timescales.

4.2 Final contributions

Kay Barton argued that dealing with health and homelessness was related to influencing many mainstream services, not just the familiar ones closely related to health improvement. The Scottish Executive wished to redesign primary care services through initiatives such as the Keep Well programme. Ministers were very committed to reducing inequalities in health, knew about the multiplicity of factors that affect individuals and create inequalities, and understood that joint working is needed.

She welcomed SCSH's offer to support a health and homelessness lead officers' network. Robert Aldridge suggested that health and homelessness leads needed some space to talk to each other but perhaps they could meet annually with other homelessness networks. He emphasised that a proposed health and homelessness forum would be open to people from all relevant organisations.

Martin Moffat, Head of Primary Care Development and Performance at the Scottish Executive, thanked everyone for their attendance. It had been a very useful exercise. There was a case for evaluating and reviewing the Standards, but the timing must be right. They had only been in place for two years, and some areas were less far ahead than others. The forthcoming feedback reports should help to inform this.

4.3 Summary of main points

The common themes from the day that Kay Barton identified were:

- the need for integration between homelessness and other inequality and diversity agendas and training and education
- the need for networking and co-ordination within the sector
- a possible review of the standards and associated guidance, in the light of an overall assessment of the stage that homelessness policy has reached
- the need for the Scottish Executive and Health Scotland to clarify their roles
- the overlap between homelessness and other inequalities policies.

This report records many different experiences and points about future needs were discussed in the course of the day. These are some of the recurring ones:

- The Standards have had a positive effect and there is overall progress in this field
- Partnership working is crucial
- The range of people involved needs to be widened. DAATs were mentioned several times, but also many other agencies
- Specialist services have developed further than has our ability to change the way in which mainstream services respond to people
- Skills and attitudes need to be changed, especially at the 'front line'
- Rural and urban areas face different issues but can learn from each other.

The support and development needs identified included:

- opportunities for learning and changing attitudes
- opportunities for networking, at all levels from local to national
- promotion and dissemination of good practice
- strengthening the role of Community Health Partnerships

- better systems for assessing, recording and sharing information about people's homelessness status

- more flexible systems for reporting progress on the standards, with compliance checking

- exploring options for integrating health and homelessness work into work with all people with multiple and complex needs, but proceeding with caution, not going back to believing that 'we treat everyone equally' is good enough

- improving approaches to prevention; putting resources into housing.

Appendix 1 Seminar Programme

Interactive Learning and Support Seminar on Health & Homelessness

Programme

10:00 – 10:30	Registration and refreshments
10:30 – 10:35	Welcome and introduction – Emma Witney, Head of Healthy Settings Team, NHS Health Scotland
10:35 – 10:50	Embedding the Standards - Paul Gray, Director of Primary Care & Community Care, Scottish Executive
10:50 – 11:05	Partnership working to prevent and alleviate homelessness – Robert Aldridge, Director, Scottish Council for Single Homeless
11:05 – 11:25	Question & answer session
11:25 – 11.30	Workshop introduction and move into groups
11.30 – 12:30	Workshop discussion: Working together to effectively implement the Health and Homelessness Standards
12:30 – 13:00	Networking and support needs of local strategists and planners. What needs to happen next? - Kay Barton, Head of Health Improvement, Scottish Executive
13:00 – 14:00	Closing remarks and lunch

Appendix 2 Summary of the Health and Homelessness Standards

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

Objective:
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.

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

Objective:
To demonstrate that NHS Boards are working with, and learning from, those agencies that also have important roles in the lives of homeless people.

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

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

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

Objective:
To break down the barriers which prevent homeless people from having their health needs met. Barriers may be structural, policy based or attitudinal.

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

Objective:
To assist NHS Boards to understand the ways in which services can operate with the greatest positive impact on the health of homeless people.

Standard 6:
The board is effectively implementing the Health & Homelessness Action Plan.

Objective:
To formulise the ongoing use of the Health and Homelessness Action Plan as the main planning tool for local health and homelessness activity.