# Questions for health and social care stakeholder group meeting

**Opening questions**

- **What is your experience of working with people at risk of homelessness or with unstable / insecure housing? How would you identify when people have unstable housing or are at risk of homelessness?**

  Since our founding in 1599, we have always had a commitment to provide medical services for those unable to afford medical care. We currently provide financial support to the Glasgow Winter Night Shelter through our HOPE Foundation, and have also recently supported Social Bite.

- **What is your experience of working with homelessness and housing services/or experience of how different parts of the health service interact with homelessness and housing services?**

  We provide Education and Assessment for Doctors in training and support throughout their careers. This includes discussing access to health services and issues for various patient groups, including those who are homeless, have a mental illness, are using illegal drugs or are ex-offenders

- **Do you recognise the picture presented by the statistics in the briefing on the number of people with homelessness experience using your services, and the cost implications of this?**

  Yes.

**Engagement of people at risk of homelessness with H&SC services**

- **Which health and social care services are most likely to have contact with people who have unstable housing? What are the flags that health and social care services will see when someone is at risk of homelessness?**

  Engagement with those who have unstable housing or who are homeless presents challenges as they tend to be the most difficult to contact and be in continued contact. This group tends not to have a stable address, they may not be registered with a GP, and they may not have telephone or internet access.

  This group tends to access emergency or urgent care services as their first point of contact. This would include primary care services, walk-in clinics (including Accident and Emergency departments, and the 111 or 999 services if they have access to a phone.

  Individuals at risk of homelessness may have a higher prevalence of long-term health issues, including diabetes, mental illness and drug dependency.

- **In your experience, what do health and social care services already do to prevent homelessness? Examples of good practice or learning?**

  While not specifically targeted towards preventing homelessness, we feel that the Navigator programme developed by the Violence Reduction Unit in association with Medics Against Violence would be a good model to examine.

The Navigator service, which currently runs from hospitals in Glasgow, Kilmarnock and Dundee, encourages patients involved in violence to make the positive changes needed to improve their lives.

Navigator staff connect vulnerable patients with support services that can help address their needs including addiction, mental health problems and all forms of violence, including domestic abuse.

Working with the A&E teams the Navigators also support clinical staff to diffuse challenging situations, enabling the best care for patients.

The service has helped almost 2,000 people to date in other areas of Scotland since its inception in 2015.

- **What (other) practical steps could different parts of the health service take to help prevent homelessness for people they're working with and whether they're aware of any examples of good practice?**

While it is possible to refer people for long term follow up, the transient nature of visits to health services by this group means members can be difficult to contact if they do not attend. We would welcome work to provide this group with greater access to communications to help support effective healthcare.

*Identifying people at risk of homelessness*

- **In your experience do you/ people working in health and social care services know where to signpost people or who to contact for advice if they identify that a patient is homeless or in an unstable/ insecure housing situation?**

We believe that most acute services are well aware of the services available, but that more could be done to practically sign post individuals who are homeless or at risk of homelessness. The Navigator model demonstrates that where additional support is provided to deliver practical support in addition to signposting, positive results are possible.

- **What questions (if any) are patients asked when they come into hospital or register with a GP about their housing situation? Is this consistent across different parts of the health service? Would a standardised way of recording housing status help to track outcomes for people who are experiencing or at risk of homelessness?**

Health Services are busy places, and so it is not always possible to ask a range of contextual questions of those who present for treatment. We believe that implementing a standard method of recording contextual information may be helpful, but training and support should be provided to ensure that health service staff are able to deliver this additional work effectively.

- **What assessment is done of people's housing situation as part of a social care assessment?**

- **What are the triggers for accessing social care services? Are there particular barriers that people at risk of homelessness might face? How could these be addressed so that people access support before they lose their housing?**

- **Who are the key parts of health and social care services with a role in identifying and assisting people at risk of homelessness?**

*Working with housing and homelessness services*

- **Is there anything more that homelessness or housing services could do to help you in delivering your services?**

  *Housing First*

- **What is the experience of working between Housing First and health and social care services? What can we learn and what could be strengthened?**

**Leaving health and social care services into homelessness**

- **What do you think is needed to make sure people go into suitable housing when being discharged from hospital or institutional care?**

  We believe that establishing a presence in the Hospital and primary care setting would be helpful to this transition, as would the adoption of an expanded "Navigator" model.

**Health and social care strategic frameworks**

- **What is the best way to make strategic connections between health, social care and housing / homelessness services? Are there shared outcomes for health, social care and homelessness services? Are there barriers of language or culture that we need to address?**

  We believe that these sectors should agree a joint strategic and funded approach to address this issue.

- **Are the key services all within the H&SC partnerships or are some beyond that? What about GPs?**

  Primary care must be part of the partnership. These patients often lack continuity of care, which can often be a factor in reduced health outcomes.

- **What frameworks do health and social care services currently work to? Is there anything that already relates to housing / homelessness in those?**

- **What are the inspections and audit frameworks or processes, complaints processes for health and social care services? Could these have relevance for what we are trying to achieve?**

- **What role could services commissioned by health and social care partnerships play in preventing homelessness? E.g. Community connectors in GP surgeries. How are third sector services commissioned by health and social care?**

**Legal duties**

- **We've been asked to consider legal duties on a range of public bodies. What do you think would be most useful? What would be needed so that services could implement any new requirements effectively?**

  Legal duties cannot be enforced without proper funding

- **How could a generic "duty to prevent homelessness" be made meaningful?**

While this would be a highly commendable aim, it would require a level of commitment and engagement to the wider contextual issues relating to health that is currently not present in the system.

- **How could we connect any requirements to existing responsibilities or frameworks?**

- **Would a duty on health and social care bodies to refer to the local authority where there is reason to believe there is a risk of homelessness have value in a Scottish context?**

- **One proposal is for a requirement to assess healthcare needs and provide support where it is identified that someone is at risk of homelessness.  This would mirror a duty on local authorities to assess and provide housing support.  How might this work? Should it also cover social care needs? What would be needed to make such a duty workable in practice?**

  Such a scheme could only be successful if dedicated services were developed and funded.

- **Is there anything else we need to consider?**