	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. The recommendations in this guideline were largely developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication. See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	[**Faculty for Homeless and Inclusion Health and Pathway Charity – joint submission by both stakeholders**]

Integrated health and social care for people experiencing homelessness

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments Wednesday, 03 November 2021 at 5pm Email: HomelessnessIHC@nice.org.uk

Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	[None]
Name of commentator person completing form:	[Dr Nigel Hewett Secretary to the Faculty for Homeless and Inclusion Health and Medical Director Pathway Charity]
Type	[office use only]

Comment number	Document [guideline, evidence review A, B, C etc., methods or other (please specify which)]	Page number Or **'general'** for comments on whole document	Line number Or **'general'** for comments on whole document	Comments Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
				Overall comment -we welcome this guidance and commend the committee for the thorough consideration of the available evidence.
1	Guideline	General	General	While we understand and accept the constraints that have led to this guidance focussing on adults, we are also painfully aware that half of those in temporary accommodation in England are children, and children brought up in poverty are more likely to become homeless adults. Could this guidance include a recommendation that future guidance for children and families experiencing homelessness should be a priority?
2	Guideline	General	General	The guidance refers to health and "social care staff". It would be helpful to clarify that "social care staff" in this context includes hostel, housing support and voluntary sector workers (who may also be peers) who are commonly pivotal in outreach, in reach and advocacy services promoted by this guidance, and often are essential to providing the necessary trusting relationships. Currently such workers often have the role of "next of kin" but may be excluded from multidisciplinary meetings because their role is not recognised.
3	Guideline	3	8	Definitions are always a challenge in this area, but this list appears to exclude people fleeing violence - domestic or

				gang related, those in transition such as leaving prison or being discharged from hospital, and those at risk of homelessness due to legal precarity. A possible solution is to add this sentence – "in summary, people aged 16 and over who are likely to be considered "homeless or threatened with homelessness" as defined in Section 175 of the Homelessness Reduction Act 2017"
4	Guideline	6	4	Review C has multiple examples of the benefits of outreach services. It would be helpful to reflect this in the guidance. This sentence could be improved as follows- "Recognise that more effort, targeted ***and outreach*** approaches are often needed…."
5	Guideline	6	19	The general principles are important for framing the understanding and application of the rest of the guidance. A key component of entrenched homelessness is multi-morbidity, with roots in poverty, deprivation, and trauma. For this reason, most inclusion health clinicians recognise the importance of contributing to addressing the social determinants of health through their practice. This could be recognised by adding the following general principle – "Recognise the importance of addressing the social determinants of health and multi-morbidity through poverty informed care (such as advocacy, support and referral for benefits and housing advice), multi-disciplinary working and cultural competence, while always considering safeguarding and Mental Capacity assessment."
6	Guideline	8	6	Some people experiencing homelessness have literacy problems and are digitally excluded. Under communication methods it is therefore important to also include "face to face/in person."
7	Guideline	12	10	Palliative and end of life care (EOLC) requires a specific assessment, and should be included in this sentence, after "…alcohol and drug recovery needs, ***palliative and end of life care***,". This is supported by accepted evidence (Shulman 2018) which shows that palliative and EOLC planning for homeless people is often lacking and often leads to sub-optimal EOLC.
8	Guideline	12	24	Suggest add "referral for legal advice" to the practical needs line, many homeless people need professional legal advice to support rights to housing or immigration status in order to protect their health.
9	Guideline	13	16 & 23	We would suggest "homelessness **health** leads" to differentiate this role from a housing specific post.
10	Guideline	15	15	This guidance highlights elsewhere the importance of trauma informed, and psychologically informed services. Would the committee consider adding "trauma informed services" as a very useful universal approach which will help remove a barrier to access? Report of a training pilot here.
11	Guideline	16	20	In our experience, as well as care packages, young frail homeless people with significant care needs also have difficulty accessing residential care. This sentence could be improved as follows – "…social care support get long-term care packages, ***or care home placement***, irrespective of their age."
12	Guideline	18	4	It is important to be clear when we are talking about Capacity under the Mental Capacity Act, rather than "capacity" which may mean capability or availability. This sentence might be better to state "Mental Capacity".
13	Guideline	19	10	This guidance emphasises the importance of recording housing status. Medical providers can also provide important evidence for access to benefits to prevent further homelessness. The detailed assessment should therefore include a "housing and benefits history" to ensure appropriate advocacy for secondary prevention of homelessness. So – "acute and long-term conditions, ***housing history, access to benefits,*** and social care needs"

14	Guideline	19	10	In our experience there is a danger of re-traumatising vulnerable people by asking them to continually repeat their stories. Suggest add to this bullet point as follows – "while minimising the risk of re-traumatisation, by avoiding unnecessary repetition of a history which is already on record." This is supported by Review A,B, P76, line 51.
15	Guideline	19	12	Suggest add a further bullet point – "if the death of the patient in the next 6 to 12 months would not be unexpected, consider involving the patient in palliative and end of life care planning"
16	Guideline	19	19	In our experience the voice of the hostel worker or housing support worker is often ignored by health staff, and they frequently have important information to share. Suggest add "including housing support or hostel workers".
17	Guideline	19	20	Would the committee consider including a link (https://www.pathwaypartnership.org/what-we-do) to the support available from Pathway Charity to set up homeless multidisciplinary teams in secondary care? This is supported by evidence accepted by the committee (Hewett 2016, Khan 2020) and is part of the NHS long term plan (p42).
18	Guideline	22	15	There are other specific types of accommodation which are worth including here, by adding to this sentence – "including dry / abstinence based services and those with onsite social care."
19	Guideline	23	6	In our opinion the Care Act 2014 has great potential for improving the care of vulnerable homeless people. For this reason we feel that all practitioners should consider the potential benefit of a safeguarding referral, with particular reference to provisions for self-neglect. Please consider if the guidance could be strengthened by this sentence to 1.10.1 – "but all practitioners should have expertise in assessing self neglect in relation to the Care Act 2014."
20	Guideline	24	22	Shulman 2018 makes the important point that not everyone will recover, and a relentless focus on the "recovery journey" may mean that opportunities to address person centred palliative and end of life care are missed. Suggest add this sentence – "Not everyone will recover, if the death of the patient in the next 6 to 12 months would not be unexpected, consider changing the focus of conversations to exploring what living well means to someone and involving the patient in palliative and end of life care planning."
21	Guideline	25	9	In our opinion cultural competence is also important and worth naming – the sentence could be improved as follows – "homelessness as part of equality and diversity training, ***including cultural competence***, the impact of…"
22	Guideline	25	13	In our experience consideration of legal duties can omit Safeguarding duties. Would the committee consider improving the sentence as follows? – "***Safeguarding***, legal duties and powers."
23	Guideline	28	18	This section concerns recovery orientated language. However, Shulman 2018 points out that, as everyone will not recover it is important that there is not a pressure on health and homelessness staff around recovery to the extent that it detracts from person centred conversations. To reflect this we suggest adding the following sentence. "However, it is important to recognise that if recovery is unlikely due to someone's illness, conversations might focus more on exploring what is important to them and what living well means to them."
24	Guideline	30	14	In our experience the "teachable moment" or "light bulb moment" for people with complex needs on the cusp of engaging with change needs a bespoke, rapid and flexible response. This is the basis of "Housing First". We would like to see research into bespoke rapid interventions, such as immediate admission for alcohol rehabilitation for people following an unplanned detox during an acute hospital admission. Would the committee consider this idea?
25	Guideline	39	3	Many clinical record systems do not yet include accurate coding choices for recording housing status. The need for this is included in the PHE homelessness: applying all our health link which follows line 3. Would the committee

				consider adding advice that "accurate recording of homelessness status requires local data systems to support appropriate coding"
26	Guideline	42	25	Local services are limited by the homelessness coding options offered by primary and secondary care clinical computer systems. We suggest adding – "national consensus and implementation of an appropriate range of clinical homelessness codes for any setting would support consistency and local action".
27	Guideline	44	15	Concerning MDT's in hospitals, research accepted by the committee (Hewett 2016, Khan 2020, Cornes 2020) shows that MDTs in hospitals are not just cost effective, but improve outcomes for homeless people. The accepted evidence warrants the following addition to this sentence – "having multidisciplinary homelessness teams in hospitals resulted in some cost savings ***and improved outcomes for people experiencing homelessness"***
28	Guideline	57	22	Concerning hospital MDT's, the Pathway approach is the only nationally adopted approach, highlighted in the NHS Long Term Plan (p42), funded and provided by the NHS, but supported by the Charity. Given that the committee have accepted the evidence (Hewett 2016, Khan 2020, Cornes 2020) for the cost effectiveness and improved outcomes produced by the Pathway approach to Hospital MDT's, it would be helpful to commissioners to provide a link to the support available from Pathway Charity to set up and support such services. https://www.pathwaypartnership.org/what-we-do
29	Guideline	60	9	We have some concern about the suggestion that intermediate care can be provided in hostels, with the implication that this would be a cheaper option. Does the committee have evidence to support this assertion? Our experience is that good quality intermediate care is difficult to provide in a general hostel, with particular challenges around substance use and control of prescribed medication.
30	Guideline	60	24	Would the committee please look again at the accepted evidence (Hewett 2016, Khan 2020, Cornes 2020) supporting the Pathway approach to providing homelessness MDT's in secondary care (including physical health settings and psychiatric care). We believe that this evidence would support including the following sentence and link at page 60 line 24. "The Pathway approach to homelessness MDT's in secondary care has an evidence base suggesting improved outcomes and cost effectiveness"
31	Guideline	69	18	An additional HEE resource that might be worth including is here https://www.hee.nhs.uk/our-work/mental-health/resources scroll down to Inclusion Health Education Mapping and Review.
32	Guideline	69	19	Would the committee also consider including a suggestion of the potential benefits of joining supportive networks such as the Faculty for Homeless and Inclusion Health, LNNM and QNI network?
33	Evidence Review A,B	53	Table 13	Cornes 2020 paper – the analysis of the benefits of clinically led vs housing led MDT's does not include the finding that clinically involved MDT's increased planned care for patients after discharge, compared to housing led MDT's. The Cornes paper found that housing led teams were more cost effective – because clinicians cost more and outcomes were similar. Given the wider findings of the NICE committee about the importance of multidisciplinary working, including clinicians, it is importance to look beyond which service is cheapest and include outcomes like more planned care, to promote clinically involved multidisciplinary care for hospital patients.

Insert extra rows as needed

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Checklist for submitting comments

- Use this comment form and submit it as a **Word document (not a PDF)**.
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **page and line number (not section number)** of the text each comment is about.
- Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each organisation**.
- Do not paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; do not cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
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- Spell out any abbreviations you use
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- **We do not accept comments submitted after the deadline stated for close of consultation.**

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