Draft Homelessness Action Plan 20th June 2016

What are trying to achieve (Outcomes)	What will help us to achieve this outcome (Objectives)	What do we need to do (Actions)	Who will take this forward (Lead)	Timescale
Outcome 1 *A reduction in the inequalities resulting in homelessness*	Actions taken to tackle the wider determinants of health inequalities through strategic and local community planning	1.1 Ensure upstream preventative activity within NLP and SLP Community Plan and Local Outcome Improvement Plans with a focus on addressing poverty in its widest sense and preventing the consequences of poverty, increasing social coherence and inclusion and promoting the place standard approach 1.2 Delivery of the Lanarkshire Health Inequalities plan 1.3 Deliver Positive Destinations programme in North Lanarkshire 1.4 Through DsPH group, influence and direct Scottish Government to ensure the nationally driven recommendations of the ScotPho report Restoring the Public Health Response to Homelessness in Scotland (2015) are delivered	LAPs/LATs Relevant South Community planning fora NL /SL CPP Barnardos Director of Public Health and Health Policy	
Outcome 2 *A coordinated early intervention approach to address the needs of those at risk of, or experiencing,*	Commitment from all partners to address the needs of this client group	2.1 Agreement through North JIB and South IJB and Local Area Partnerships to prioritise homelessness within local action plans with specific outcomes and actions which are monitored over time.		
	Routine inquiry regarding housing and financial security status	2.2 Review health and social care assessments to ensure they include questions on housing provision		

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homelessness in order to mitigate negative impact on health and wellbeing.	Better joint working and connectivity between agencies involved in the care of this client group.	and financial security. Priority areas for review include A&E, midwifery, health visiting, mental health, addictions and social work (care leavers).		
		2.3 In line with above action ensure staff are skilled and confident to raise these issues with patients and to identify signs that patients are at risk of losing accommodation and are aware of resources that can be offered to support clients (e.g. financial inclusion app). 2.4 Where appropriate develop and implement robust referral systems between agencies.	Identify relevant workforce development groups to take this forward	
Outcome 2. *(contd.) A coordinated early intervention approach to address the needs of those at risk of, or experiencing, homelessness in order to mitigate negative impact on health and wellbeing*	Clients in crisis or at transitional points e.g. prison , hospital discharge, care leavers (in line with Care Leavers Covenant) who are identified as at risk of homelessness or experiencing homelessness receive a coordinated multi agency response with a focus on early intervention.	2.5 Agree a process and protocols to identify and support each vulnerable client group within each locality using a lead person/care programme approach, linking with other local developments e.g. discharge hubs, corporate parenting. Test this approach in one locality in the first instance (e.g. Airdrie locality action inquiry group). 2.6 Make better use of systems already in place and synchronise system to improve communications (*see Outcome 6 below)* 2.7 Review mental health and addictions support for this client group to support early intervention including emergency and out of hours response.	Multi agency group leads – housing, acute, primary care, mental health and addictions, third sector Improving Response to Distress Group Third	

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Outcome 2. *(contd.) A coordinated early intervention approach to address the needs of those at risk of, or experiencing, homelessness in order to mitigate negative impact on health and wellbeing*		2.8 Review the high incidence of self harm within younger people and put in place a plan to better identify and support these clients at an earlier stage in order to prevent future homelessness.	Sector/Barnardos/ Health and Homeless team/ IRD Group/ Corporate Parenting	
	Ensure clients moving locality to access temporary accommodation are reviewed to assess impact on families and access to primary care	2.9 New process to be in place from 31st Aug through Named Person Service to ensure that named person is notified of all families with children experiencing homelessness and all families moving across localities and in to North Lanarkshire. 2.10 Improve access to healthcare within partnerships to ensure GP Registration and increased flexibility around access to health services .This approach should take into account the transient nature of homelessness which may impact on delays to treatment	Public health nursing Health and Homeless team TBC	
	Clients are referred to the Health and Homelessness (H&H) service where appropriate	2.11 Review referrals to identify areas of low uptake and appropriateness of referrals. 2.12 H&H team to undertake updates to Housing teams outlining criteria for referral, reissue referral pathway and feedback on quarterly report to local housing teams.	H&H team with support from managers	Regular
	Ability to report outcomes	2.13 Notification of named locality housing officer	Health and	

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Outcome 2. *(contd.) A coordinated early intervention approach to address the needs of those at risk of, or experiencing, homelessness in order to mitigate negative impact on health and wellbeing*	following referrals from H&H service to mainstream services	included in referral letter to mainstream service in order for outcomes/DNA's to be reported back and followed up (consent issues will need to be considered here)	Homelessness team MIDiS reporting	
	Ensure housing staff and support providers are aware of health improvement programmes and services and how to refer clients to these services	2.14 Ensure systems are in place to ensure housing staff and support providers are aware of heath improvement programmes and services 2.15 Ensure staff have the confidence and skills to raise health improvement services and issues appropriately with clients (workforce development). 2.16 Explore whether delivery of screening services may need to be tailored to meet the needs of different client groups	Health Promotion staff Keep Well Workforce development Public health	

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	Services providing care are more responsive and flexible to the needs of people at risk of or experiencing homelessness	2.17 Multi agency training and workforce development on rights based approaches/attitudes and values 2.18 Test the concept of psychologically informed environment with a joint agency team and scale up over time if successful. 2.19 Roll out Housing Options toolkit within Housing teams	Link in to other agenda's e.g. Distress work, EBCD,SEMH group, dual diagnosis working group, co-morbidity working group NL Housing teams	Services providing care are more responsive and flexible to the needs of people experiencing homelessness
	Incorporate the views of those at risk of or experiencing homelessness into service planning in order to ensure services meet needs	2.20 Develop mechanisms for service user consultation across all agencies (NHS, Council, third sector)	North Lanarkshire Service user forums. Relevant south Lanarkshire forums Third sector partners	
Outcome 3 *Clients at risk of or experiencing homelessness who have complex needs*	Development of a multi agency case management model for the most vulnerable clients with complex needs.	3.1 Gap analysis of range of existing groups looking at addressing the needs of vulnerable individuals 3.2 Establish criteria to define vulnerable individuals	Locality action enquiry groups to identify most complex within their locality.	

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are supported through a multi agency person centred approach with a focus on recovery.		3.3 Develop an alert /tagging system *(see Outcome 6 below)* for acute and primary care health services (Trakcare and GPAS) to ensure vulnerable individuals with complex needs are identified and supported as they journey through services. 3.4 Agree pathways and protocols to support alert system which link NHS to housing and support services. 3.5 Put in place a named case worker model and care plan approach with proactive engagement, regular review, distress/crisis management planning and person centred care plans which include housing plans. 3.6 Establish a workforce development plan to support this approach using dialogue groups to identify suitable learning methods and link in to other WFD plans (e.g. ADP).	Multi agency approach. Locality planning groups Improving Response to Distress Group This may require a specific coordinator role initially to embed process	
Outcome 4 ***Children, at risk of or experiencing homeless have their needs met***	Ensure every child experiencing or at risk of homelessness is up to date in their child health surveillance and vaccination status.	4.1 GIRFEC notification process to be replaced with the Named Person service with H&H service notified of all families moving in to Lanarkshire. This will ensure all children's health such as vaccinations, child health surveillance and	Health visiting	

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		wellbeing needs will be met when affected by homelessness.		
	Ensure children experiencing homelessness are supported by parents and services to mitigate the impact on health and wellbeing through a Child's Plan (or wellbeing assessment)	4.2 Agree between partners that homelessness is a significant event 4.3 Identify what issues are raised as part of wellbeing assessment if experiencing homeless and address through Child's Plan 4.4 Identify and address gaps in service provision specifically for age and subsequent pregnancies (FNP, First Steps, substance misuse midwifery services, peri-natal mental health, universal services, third sector services)	Named person service Education School nursing Health visiting Health and Homelessness team	
Outcome 5 *Appropriate and relevant services are available to pregnant women at risk of, or experiencing homelessness, to support wellbeing of mother and unborn child*	Ensure vulnerable pregnant women are identified early and attending midwifery services	5.1 Review retrospective midwifery data to establish routes of referral and where and when women first presented. 5.2 Establish and evaluate pathways (communication and referral) between housing and health to prevent vulnerable women at risk of homelessness booking late 5.3 Review recommendations to remove age criteria for access to support services (e.g. FNP and First Steps) for pregnant women despite how many pregnancies they have had.	Substance misuse specialist midwife service Community Pharmacy FNP Family Planning Maternity services Peri-natal mental health services	

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		5.4 Review what information is captured at booking regarding housing and risk of homelessness (see outcome 2 above) 5.5 Scope out transferability of the substance misuse midwife model 5.6 Develop/review referral pathway to peri-natal mental health service 5.7 Promote access to family planning services to prevent unplanned pregnancies. 5.8 Ensure all pregnant women in this client group have access to holistic therapies to combat stress within pregnancy in line with epigenetic research evidence (this will require additional funding)	Housing, Health and Homelessness service, Addictions, Mental health	
Outcome 6 *Agencies supporting homeless people and families have improved data sharing processes such as tagging of records to help facilitate a more*	Scope out opportunities available within existing and planned electronic systems under the HSCP	6.1 Introduce Emergency Department alerts on Trakcare for this client group 6.2 Use of Electronic Key Information Service(EKIS) which is a shared system between a number of health services such as GP, mental health services, ED and out of hours. 6.3 Explore use of model similar to the Electronic	IT / e Health Murdoch Wilson (evidence based co-design work)	

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proactive integrated approach to service delivery.		Alert System for Child Protection		
	Introduce tagging of MiDiS records and regularly review outcomes (to be agreed) for this client group from MIDiS reports	6.4 Integrated locality planning teams to review and agree combined health, housing and support outcomes actions with clients as part of joint care planning	Working group Locality planning groups	Extract data from MIDiS
Outcome 7 *Evidence of improvement over time against agreed outcomes*	Improved ability to share information between agencies Use data to develop a better understanding of the health needs of this population Agreed set of patient focused and service related performance measures which include suitable and sustainable housing and support and monitor these over time	7.1 Review national data sharing agreement and develop information sharing protocol on data needed linked to key outcomes 7.2 Examine ways data can be accessed on the health needs of the whole family rather than just lead HL1 applicant 7.3 Identify common demographics and health issues experienced by children in this cohort (e.g. hospital data on neonatal substance and alcohol misuse and low birth weight) and at different ages in order to inform service provision 7.4 Incorporate relevant indicators in to the HSCP JSNA dataset including financial costs of services used by the client group	Data sharing group and ISD	