Integrated health and social care for people experiencing homelessness
Consultation on draft guideline - Stakeholder comments table
06 October 2021 – 03 November 2021

Stakeholder	Document	Page No	Line No	Comments	Developer's response
Action on Smoking and Health (ASH)	Guideline	General	General	ASH welcomes this positive guidance however there are opportunities to improve the quality of support offered to people experiencing homelessness through this guidance by making the importance of addressing smoking more prominent throughout. People experiencing homelessness are significantly more likely to smoke than adults in the general population and are likely to be more heavily addicted that other smokers. In 2014, around 77% of people experiencing homelessness smoked compared to 17% in the general population. A 2016 report found that many people experiencing homelessness smoked more than 20 cigarettes per day compared to an average of 11 cigarettes per day in the general population (6). The consequences of this are clear, with people experiencing homelessness having a 3 times higher chance of dying from chronic lower respiratory diseases, which are primarily caused by smoking, and dying on average 32 years younger than an adult in the general population.(7, 8) There is not only a clear need to provide smoking cessation and harm reduction support to people experiencing homelessness, but also a need to improve the implementation of and access to existing support. According to research by Groundswell, 50% of people who smoke and are	Thank you for your comment. The committee agreed to address smoking in the guideline by including it in the recommendation on how outreach can be used to promote health and providing preventative health opportunities such as smoking cessation. Otherwise, they argue that smoking is covered implicitly by various recommendations about assessing and responding to the health and social care needs that people experiencing homelessness may have.

				experiencing homelessness want to quit and 65% have made a quit attempt. However, significant barriers stand in the way of success – results from the same Groundswell survey show respondents reporting having poor access to information about quitting support and 66% reporting having received no advice to quit in the 12 months prior to survey.2 Recommendations: 1. Make more explicit reference to addressing smoking throughout the guidance – for example, tobacco dependency treatment and stop smoking services/advisers could be mentioned in sections 1.3.2 and 1.3.3, respectively, but are not. Similarly, in section 1.5.14, tobacco dependency could be cited alongside other factors that outreach services could offer support for rather than relying on this to be picked up, if at all, through 'primary health care needs'. 2. Include a recommendation to train staff to varying appropriate levels to deliver support for smoking cessation – without a push to train staff, people experiencing homelessness may not be referred to appropriate stop smoking services or receive appropriate stop smoking support. This should include some staff being fully trained to deliver stop smoking support and adapt it as necessary to clients and others being able to deliver Very Brief Advice on smoking cessation and refer clients onto more intensive support. Failing to make greater reference to smoking and stop cessation support throughout the guidelines	

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				and relying on the discretion of individuals risks this vital issue being paid insufficient attention in the planning, commissioning and delivery of multidisciplinary integrated care for people experiencing homelessness.	
Centre for Homelessness Impact	Guideline	3	10	This is only one type of temporary accommodation. Suggest replacing by 'are temporary residents of hostel, B&B, nightly-paid, privately managed accommodation and other types of temporary accommodation'	Thank you for your comment. The committee believe that the different types of temporary accommodation you list are covered by the definition of the population. Different types of temporary accommodation are listed in the definition and B&Bs are specifically mentioned in the next bullet.
Centre for Homelessness Impact	Guideline	6	18	Also reflect that people experiencing homelessness may face stigma / conscious and unconscious biases that affect how they receive services	Thank you for your comment. The committee agree with you that people experiencing homelessness may face stigma and bias in health and social care and attempts to mitigate this are evident throughout the recommendations, for example in the recommendation about promoting engagement by providing services that are person-centred, empathetic, and address health inequalities, are inclusive and respond to people's diverse needs.
Centre for Homelessness Impact	Guideline	7	10	This recommendation currently reads 'Be aware that people experiencing homelessness may find it difficult to look after themselves'. We would recommend that this is replaced by 'Be aware that *some* people…'. This is important to reflect that not all people experiencing homelessness have high support needs	Thank you for your comment, the suggested change has now been made.

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Centre for Homelessness Impact	Guideline	7	10 - 14	Consider rephrasing. Services are difficult to engage with, rather than people being hard to reach or disengaged	Thank you for your comment, the recommendation wording has been revised as suggested.
Centre for Homelessness Impact	Guideline	8	3	Staff should be non-judgemental. This point could be stronger and provide some guidance around the type of training that could be put in place to support this.	Thank you for your comment. The committee think that this recommendation and the recommendation on training for staff covers this. For example, the guideline recommends that health and social care staff could get training on • understanding the health and social care needs of people experiencing homelessness, and their rights to access services • homelessness as part of equality and diversity training, including the responsiveness to the impact of discrimination and stigma and of intersectional, overlapping identities • psychologically informed environments and trauma-informed care. These all should play a role in staff being non-judgmental towards people experiencing homelessness.
Centre for Homelessness Impact	Guideline	9	14	Feels a bit general and given the needs change all the time consider recommending these take place every two years	Thank you for your comment. No evidence was located about how frequent local homelessness health and social care needs assessment should be and the committee therefore could not recommend specific frequency. However, they have added that local authorities should ensure that local homelessness health and social care needs assessments are up to date and relevant, to reflect any changes in e.g. population or policies.

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Centre for Homelessness Impact	Guideline	10	20	'Commissioners should define and measure outcomes related to homelessness …' This could go a step further and ask them to define what ending homelessness should look like in their area and track progress over time.	Thank you for your suggestion. Although the committee are sympathetic to your point, they were unable to make this change because it is beyond the scope of this guideline to make recommendations related to the prevention of homelessness.
Centre for Homelessness Impact	Guideline	19	1	It feels important to recognise that services have a responsibility not to re-traumatise people, and that this should be a key consideration when doing needs' assessments	Thank you for your comment. The committee agree and have revised the recommendation in the section you are referring to specifically say that unnecessary and potentially distressing repetition of a history which is already on record should be avoided. This was already discussed in the rationale and impact section.
Centre for Homelessness Impact	Guideline	21	18	When patients are discharged from hospital to a place of safety, the discharging officer must require the patient to prove a substantial connection with the local area. For people experiencing homeless, in many cases these patients are not able to access services (such as discharge to a hostel or temporary accommodation) because they cannot meet the requirement to prove a substantial connection with the health authority area funding the services eg they cannot, by definition, produce bank statements or utility bills etc which are the normal types of evidence required. Some anecdotal evidence suggested that this can delay discharge for several days. Should the guideline consider whether this is really a necessary requirement in such circumstances? Should it not apply to people experiencing homelessness?	Thank you for your comment. The committee think that with a working knowledge of the relevant legislation a health or social care practitioner would be clear that a housing authority should not be demanding such proof when making arrangements for interim accommodation to avoid discharge on to the streets. As far as they are concerned, Section 10 of the Code of Guidance (2018), which is about assessing local connection, should be considered on a case by case basis and does not supersede the duty to assess a person's needs before questions over their local connections, especially so in the context of domestic abuse and other threats to violence.

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Centre for Homelessness Impact	Guideline Evidence review	64 38	9 - 11 37 - 42	There are some references suggesting that Housing First 'increased suicide ideation' and a 'possible increase in suicide attempts'. These references are based on Aquin et al 2017 and Tinland et al 2021. However, upon further exploration of these papers, we consider these statements need to be softened. Tinland et al show a higher proportion of people deceased in the HF arm vs TAU, but the quality of this study is deemed as 'Very Low' due to 'very serious' risk of bias (page 434 in the Evidence Review documentation). This should be reflected in the strength of the claim made. In the case of Aquin et al, the guidelines and the evidence review suggest that HF would increase suicide ideation. This could be misleading because while the proportion of people reporting suicide ideation in the HF group is higher than in TAU at 2 years, this is not the case for other time points. More importantly, the figure at each time point is lower than at the baseline so a more appropriate description would be that suicide ideation is reduced more slowly in the HF arm than in TAU.	Thank you for your comment, in response to which analysis of the two papers in question has been revisited, and discussed with the guideline committee. The guideline technical team agree that the quality of the evidence on mortality outcome data from Tinland 2019 should be explicitly mentioned and have added it to the discussion section in review A/B, where appropriate. It should also be noted that since the consultation, previously missed mortality data from Somers 2017 (part of the Canadian Housing First trial) has been added to the meta-analysis for the outcome on mortality. Although the effect estimate of pooled data is lower than for Tinland alone, the result is statistically significant and clinically important, according to the methodology agreed a priori for this review. However, the limitations of this result are acknowledged in the report, Analysis on 'suicidal ideation' showed a clinically important effect at 24 months, and no other time point as stated in the evidence review. Analysis for the guideline of the data from Aquin 2017 considered the baseline data provided by the authors in order to assess bias in the randomisation process, as it is not typical to use this data to calculate the relative risk. Upon further investigation of the outcome data on 'suicidal ideation' from Aquin 2017, discrepancies were noted in the reporting of

					people randomised to each arm (i.e. the denominator) and the percentage values reported in table 2, which might explain the difference in conclusions between the analysis for the guideline and the analysis by the study authors. The presented analysis in evidence review A/B follows Cochrane's preferred methodology of using the intention to treat principle, which shows the results as clinically important at 24 months only but not at earlier timepoints. However, the guideline technical team and the committee recognise the limitations of this approach as well, as it assumed all people without outcome measurement would not have the outcome. It is important to note that although the committee noted the results from the analysis of outcome data on mortality and suicidal ideation, this was not a finding that informed recommendations and therefore this text has been removed from the guideline rationale section. The findings did however prompt an interesting discussion around the strong feelings of isolation, loneliness and stress that can be experienced after a move to independent accommodation. In the committee's experience this can be an isolating step for someone recently experiencing homelessness and the evidence highlighted the crucial importance of providing emotional and practical support throughout and following the move. Committee members with lived experience of homelessness corroborated this and agreed that emotional and

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					practical support are crucial in these circumstances
Centrepoint – National Youth Homelessness Charity	Guideline	6	14 - 18	It is critical that services adopt a Psychologically Informed Environment or Trauma informed approach, not just 'consider' it given the high levels of past trauma in this population and the growing evidence base for these approaches with homeless individuals. The word 'consider' is not sufficient in our opinion.	Thank you for your comment. The word 'consider' is used in the context of NICE guidance to denote a weaker recommendation made because the committee lack the robust evidence on which to make it any stronger or more certain. Please note however that the fact the committee did not review convincing evidence about PIE led them to make a recommendation for future research on precisely that topic.
Centrepoint – National Youth Homelessness Charity	Guideline	6	19 - 21	What do you mean by 'professional expertise' here? Many of our staff in the charity do not have 'professional qualifications' such as social work or nursing qualifications but have significant skills and experience of working with homeless young people, particularly in terms of engagement and building trusting relationships over time.	Thank you for your comment. This has now been removed from the recommendation.

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Centrepoint – National Youth Homelessness Charity	Guideline	7	10 - 14	Does this point refer to more assertive outreach approaches, which have been found to be helpful with this population? If not, why not? The language of 're-engagement' in this point doesn't really recommend an approach and suggests that engagement is 'all or nothing' rather than transitional (as it can often be). This population may also struggle to engage because of past negative experiences of statutory services, not just because of 'circumstances'.	Thank you for your comment. The wording in this recommendation has been revised and it no longer refer to "circumstances". This recommendation is in the section on General principles and the more specific approaches are covered elsewhere in the guideline. Re-engagement may be through assertive outreach (covered in the section Outreach services) or it could be through other means of lowering barriers for access and engagement (covered in for example section on Supporting access to and engagement with services).
Centrepoint – National Youth Homelessness Charity	Guideline	9	5 - 9	On the commissioning of services for this population, partnerships with other agencies (e.g. voluntary or charity) sector should also be considered – many like Centrepoint are already providing these services 'in-house' because our population are unable to access statutory services due to waiting lists or not meeting thresholds for services. It would be helpful to have access thresholds set differently to traditional health or social care services (e.g. intervening earlier when problems are not so severe rather than waiting until the homeless person is in crises). Other issues that need to be considered in commissioning are around location of services, type of staffing, flexibility of appointments etc.).	Thank you for your comment. Involving voluntary and charity sector providers to inform planning and designing of services is recommended in the guideline and the committee agree this is important. The guideline also recommends various ways to improve access and engagement to services, such as avoiding restrictive eligibility criteria, lowering practitioners' caseloads (which impacts staffing) and flexible appointments.

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Centrepoint – National Youth Homelessness Charity	Guideline	10	20	With regard to defining and measuring outcomes – this point could be expanded to highlight that a wider range of outcomes (both 'hard' measures such as attendance and 'soft' measures such as self-reported symptom change) are valuable with this population and that change can take 'longer' than with a non-homeless population, due to complexity of needs that involve not just the health issues, but also social issues (e.g. housing, employment), which can impact on both physical and mental health.	Thank you for your comment. The committee did not think this should be specified in the recommendation but it would be expected that the outcomes measures would be meaningful i.e. include outcomes relevant and meaningful to the people experiencing homelessness.
Centrepoint – National Youth Homelessness Charity	Guideline	10	28 - 29	Can you also include 'offenders' or those leaving custody in this list of vulnerable groups as a failure to source appropriate housing and link this group into appropriate statutory services on release, can contribute to homelessness, relapse of reoffending and health issues. Another vulnerable group is those with disabilities (e.g. learning disabilities / Neurodiversity such as Attention Deficit & Hyperactivity Disorder / Autism Spectrum Disorders), who are often over-represented in our homeless young people and are unable to access assessments, treatments or suitable housing placements.	Thank you for your comment. The committee agreed to include 'disabled people' in to the list of examples based on your and other stakeholders' comments. These are indeed just examples and is not aiming to be an exhaustive list. Although the committee recognise that people leaving prison are at an increased risk of homelessness, people staying in institutions in the long-term (which would include people in prisons) are not covered in this guideline. This is stated in the scope of the guideline published in December 2020, available on the guideline's website. However, people who have recently left prison and are now homelessness are within the scope of the guideline, however, the committee agreed not to specify them in this list.

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Centrepoint – National Youth Homelessness Charity	Guideline	11	16 - 18	Again, the word 'consider' on the point about case-loads could be stronger. This population is often complex and the lack of recognition of this means that the expectation on case load sizes can be unrealistic leading to poor care because workers have a lack of time to form positive working relationships and provide the level of flexible support required. Being clear in the guidance will ensure the right level of staffing can be commissioned.	Thank you for your comment. 'Consider' reflects the strength of the supporting evidence. Unfortunately, even though the committee agreed that smaller caseloads and longer contact time are essential to facilitate trusting relationships, improve engagement with health and social care etc., there was no supporting effectiveness evidence. Also, the supporting economic evidence was only exploratory, based on many assumptions, and showed that reducing caseloads may potentially be a cost-effective approach. As a result, the committee could not make a stronger recommendation on this.
Centrepoint – National Youth Homelessness Charity	Guideline	14	22	Peer supporters should also have access to reflective practice sessions, as 'regular' staff are noted to be advised to do so on Page 13, Line 7-8.	Thank you for your comment, reflective practice has been added as an example in this recommendation.
Centrepoint – National Youth Homelessness Charity	Guideline	16	2 - 7	Where it is noted that this population may fail to attend an appointment, it may not just be about considering peer supporters or advocates to help them attend, but also that 'outreach' offers to go to the person, or the location of the service is considered. For example, in Centrepoint, centralising our health delivery hubs to where the homeless young people are already (e.g. in the centre of town, within residential services) have enabled attendance to sessions to increase as it is 'easier' to attend. The use of remote technology (e.g. phone, video calling) has also increased contacts rather than expecting an individual to travel to a face to face appointment, which also reflects the shift in the delivery of other services post COVID-19.	Thank you for your comment. The committee think this is already covered by the recommendations. The guideline recommends different approaches including outreach services to for example the street, day centres and hostels, drop-in services and 'one-stop shops' for multiple services as well as providing incentives or enablers to lower barriers such as digital connectivity, travel support and vouchers.

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Centrepoint – National Youth Homelessness Charity	Guideline	16	15 - 18	Can the guideline also reference learning disabilities here, as often those with a dual diagnosis of a mental health disorder and a learning disability face the same exclusions from the respective services as those with a dual diagnosis of mental health and substance use.	Thank you for your comment. The recommendation has been reworded to capture that people experiencing homelessness can have multiple other coexisting needs and kept coexisting mental health issues and problem substance use as an example only.
Centrepoint – National Youth Homelessness Charity	Guideline	18	6 - 7	Again the word 'consider' here to be 'ensure' as MDT working is critical with this group whether in an outreach or standard team.	Thank you for your comment. The recommendations have been revised so that the multidisciplinary nature of outreach is strengthened by referring to " multidisciplinary outreach" in the first recommendation in this section.
Centrepoint – National Youth Homelessness Charity	Guideline	18	20 - 21	Can 'consider' be 'offer'. All those experiencing homelessness and are currently disengaging will need this approach. There is evidence form the Psychologically Informed Environment (PIE) approach that 'engagement' work is critical and is ongoing with this population. It is often helpful to make initial support 'tangible' (i.e. helping them access benefits or housing) before emotional (i.e. addressing mental health symptoms).	Thank you for your comment. The committee agrees that assertive outreach might be useful for anyone who finds it difficult to engage with services, however, no evidence was identified on the effectiveness of assertive outreach so the committee were unable to make a stronger recommendation about this.

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Centrepoint – National Youth Homelessness Charity	Guideline	19	10	Social care needs can include 'housing' needs. This could more explicit in the guidance, given the impact of homelessness upon physical and mental health.	Thank you for your comment. The focus of this section is on assessing the health and social care needs of the person. However, the committee recognise that the person's housing situation plays a role in this and have revised the recommendation with a consideration to the individual's housing situation. There are also recommendations on a comprehensive and holistic assessment and made some further additions to reflect that to fully integrate with other services, including housing, health and social care services, may need input from other services or vice versa. There is also a whole section on housing in relation to health and social care support.
Centrepoint – National Youth Homelessness Charity	Guideline	21	19 - 20	Can it be added that hospital discharge teams should ensure that they avoid discharge to the street whenever possible AND that if discharging to a provider (e.g. a hostel) that they ensure that staff or provider of this service is invited to a discharge planning meeting and is involved in this process? We have many incidents where this is not done currently, with a negative impact on the homeless young person due to the lack of preparation and unawareness of staff that the young person has even been discharged. Transitions are all about appropriate communication between agencies – a point to ensure good information sharing in these circumstances would also be a welcome addition to this section of the guidance.	Thank you for your comment. On the basis of yours and a number of other stakeholder comments, the committee changed this recommendation so it now states that hospital discharge teams and specialist homelessness multidisciplinary teams, where available, should have procedures to minimise self-discharge and prevent discharge to the street. Where this happens, the recommendation also now states that the incident should be reviewed and learning should be implemented. In terms of the other issues you raise, the committee believe that the recommendations already address these including a recommendation specifically about ensuring that all handovers of care responsibilities are planned and coordinated, and relevant information is shared if agreed.

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Centrepoint – National Youth Homelessness Charity	Guideline	25	5 - 6	We would also welcome a recommendation on staff receiving training in Psychologically Informed Environment (PIE) approaches to working with homelessness.	Thank you for your comment. The committee agreed to add psychologically informed environments to the list of training areas alongside trauma-informed care.
Centrepoint – National Youth Homelessness Charity	Guideline	25	19 - 21	Again the word 'consider' – We would recommend that the word 'ensure' that staff have access to regular support, supervision and reflective practice is used instead, and indeed this fits with the earlier firmer recommendation in the guidance that staff do have reflective practice.	Thank you for your comment. The committee did not feel that they had the basis on which to make this recommendation any stronger so in the context of NICE guideline development, this led them to have to use the 'consider' terminology.
Centrepoint – National Youth Homelessness Charity	Guideline	28	4 - 13	A Psychologically Informed Environment (PIE) also considers the role of the physical environment upon an individuals' physical and mental health needs. Can this be added to the description, as it highlights the need for appropriate housing that meets the needs of the individual and provides a 'home' rather than just a bed for the night, and how just relying on the latter can actually negatively impact on an individual's physical / mental health.	Thank you for your comment on the basis of which the definition has now been revised.

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Change Communication	Guideline	General	General	Change Communication is a charitable organisation working with people who have communication difficulties and are experiencing homelessness. We provide speech and language therapy (SLT) to people sleeping on the streets and living in hostels. We also provide communication information, guidance and training to organisations that support people experiencing homelessness. We believe we are the only organisation providing this service in the UK. We are delighted NICE has produced draft guidance to improve access and engagement with health and social care for people experiencing homelessness. Our comments seek to strengthen the guidance so that communication needs are addressed as a risk factor and barrier to accessing health and care services.	Thank you for your comments in this consultation and providing information about your organisation. Please see our responses to individual comments.
Change Communication	Guideline	General	General	Change Communication welcomes the recognition that people whose first language is not English may have additional communication needs such as interpretation and translation services. However, our comments are focused on clinical communication issues including attention, listening, social interaction, understanding, expression, speech and voice. Difficulties in these areas may be present in any language and interpretation and / or translation services alone will not address these clinical matters though it may help to uncover them.	Thank you for your comment. As suggested, 'speech, language and communication difficulties' have been included in the recommendation on taking into account people's communication and information needs and preferences.

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Change Communication	Guideline	3	24	We note that speech, language and communication needs (SLCN) are not mentioned in the list of experiences, differences and disorders. Andrews and Botting (https://onlinelibrary.wiley.com/doi/full/10.1111/1460-6984.12572) found that SLCN are more prevalent in UK adults experiencing homelessness than the general UK adult population. Pluck et al (https://onlinelibrary.wiley.com/doi/abs/10.1111/1460-6984.12521) found adults that experienced homelessness had more difficulties with understanding and expression than adults from a similar socio-economic group that had not experienced homelessness. This evidence and our experience in the field warrants the addition of SLCN as a need and contributing factor for becoming / remaining homeless.	Thank you for your comment. It was not intended to provide an exhaustive list here. The committee agreed that there are many communication needs that are relevant to this population, who require support that is appropriate to their needs. They have tried to reflect this in revisions to the recommendations.
Change Communication	Guideline	4	23	We are pleased to see communication is recognised as a barrier in the guideline, but feel the guidance would be strengthened here by altering this line to read “appropriate communication”. The guideline currently reads as though only lack of communication is an issue.	Thank you for your comment, the text has been revised as suggested.
Change Communication	Guideline	7	15	We welcome the section titled “Communication and Inclusion” but feel the section would have been more robust if a speech and language therapist was part of the Committee and had contributed to the development of the guidance. The addition of a speech and language therapist on the Committee now would improve the revision and updating of the guidance.	Thank you for your comment. Unfortunately, it is not possible to change the committee composition at this stage. The committee composition was discussed and agreed at the time when the scope for the guideline was determined. In order to manage the size of the committee, we had to carefully consider which professionals would be most needed in the committee and speech and language therapist

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					was not prioritised to be included in the composition.
Change Communication	Guideline	8	5	It is our experience that most homelessness services do not ask for a person's communication preferences. Further most people that Change Communication works with have not been provided with speech and language therapy at any point in their life. This means they have never had an opportunity to talk about their communication difficulties in order to explore what does work best for them and state a preference. To help address this barrier we suggest an additional recommendation: health and social care staff working with people experiencing homelessness should undertake Communication Access UK training (https://communication-access.co.uk/). This training is free, online and short. Change Communication has no links to this organisation and receives no benefit from recommending it to others.	Thank you for your comment. The guideline recommends that each person's communication and information needs, preferences and circumstances should be taken into account. The committee also added to the recommendation around provision of extra support to those with speech, language and communication difficulties. Furthermore, theyagreed to revise the recommendation on homelessness MDTs providing wrap around health and social care support to meet the person's needs to include a specific mention of communication needs. The committee was not able to make a long list of different areas for training for staff and had to prioritise what they considered the most important ones. Particular training courses or programmes are not generally recommended without a supporting evidence base.
Change Communication	Guideline	8	5	The Accessible Information Standard has been a legal requirement for publicly funded health and care organisations since 2016. We do not see it mentioned in the guidance at all. Our experience is that this law is barely known about and generally not used to support access to health and care services. We believe the guidance can be strengthened by inserting an additional recommendation here that health and social care staff working with people experiencing homelessness should have knowledge of and	Thank you for your comment. Since it is a legal requirement and applicable generally and not specific to homeless, it was not considered necessary to mention this in the guideline. However, in the section on communication and information, the guideline cross-refers to other NICE guidelines where this has been covered, for example NICE guideline on people's experience in adult social care services (NG86) and NICE guideline on babies, children and young people's experience of healthcare (NG204) .

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				implement the Accessible Information Standard in their work.	
Change Communication	Guideline	8	9	Many of the clients we work with prefer face to face communication. Change Communication is concerned about the 'drive to digital' in relation to people experiencing homelessness. There is no evidence that, for this specific group, virtual contact is as effective as usual care. The consultation specifically asks for issues relating to COVID-19 to be considered by stakeholders. Change Communication believes the guidance can be strengthened by adding "Delivering health and care services to people experiencing homelessness by phone or video removes communication support. Carefully consider the method of service delivery for each person and its impact on the accessibility and effectiveness of your service".	Thank you for your comment. Face to face has been added as an option of communication methods. The recommendations already capture that people's communication and information needs and preferences should be taken into account and the guideline is not pushing for virtual/digital services but trying to make these more accessible for people experiencing homelessness (if this is needed or preferred).
Change Communication	Guideline	8	15	Change Communication is concerned that the guidance conflates communication confidence and SLCN here. An advocate may help support somebody to feel more comfortable and confident in accessing health and care services, but it is not necessarily the case that they have appropriate training to help with literacy or reinforcing information in ways that are appropriate for someone with SLCN. We recommend adding "suitably trained" to this line.	Thank you for your comment. The committee was of the view that this needs to be broader and that some people experiencing homelessness might want a friend or support worker, who is not trained, to advocate for them. However, it could also be an independent advocate, i.e. someone who would be trained. The committee was concerned that many people could be cut out of services if limited only to qualified advocates. Also, there is no supporting evidence that using only suitably trained advocates is the right thing to do. The committee slightly reworded the recommendation to make the above clearer.

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Change Communication	Guideline	8	22	We think the guidance can be strengthen here by adding: their rights to accessible information in line with the Accessible Information Standard.	Thank you for your comment. Since Accessible Information Standard is a legal requirement and applicable generally and not specific to homeless, it was not considered necessary to mention this in the guideline.
Change Communication	Guideline	9	General	Change Communication is concerned that planners and commissioners with no knowledge of SLCN and SLT will not think to involve NHS or third sector SLT services as part of their health and care needs assessment. Change Communication has made numerous efforts to engage with clinical commissioning groups to ensure that the communication needs of people experiencing homelessness are identified, measured, recorded and met, but we have found it extraordinarily difficult to make contact with the right part of these organisations. We suggest this part of the guidance could address unconscious incompetence by explicitly stating that planners and commissioners should actively seek the views and experience of multidisciplinary health and social care services that have historically not been accessed by people experiencing homelessness.	Thank you for your comment. The committee agreed not to specify which specific health and social care services should be involved in planning services, however, the guideline makes it clear that planning services should be integrated and collaborative. Based on consultation feedback the committee have otherwise added communication needs to different sections in the guideline as they agree this is an important consideration.
Change Communication	Guideline	12	15	We are concerned that communication needs are not included in the list of services that comprise “wraparound health and social care support” despite the guidance recognising that communication needs can act as a barrier to accessing a range of services listed here. We believe the guidance can be strengthened by adding “- communication needs (such as speech and language therapy).”	Thank you for your suggestion. The committee agree with your point and have added communication needs to this list, although they have kept it deliberately general because of course communication needs in this context would be broader than those assessed or supported by speech and language therapy.

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Change Communication	Guideline	15	9	A report from the Chief Scientist's Office in 2004 (CZG/2/100 "Consultation between General Practitioners and people with a communication disability") provides information about environmental factors that present barriers to communication for people with communication disability. These include open and public reception areas, busy waiting rooms, and phone call access only to make appointments. We think the guidance can be strengthened by adding an example here such as "Provision of communication friendly environments including staff trained in accessible communication."	Thank you for your comment. Based on the consultation feedback, the committee agreed to add to a recommendation within the section on Communication and information that providing extra support for people with speech, language and communication difficulties is an example of how to take into account each person's communication and information needs and preferences and their circumstances. The committee do not think more detail of how this is done is needed in the guideline as this will depend on the person's individual needs, preferences and circumstances.
Change Communication	Guideline	16	24	We suggest the addition of "easy read and accessible materials" here.	Thank you for your suggestion. The committee did not make this change because they felt the point had already been made in an earlier recommendation to ensure that written information is available in different formats and languages, including Easy Read.
Change Communication	Guideline	30	General	We are concerned that communication needs are not included in the list of needs that may require "wraparound health and social care support" despite the guidance recognising that communication needs can act as a barrier to accessing a range of services listed here. We believe the guidance can be strengthened by adding "communication needs."	Thank you for your comment. The committee agreed to specify communication needs in the recommendation about MDTs providing wraparound health and social care support.

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Company Chemists' Association	Guideline	4	15 - 19	This section discussed the response to homelessness during covid. Community pharmacy offers services to local communities, including people experiencing homeless. During the pandemic, attempts were made by local councils to house homeless people in refuges, bed and breakfasts, hotels, and shelters. However, the disruption to everyday life had a significant impact on people experiencing homelessness, especially those with other health concerns that needed to be managed. Community Pharmacy faced into exceptional demand during the pandemic. During the initial surge in 2020, Public Health England guidance to pharmacy on how to manage face to face services was not provided immediately, resulting in individual businesses making risk assessed decisions. There were also regional variability as different regional services worked to differing standards. For people accessing addiction services from community pharmacy, they suddenly found that they were unable to attend the pharmacy frequently for prescriptions and/or supervised consumption. Supervised consumption is effective at preventing accumulation of drugs at home, namely methadone. It could therefore reduce harm from accidental overdose – either by the drug user or a member of their family. Lessons have been learned around how to handle dispensing liquid methadone when	Thank you for your comment. The committee agree with you that the pandemic has caused various challenges to services for people experiencing homelessness and support related to harmful drug or alcohol use. It is beyond the scope of this guideline to make specific recommendations on drug and alcohol treatments although the committee refer to assessment and support in this context throughout the guideline. The committee also referred to NICE's guideline on coexisting severe mental illness and substance misuse, which should provide guidance on the issues that you raise. The committee also agree that policy measures on people experiencing homelessness need to be evidence-based, and that's what NICE guidelines aim to do. However, it is beyond NICE's remit to request other agencies to make evidence-based decisions.

				supervised consumption services have been suspended. Some of our members were able to deliver prescriptions to patients in their sheltered accommodation. There were, regrettably, negative outcomes for some patients. In most cases the Drug Addiction Teams (DATs) are responsible for the service user as their 'client' and need to be prepared for making alternative treatment plans for service users, particularly the very vulnerable and those who are shielding. However, guidance from government departments including Public Health England, the Home Office and the Department of Health and Social Care needs to assess policy measures on people experiencing homelessness before implementation. They also need to ensure that policies are clear and communicated well to all audiences.	

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Company Chemists' Association	Guideline	4	17 - 23	This section of the guidance discusses barriers to access and care for people experiencing homelessness. It also discusses the lack of trusted contacts and the stigma and discrimination that people experiencing homelessness can face. Community Pharmacy has a greater coverage in areas of high deprivation than any other health care provider. This means that the most vulnerable people in society, including those experiencing homelessness, are more likely to attend a community pharmacy than a GP surgery. Community pharmacies are trusted partners to local communities. Therefore, there is an opportunity to provide more consistent and joined up services to people experiencing homeless by reviewing their care pathway and the role that community pharmacy plays and whether there is more it could do in the future. This provision of services would be even more effective with consistent and thoughtful integration of community pharmacy into the wider health system, to ensure continuity of care for patients. This will be particularly helpful for those facing homelessness, whose needs will be addressed by partnership among organisations working across local place and population.	Thank you for your comment. The community pharmacy was included as one of the interventions for integrated prevention and early intervention. However, no studies were found on this that met our study design inclusion criteria. As a result, the committee did not make recommendations on this. Even though the recommendations do not make specific reference to community pharmacy there are references to various community services and care models which depending on local needs may include services provided by community pharmacy.

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Company Chemists' Association	Guideline	4	24 - 32	This section of the guidance covers the cost of homelessness. Community pharmacy can create savings in the NHS by reducing the number of hospital admissions through targeted services. The Discharge Medicines Service (DMS) reconciles medications prescribed during a hospital stay with medications a patient was already taking. Since this service was launched in February 2021, it is estimated (by National Patient Safety Improvement Programmes) that over 3, 012 admissions have been avoided. A report by the King's Fund notes that there has been a 130 per cent increase in hospital admissions related to homelessness between 2013/14 to 2018/19. In addition to discharge medicines services, more needs to be done to manage and treat long term conditions that can become acute, such as respiratory illnesses. The King's Fund suggest that there is an opportunity for commissioners to consider more targeted services to people experiencing homelessness from community pharmacy. Community pharmacy currently offers supervised consumption services to drug users, which helps to manage drug dependency by dispensing drugs and monitoring drug consumption at regular intervals. Pharmacy teams also become part of the drug users support network, and this is invaluable when it comes to noticing that the service user has failed to attend to take their	Thank you for your comment. The community pharmacy was included as one of the interventions for integrated prevention and early intervention. However, no studies were found on this that met our study design inclusion criteria, i.e. experimental studies using a randomly assigned control group design or experimental studies using a non-randomly assigned control group design with match comparison or another method of controlling for confounding variables. Also, the reference that you have provided is not specific to people experiencing homelessness so it cannot be included. As a result, the committee did not make recommendations on this, and no economic considerations were included in the section on the cost of homelessness. Even though the recommendations do not make specific references to community pharmacy, there are references to various community services and care models that may include services provided by community pharmacies depending on local needs. The committee agree that there are regional variations and funding issues. Where possible, variation in practice is acknowledged, and hopefully, this guidance will reduce such variations in care. However, NICE does not have a remit to make recommendations on funding decisions.

				medication or is having deteriorating health or personal issues. Where supervised consumption services are offered, they are negotiated between the Local Pharmaceutical Committee (which represents pharmacy contractors) and the Local Authority. This funding stream can make implementation difficult because some Local Authorities are struggling financially and are therefore rolling back on such services. Furthermore, as drug dependency rates among the population are higher in areas of deprivation this means that those that need this support miss out. The Pharmaceutical Services Negotiating Committee (PSNC) produced a report (31) in 2016 which identifies the value that drug consumption services can have to the local community. The report notes that: For many of these interventions the scale of value created is substantial and greatly exceeds the cost to the NHS of delivering them. Each patient treated with supervised consumption, for example, generated in excess of £4,000 in value in 2015 alone, and a further £7,500 in the long term. Therefore, the costs of providing a supervised consumption service is outweighed by the value this service creates for the NHS and wider society. Savings include areas such as crime prevention. However, the short termism in commissioning means that these savings are not being realised in areas where services are being reduced or cut. Furthermore, regional variations in services	

				mean that service users' care is dependent on their postcodes. To address this, a nationally agreed tariff for supervised methadone consumption should be agreed to help eliminate geographical variability.	
Company Chemists' Association	Guideline	8		**1.1.1, 1.5.1, 1.2.2.** This section discusses targeted approaches which are accessible and available and same quality as population healthcare. Community pharmacists are a regular touchpoint for people experiencing homelessness. They are also a key part of the primary care system dispensing medicines safely and effectively, offering services from minor ailments, to stop smoking to identification of conditions such as hypertension. As community pharmacists are clinically trained health professionals this is an area that may continue to grow with the appropriate funding and capacity. The contribution that community pharmacy can make to local population-based health care needs is accessible to people facing homelessness because community pharmacy services can be accessed without an appointment and because community pharmacy is at the heart of local communities. Additionally, further services could be introduced to support drug users and tackle health inequalities. Hepatitis C testing is currently offered in pharmacies for needle and syringe	Thank you for your comment and the further details you provide about the contribution of pharmicists in this context. A small amount of evidence was located in the qualitative review underpinning this guideline which suggested that people experiencing homelessness do not have the same access to pharmacy as the general population and that the access they do have is characterised by poor experiences. The committee considered this along with other findings about a lack of access to services and negative experiences and one of the ways in which they sought to mitigate this was through an emphasis on outreach services which encompass the full range of people's needs. They did not specify the services that should be included in an outreach services but took the approach of describing which needs should be covered by these services. Without the evidence to state which particular professional groups would be most effective or cost-effective at meeting those needs the committee did not feel they had the basis to recommend a specific configuration of outreach services. However they were clear that outreach services have a role to play in identifying health problems earlier, promoting health and supporting engagement

				exchange users. This was introduced as a national service through the Community Pharmacy Contractual Framework (CPCF) in 2020 for a two-year period. Additionally, services could be offered so that the drug user is targeted with further inventions when they attend their drug consumption appointment. We believe that the role of the pharmacy team in the service users care could be strengthened. A report produced by the NHS National Treatment Agency for Substance Misuse (34) in 2006 notes that pharmacist independent prescribers could be a support to service users on a long-term maintenance or detoxification programme, and the drug user could be monitored locally. Independent prescribing in community pharmacy is still an area to be utilised and is key to addressing health inequalities among populations. Furthermore, community pharmacy could be tasked with long-term management of conditions of people experiencing homelessness which would provide the individual with accessible high quality and supportive care with improved outcomes over time.	with care and that this could include supporting access to national screening programmes, assessment for long-term conditions, infectious diseases, and mental health needs and providing preventive health opportunities such as vaccination, drug and alcohol treatment services, harm minimisation, smoking cessation and nutrition advice. From your response, it seems clear pharmacists will have a clear role in the implementation of these recommendations.

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Company Chemists' Association	Guideline	8		1.1.11 Literacy Higher levels of health literacy are associated with people being housed, higher levels of education, non-psychotic mental health diagnoses and lower levels of drug use (35). Therefore, the ability to read and interpret instructions on prescriptions and interpret health advice is likely to be lower among people facing homelessness than the general population. Community pharmacy can work with patient to improve their understanding of their own health needs. There is scope for pharmacy to do more work with people experiencing homelessness to improve health literacy and outcomes.	Thank you for your comment. The committee agree with you that there is a huge potential for pharmacists to contribute to the implementation of many aspects of this guideline but they did not locate evidence that provided a basis for them to specifically recommend they assume a dedicated role.

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Company Chemists' Association	Guideline	8		1.1.12 Specialist services including drug recovery The main service that community pharmacy offers drug users is supervised consumption. This is where pharmacists provide supervision of oral or sublingual self-administration of methadone, buprenorphine, buprenorphine in combination with naloxone and naltrexone by service users as part of an agreed substance misuse treatment programme. Pharmacists commonly dispense oral liquid methadone on an instalment prescription, where the prescriber specifies the instalment amount and the interval between each instalment. However, controlled drugs may be prescribed and dispensed without supervised consumption. By providing the service user with supervised consumption, the pharmacist builds up frequent interactions with this individual and this provides a safety net so that issues with adherence, other health issues and safeguarding issues can be identified and reported to drug action teams (DATs) and other bodies, where appropriate.	Thank you for your comment. The community pharmacy was included as one of the interventions for integrated prevention and early intervention. However, no studies on this were found that met our study design inclusion criteria. As a result, the committee did not make recommendations on this. Even though the recommendations do not make specific reference to community pharmacy there are several references to various community services and care models which depending on local needs may include services provided by community pharmacy. Reference is also made to NICE's guideline on coexisting severe mental illness and substance misuse which should provide further guidance on the issues that you raise.

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Company Chemists' Association	Guideline	21		**1.8.1** Transition between settings Community pharmacy has a key role in the transition of people between settings. For example, the Discharge Medicines Service ensures that patients being released from hospital have their medicines reconciled by a clinically trained pharmacist to ensure that duplicate prescriptions or medicines with negative contraindications are not given to patients. This improves health outcomes and reduces the number of unnecessary hospital readmissions. For the most vulnerable people, including people experiencing homelessness, it is important that they have an effective handover and do not fall between gaps. This may be a transition between a drug and alcohol team to community pharmacy for supervised consumption services, transfers from prisons, transfers from mental health teams and so on.	Thank you for your comment and for the information about this service. The committee did not review evidence which would have provided the basis to specifically recommend community pharmacy in this context. However please note that the section on models of multidisciplinary service provision is intended to cover the full spectrum of health and social care services and recognises the contribution that the full range of services has to make in supporting people and addressing often complex needs. The role of community pharmacy is therefore captured in this context.

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Crisis	Guidelines	General	General	We have some concern with how the evidence on Housing First has been presented in these guidelines and we are worried that the committee has unintentionally failed to present a balanced picture of the evidence with regard to Housing First. In particular, given the worrying mentions around suicidality and mortality in these guidelines, as well as the statements around the associated wraparound support, we are concerned that the guidelines in their current form could imply that Housing First is not a valid intervention. While this may not have been the committee's intention, there may be the unfortunate consequence of how the evidence has been presented. As reported by Mackie et al (2017), the quantity of evidence on Housing First far exceeds that for any other intervention targeting rough sleepers, and the quality is strong. Randomised Controlled Trials have been conducted showing significant success in ending people's homelessness and succeeding in supporting people to sustain a tenancy. While we accept that the evidence for health outcomes related to Housing First present a more mixed picture, potentially partially explained by the fact that it is harder to analyse health outcomes than it is to measure tenancy sustainment, there is evidence that suggests Housing First can improve health-related outcomes. Recent evidence from France, for example, found that on average, Housing Frist participants	Thank you for your comment, in response to which the analysis of the two papers in question, have been revisited and discussed with the guideline committee. The committee discussed that Housing First is an effective intervention to reduce homelessness and agreed with many of the principles highlighted in the model. However, the committee agreed that the evidence did not show its suitability in improving access to, or engagement with health and social care, which was the objective of the review question. The committee discussed that there is huge variation in the fidelity of the housing first model and agreed not to specify Housing First in the recommendations although many of the principles of the model are reflected in the recommendations. Upon further investigation of the outcome data from Aquin 2017 on suicidal ideation, discrepancies were noted in the reporting of people randomised to each arm (i.e. the denominator) and the percentage values reported in table 2. The presented analysis in evidence review A/B follows Cochrane's preferred methodology of using the intention to treat principle, which shows the results as clinically important at 24 months only but not at earlier time points. The limitations of this approach are recognised in that assumes that people without an outcome measure would all not have the outcome.

				spent significantly less days hospitalised than Treatment as Usual participants over time. Compared to Treatment as Usual participants, Housing First individuals spent 48% less on health care, indicating reduced need (9). Other studies have also shown that Housing First participants experience fewer hospitalisations and a greater reduction in emergency room visits compared to those receiving treatment as usual (Baxter et al., 2019). Overall, based on the research findings to date, Housing First demonstrates most of the ideal features of a mental health intervention (as defined by Bond et al, 2010). As presented in this paper, the presence of these ideal features is an important reason for its dissemination internationally (10). Evidence also indicates, that on balance, Housing First may be equally and is sometimes more effective than treatment first models in reducing levels of substance misuse (11). This may well be because the provision of stable housing offers a secure platform which fosters clients' recovery from addiction (and other issues such as mental health problems). Social integration and community adjustment is less studied in the Housing First literature than other outcomes, yet there is some evidence in North American RCTs that Housing First enrolment was associated with greater perceived choice for individuals displaying psychiatric	Discrepancies were noted in the reported data on mortality from Tinland 2019, who conclude no significance between the two arms. However, when the relative effects were calculated (authors do not report this), the result showed a significant difference (p=0.04) favouring treatment as usual over housing first. The authors report a p value of 0.056 but it is unclear how they calculated this value. In light of another stakeholder comment, the narrative description of results in Somers 2017 has been reviewed and the technical team were able to extract additional data and add them to the meta-analysis for the outcome of mortality. Although the effect estimate of the now pooled data is lower than for Tinland data alone, the result is statistically significant and clinically important, according to the methodology agreed a priori for this review. However, the limitations of this result are acknowledged in the report, and with the wide confidence intervals, close to the line of no effect, the committee was unconvinced about there being an association between Housing First and mortality. This has been explained more clearly in the committee's discussion of the evidence section of the review. It is important to note that although the committee noted the results from the analysis of outcome data on suicidal ideation and mortality, these were not decisive findings informing the recommendations and therefore this text has

				systems, and that choice is a predictor of increased psychosocial integration (12). Woodhall Melnik and Dunn highlight a variety of studies that show improvements in participants' perceived quality-of-life using a range of measures and scales (13). This includes RCTs in North America (14). Housing First studies generally find that participants use fewer emergency and criminal justice services than Treatment as Usual clients (15) and are more likely to remain in health treatment programs (16) All of which say, that Housing First is clearly effective in ending long-term/recurrent homelessness associated with high and complex needs, and while the outcomes in mental health, substance misuse and social integration are sometimes more mixed, there is no evidence that Housing First has a negative impact upon these secondary outcomes, and some evidence that it can improve secondary outcomes. We also want to stress the point around high fidelity Housing First. There are many programmes that call themselves 'Housing First' both nationally and internationally. However, many of these programmes will deviate from high fidelity approaches, often with negative effects upon participants (17). We would urge the committee to ensure that they have considered the fidelity of Housing First programmes in the studies analysed and cited. We agree that the wraparound support	been removed from the guideline rationale section. The findings did however prompt an interesting discussion around the strong feelings of isolation, loneliness and stress that can be experienced after a move to independent accommodation. In the committee's experience this can be an isolating step for someone recently experiencing homelessness and the evidence highlighted the crucial importance of providing emotional and practical support throughout and following the move. Committee members with lived experience of homelessness corroborated this and agreed that emotional and practical support are crucial in these circumstances.

				associated with Housing First is often variable and lacking. However, this is not a problem with Housing First as an approach per se, but rather a problem with the wider systems that surround Housing First and that Housing First programmes often rely upon. For example, Intensive Case Management models of Housing First rely on the accessibility of wider services, such as NHS services, to work effectively. As reported in interim evaluation reports (2020, 2021) from the three-government funded Housing First pilots in England, access to health services especially mental health, has been one of the biggest challenges for the pilots. Barriers to effective referral into health services is not unique to Housing First, on the contrary, the lack of wraparound support (provided by a wider array of agencies) is an issue that will be similarly faced by other homelessness accommodation providers such as temporary accommodation. In this context, it is important to see Housing First not as a 'treatment' model, but as a model of care and homelessness service provision intervention. It is important to recognise the complexity and severity of poor health among some Housing First clients. In this sense, for some people who are very ill Housing First may be more akin to social care interventions that seek to support the management of ill-health and maintain or improve quality of life, rather than necessarily ameliorating or eradicating poor health. Housing First is ultimately a targeted intervention, designed for people with the most complex	

				needs, people whom the mainstream homelessness system has failed, often as a result of acutely compounded factors such as prolonged periods of rough sleeping, acute mental health issues, substance misuse, and interactions with criminal justice, often rooted in childhood adverse experiences and poverty. Similarly, given the complexity and severity of Housing First clients, another important dimension is planned versus unplanned care. Housing First enables planned use of healthcare services, rather than the unplanned use associated with homelessness and rough sleeping. We also know from our own experience that clients in Housing First will use healthcare services in a more planned way that prior to entry into the programme. It is also important to note that the English pilots and the Scottish pathfinders are both being rigorously evaluated, with academic input. While the final evaluations have not yet been published, important data on Housing First in a UK context is forthcoming.	

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Crisis	Guidelines	General	General	Preventing homelessness for more people would be expected to lead to a reduction in contact with NHS services, resulting in cost savings for the NHS. Studies have shown that people's interactions with health services increase before they became homeless, and peak at around the time of the first homelessness assessment (18). From up to four years prior to the date of the first homelessness assessment, the A&E attendances for people in the homeless cohort increased relative to those of people in the control group. Immediately prior to the date of the first homelessness assessment A&E attendances increased sharply. This is also the case for acute admissions to hospital (19). This indicates that there are likely to be multiple opportunities for interventions to be made within the health service to prevent someone from becoming homeless before their situation reaches crisis point. The point at which someone is discharged from hospital is another key time where a successful intervention could be made to prevent homelessness. Homeless Link reported in 2014 that more than 36 per cent of people were discharged from hospital onto the street, without underlying health problems or housing being addressed (20). We would urge the committee to specifically look and mention health's role in the prevention of homelessness in the NICE guidelines.	Thank you for your comment. The focus of the guideline is on improving access to and engagement with health and social care for people experiencing homelessness and whilst preventing homelessness in the first place is of course an important issue, this is not in the scope of this guideline. Although preventing repeat homelessness through access to appropriate health and social care support for people experiencing homelessness is a key issue and covered in this guideline. We have added some discussion around this in the committee's discussion of the evidence section in evidence report C. Discharge from hospital for people experiencing homelessness is covered by the guideline and the committee have made different recommendations relating to it, including recommendation on intermediate care (step down), homelessness MDTs supporting mainstream providers to ensure safe, timely and appropriate hospital discharge and engagement with onward care, and recommendations on transitions between settings. The latter recommendations were informed by the evidence on Critical Time Intervention. The committee agreed to revise the recommendation about reviewing any self-discharges and discharges to the street based on consultation feedback to clarify that clinical teams, working with hospital discharge teams and specialist homelessness MDT, where available, should have procedures to minimise self-discharge and

				Tailored and intensive case management approaches have been shown to be successful in preventing and relieving homelessness, while also ensuring people can access appropriate medical treatment. A major review by The Lancet found that when case management approaches, such as Critical Time Intervention (CTI), are combined with assertive community-based treatment they reduce homelessness, with a greater improvement in psychiatric symptoms compared to usual care or standard case management approaches. This has much in common with the Pathway model, which is described in more detail below (21). A key feature of the Pathway model is the inclusion of both clinical and housing staff in the team providing support for homeless patients. The Pathway model has been shown to be effective at preventing or relieving homelessness for patients, improving patients' health and wellbeing and reducing delays in discharging patients. At the Royal London Hospital and the Royal Sussex County hospitals, patients judged themselves to have improved management of money and relationships both on discharge and follow up, and the hospitals saw a reduction in rough sleepers on discharge from 14.6 to 3.8 per cent (22). Research at University College London Hospital (UCLH) found that discharged patients who had received Pathway care experienced a 30 per cent reduction in annual bed days from 2008 to 2011 (23). An audit of the	prevent discharge to street. In addition, when this happens, this should be reviewed and learning from it should be implemented. The committee reviewed the evidence published in relation to the Pathway model that was applicable to the review questions covered by the guideline but agreed not to specify this model in the recommendations. However, many elements of the Pathway model are covered in the recommendations. For example, the guideline recommends that homelessness MDTs could include housing options, homelessness prevention officers, and homelessness practitioners.

				hospital attendance and admission rates in the 90 days before and after a homeless patient was supported by Pathway at UCLH found reductions in A&E presentation (37.6%), hospital admission (66%) and bed days in hospital (78.1%) (24). We would recommend the committee specifically cite Pathway as an evidence-based, effective model of care that can prevent and relieve homelessness when someone is in contact with hospital-based services. As recommended in Crisis' report 'Preventing homelessness: It's everybody's business' (Jacob, 2018), we would ask the committee consider the following recommendations: • Every hospital that sees more than 200 homeless patients each year to have a full Pathway team, including a GP, nursing staff, care navigators and a dedicated housing worker. At time of the report (2018), only nine out of 140 NHS Trusts in England had this. • Hospitals that see between 30 and 200 homeless patients each year should be required to have a dedicated housing worker. • All frontline health professionals should be provided with comprehensive training to help them identify when patients are homeless or at risk of homelessness. This should also include awareness of the homeless hospital discharge protocol, and relevant local support services (25).	

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Crisis	Guidelines	General	General	We strongly welcome the committee's guidelines, which we think represents a great step forward in ensuring that commissioners and providers understand what the standards should be for homeless healthcare. We particularly welcome the committee's decision to include the need for targeted approaches to ensure effective health and social care for people experiencing homelessness and the emphasis on the need for multi-disciplinary teams and approaches embedded across the system. Now we must ensure that the political will and resources are there to make these guidelines a reality.	Thank you for your comment. It is hoped that the publication of this guideline will help with prioritising resources and efforts to improve the lives of people experiencing homelessness with the ultimate aim to end rough sleeping and homelessness.
Crisis	Guidelines	General	General	We agree with the committee that homelessness is a public health issue. Homelessness has a hugely damaging impact upon health and care outcomes. However, we are concerned that overall the guidance is very focused on how health and care services can 'manage' homelessness, rather than prevent or end it. As with any other public health issue, where harm is identified as a consequence of that public health issue (be it substance misuse, or communicable diseases) the idea is to reduce the harm or ideally eradicate the associated harms. We should conceptualise of homelessness similarly. Homelessness is associated with extreme health inequalities, and therefore, the health and care system should be aiming to support efforts to prevent or end someone's homelessness. This is the ultimate	Thank you for your comment. The focus of this guideline is to improve access to and engagement with health and social care services for people experiencing homelessness. Prevention of homelessness in the first place is not covered by this guideline. The guideline also does not cover housing provision or allocations as such. However, the committee believe that the guideline does address supporting people so that they will no longer be homeless or will not return to homelessness through integrated and multidisciplinary response to people's health and social care needs and, for many people experiencing homelessness, their severe and multiple disadvantage. Whilst acknowledging that not everyone will recover, the guideline emphases supporting the person in their recovery journey, which would include preventing and ending homelessness for that person.

				goal and should be reflected across these guidelines.	
Crisis	Guidelines	General	General	We are concerned that social care receives much less attention in these guidelines than healthcare does. Social care has a significant role to play in responses to homelessness, whether it be in conjunction with supporting people into permanent suitable accommodation (supported housing, Housing First programmes), particularly for people whose homelessness has led to acute physical and mental illness. Similarly, social care will have a leading role to play in supporting people whose homelessness has led them to be so acutely unwell that interventions such as Housing First may not suitable, people who need round the clock care. Recent research led by Homeless Network Scotland entitled 'Shared Spaces' investigates the need for certain types of supported housing as Scotland aim to move to a housing-led approaches to ending homelessness (26). Homeless Network Scotland recommend that Housing First should be the first response for people with severe and multiple needs, however if mainstream housing (including Housing First) is not possible or preferable, highly specialist provision with small, supported environments (supported housing) should be available. They estimate that in any given year, around 2-5% of the homeless population will require this highly specialist provision. While this is Scotland specific data, it gives an indication of the	Thank you for your comment. The guideline title has been clarified and it is 'Integrated health and social care for people experiencing homelessness'. The term social care has been included throughout the guideline. It is mentioned in recommendations on planning and commissioning, service provision, peers, access and engagement, outreach, needs assessment, transitions, staff support and development, and wraparound care. The Care Act 2014, which sets out local authorities' duties to assess people's needs and eligibility for publicly funded social care and support is also referred to in various instances. The committee considered social care in further additions to the recommendations and made research recommendations that include social care, e.g. structural and systems factors help or hinder commissioning and delivery of wraparound health and social care that is integrated with housing for people experiencing homelessness; and also the effectiveness and cost-effectiveness of longer health and social care contacts compared with usual care for people experiencing homelessness.

				percentage of the population that would require social care to take a leading role. We acknowledge there is a significant evidence gap with regard to social care interventions and homelessness. We would strongly recommend that NICE make a research recommendation specifically on social care, focused on improving the evidence base on how social care can work most effectively for people experiencing homelessness.	

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Crisis	Guidelines	General	General	We would urge the committee to consider social care's role in Safeguarding Adult Reviews (SARS), which as highlighted by the Rough Sleeping Strategy (2018) described SARs as 'powerful tools, which unfortunately are rarely used in the case of people who sleep rough'. We draw the committee's attention to the following study which demonstrates that SARS have a role to play in identifying failures in multi-agency working, assessments, and hospital discharge processes into unsuitable accommodation. Martineau et al. (2019). Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adult Reviews. NIHR Policy Research Unit in Health and Social Care Workforce. The Policy Institute, King's College London.	Thank you for your comment. Social Care's role in SARs and the conditions under which a SAR should be commissioned are set out clearly in the Care Act and its Statutory Guidance. If the committee recommended in stronger terms that SARs 'should' be done, this would have considerable resource implications. For this reason and without stronger underpinning research evidence, the committee chose not to place further emphasis on the conduct of safeguarding adults reviews than the Care Act already does.
Crisis	Guidelines	General	General	We would recommend that NICE explicitly state that access to and quality of housing is a health issue, particularly in the context section. As Public Health England guidance states, 'the right home environment is essential to health and wellbeing, throughout life' and 'it is a wider determinant of health' (27). Evidence shows that an unhealthy home (e.g., one that is damp and cold), an unsuitable home (e.g., one that is overcrowded), or an unstable home (e.g., one that does not offer security, such as temporary accommodation), can also contribute to ill health or prevent the management of existing ill health. NICE should state that housing is a determinant of health clearly in the guidelines.	Thank you for your comment. The text has been revised based on your comment.

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Crisis	Guidelines	General	General	People who are homeless do not face health inequalities in a vacuum, and these health inequalities are often linked to wider health inequality issues, such poverty, trauma, adverse childhood experiences, housing, race, socioeconomic position, migration status, sexual orientation, and gender identity. Efforts to tackle homelessness will need to contend with wider health inequalities in our society. We would, therefore, recommend that NICE clearly places homelessness within the wider context of health inequalities in the context section. We would also recommend that NICE explicitly references the Inverse Care Law in the context section, making it clear that those who most need medical care, including people who are homeless, are least likely to receive it. Overcoming the Inverse Care Law will be key to preventing and ending homelessness. These NICE guidelines clearly make the case for integrated approaches to improving healthcare for people who are homeless. The need for integrated approaches is particularly clear for people who are experiencing multiple disadvantage. Again, we would urge the committee to place homelessness clearly within the context of multiple disadvantage in the context section.	Thank you for your comment. The committee made some revisions to this section based on your comment. The committee also agreed to use the term "severe and multiple disadvantage" which is now defined in the Terms used in this guideline section. They did not make reference to Inverse Care Law as such but it aligns with the notions in this section and the guideline as a whole that the needs of people experiencing homelessness are often greater than in the general population whilst there are often more barriers for their access and engagement with services.

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Crisis	Guidelines	General	General	We would urge the committee to look at the role that A&E has to play in preventing or ending homelessness. People who are homeless are often frequent users of emergency care, with one study finding that people who are homeless are sixty times more likely to visit A&E in a given year than the general population.(28) This may be an indicator that people's integrated needs across housing, health, and social care are not being met. While there is little evidence on what A&E departments should be doing in response, the evidence highlights a significant issue that must be looked at in more detail. We would urge the committee to consider what needs to be done in this space.	Thank you for your comment. The committee agreed that there was scope to make more explicit reference to the role of hospital emergency departments and they therefore made some changes to the recommendations when finalising the guideline. They stated that homelessness multidisciplinary teams should coordinate care across a range of services including emergency care. They also specified that people should be helped to access help when needed, including through emergency care. The committee hope that by improving access to primary health, outreach services, preventative interventions and other approaches recommended in this guideline will also help reduce the need for emergency care use among people experiencing homelessness.

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Crisis	Guidelines	General	General	IIt is important to note that palliative care barely features in the guidelines. As noted in the guidance, people who are homeless are more likely to face premature mortality. Office for National Statistics data suggests that deaths among people who are homeless have been rising in recent years. Despite this, evidence suggests that access to palliative care is challenging for people experiencing homelessness. There has been work to understand what good quality palliative care provision looks like for people who are homeless and how to overcome system barriers. Marie Curie recently published report 'Dying in the Cold', focused on homelessness and palliative care in Scotland, suggests that complex trauma, lack of awareness among healthcare professionals, bereavement and grief, ad the impact of the pandemic are significant challenges to palliative care for this population. People living in areas of high deprivation, including people who are homeless, are currently more likely to die in hospital than the general population. We would urge the committee to consider palliative care in the guidelines. Below are some studies the committee may wish to look at: Hudson et al. Challenges to access and provision of palliative care for people who are homeless: a systematic review of qualitative research. BMC Palliative Care, 2016.	Thank you for your comment, which we discussed with the committee. Although our literature search did not identify much evidence specifically about palliative care, we did identify and include one study from the UK (Shulman 2018), which contributed to several review findings, such as 'A1.14.2 Competing priorities', 'A2.2.1 Feelings of apprehension', 'A2.2.2 Feelings of fear', 'A2.7 The skills, training and values of practitioners', 'A3.1.1 Care experiences', 'A3.2 Responses to complex healthcare needs', 'A3.3 Consistency and care continuity', 'A3.5 Individualised care and support', 'A3.11 Experiences of stigma and discrimination', in Review C. The committee discussed this comment and they agree with you about the need to improve access to palliative care for people experiencing homelessness. On the basis of yours and other stakeholder comments, they made changes to some recommendations to try to address this. They also added a recommendation about palliative care to the section of the guideline on long term support. Thank you for providing these references, which have been checked for their relevance to this review. Reasons for their exclusion are provided after each reference: Hudson et al. Challenges to access and provision of palliative care for people who are homeless: a systematic review of qualitative research. BMC Palliative Care, 2016. This reference was identified in our search but excluded at the full text screening stage.

				Webb WA, Mitchell T, Nyatanga B, Snelling P. How to explore end of life preferences of homeless people in the UK. European Journal of Palliative Care, 2018. Klop et al. Palliative Care for Homeless People; a systematic review of the concerns, care needs and preferences and the barriers and facilitators for providing palliative care BMC Palliative Care, 2018. Kennedy P, Hudson BF, Shulman C, Brophy. End of life care for homeless people: a qualitative analysis exploring the challenges to access and provision of palliative care. SAGE Journals, 2018. Mitchell Webb T, Snelling P, Nyatanga B. Life's hard and then you die: the end of life priorities of people experiencing homelessness in the UK. Academic Journal, March 2020.	Relevant studies were assessed from the systematic review and none for found to be appropriate for inclusion. Webb WA, Mitchell T, Nyatanga B, Snelling P. How to explore end of life preferences of homeless people in the UK. European Journal of Palliative Care, 2018. Although this study was not identified in our search, it would not have been included because it is a literature/narrative review, and this study design was excluded from this review. Klop et al. Palliative Care for Homeless People; a systematic review of the concerns, care needs and preferences and the barriers and facilitators for providing palliative care BMC Palliative Care, 2018. This study was included in this evidence review. Kennedy P, Hudson BF, Shulman C, Brophy. End of life care for homeless people: a qualitative analysis exploring the challenges to access and provision of palliative care. SAGE Journals, 2018. This study was included in this evidence review as Shulman 2018. Mitchell Webb T, Snelling P, Nyatanga B. Life's hard and then you die: the end of life priorities of people experiencing homelessness in the UK. Academic Journal, March 2020. This reference was identified in our search but excluded at the title and abstract screening stage because it was not the objective/phenomenon of interest for this evidence review.

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Crisis	Guidelines	8	22 - 29	Homelessness is associated with acute health outcomes. The prevention or ending of someone's homelessness is therefore of paramount importance. We agree with the recommendation that all health and care staff should be able to give patients information on local authority services, including housing services. We would recommend that in this section it is made clear that certain bodies, including emergency departments, urgent treatment centres, hospitals in their function of providing inpatient care, and social service authorities (both adult and children's) all have statutory duties to refer people who are homeless to local authority homelessness/housing options teams. The Westminster Government has also made clear that other public agencies may refer people to local authority housing options, even if their agency is not required to under the Homelessness Reduction Act (2017). We would recommend that the committee state this fact and encourage organisations that are likely to encounter people who are homeless regularly, such as general practice, mental health services, and drug and alcohol treatment services, to also refer people into housing options where relevant and appropriate.	Thank you for your comment. Duty to refer has been covered elsewhere in the guideline and was not considered relevant in this recommendation.

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Crisis	Guidelines	9, 10, 11		We strongly agree with the recommendations here. Homelessness is both a housing and a public health issue and therefore joint commissioning of services between housing, health, and social care is incredibly important to ensuring a multi-faceted approach and preventing people from falling between the gaps in services.	Thank you for your support.
Crisis	Guidelines	11, 12, 13	19 - 21, 1 - 31, 1 - 26	While we strongly agree with the recommendations in this section, we would recommend the committee explore ways for these recommendations to be made more specific with regard to how large a geographical footprint/homelessness population a multi-disciplinary team should cover. For example, whether all Primary Care Networks/all NHS Trusts have at least one multi-disciplinary team operating in their area, depending on the size of the local homeless population. We are concerned that unless we define this, there is a risk that the recommendations will not translate into changed practice.	Thank you for your support. The committee made the recommendations about multi-disciplinary homelessness teams informed by the evidence they reviewed as well as their own expertise. However they did not feel there was a basis to recommend a specific model of multidisciplinary working and acknowledge that approaches will vary according to local arrangements. They focussed the recommendations on the important principles and essential elements of multidisciplinary team working. They felt that viewed in the context of the recommendations about conducting and maintaining an up to date local homelessness health and social care needs assessment to design, plan and deliver services according to need, that this would ensure multidisciplinary services had the capacity and reach to meet local need.

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Crisis	Guidelines	21	2 - 7	We strongly agree with the recommendations here that multi-disciplinary teams lead and support transitions between services. As highlighted in Crisis' report 'Home for All: the case for scaling up Housing First in England' (2021), Housing First programmes, especially the three government pilots, have reported significant barriers when Housing First workers have attempted to support clients to access mainstream NHS services. Access to mental health services has been reported as especially challenging. The availability of Inclusion Health services, such as multi-disciplinary teams is of paramount importance in ensuring Housing First clients have access to the health and care services they need upon entry into Housing First.	Thank you for your support for these recommendations.

Crisis	Guidelines	22	11 - 15	'Everyone In' demonstrated that self-contained accommodation is significantly more preferable to congregate forms of accommodation, not least because of the public health implications of congregate accommodation during a pandemic. Mackie et al (2017) state that when it comes to congregate forms of accommodation such as hostels and night shelters (H&S), evidence indicates consistently that many (and perhaps the majority of) people who are homeless find H&S intimidating or unpleasant environments. Staying in hostels and shelters may have preferential health outcomes to living on the street. However, hostels and shelters can also contribute to poor health and even exacerbate certain conditions. For instance, the mortality rate varies from two times to eight times higher than the rest of the general population (based on studies from the USA, Canada, and Denmark). This is largely due to a combination of mental and physical health conditions that are prevalent amongst the homeless population, as well as a greater likelihood of problematic substance misuse. This may be further exacerbated by a sense of helplessness and loss of control in the H&S environment (47). A qualitative study of drug users in Bristol and London found that hostels and shelters could be a safe haven for injecting drug users, characterised as a retreat from the chaos of the street. However, they are also risky environments that facilitate drug use and risk individuals forming networks and transitioning to new patterns of use which may increase the	Thank you for your comment. The committee discussed that Housing First is an effective intervention to reduce homelessness and agreed with many of the principles highlighted in the model. However, the committee agreed that the evidence identified for this guideline did not show its suitability in improving access to, or engagement with health and social care, which was the objective of the review question. The committee discussed that there is huge variation in the fidelity of the housing first model and agreed not to specify it in the recommendations although many of the principles of the model are reflected in the guideline. Thank you for providing references, which have looked into and given reasons for their exclusion: Mackie et al. (2017). Ending rough sleeping: what works? An international evidence review. Crisis. A reference to this report was identified in our literature search but excluded at the title and abstract stage because it did not match the objective/phenomenon of interest for either reviews. Nyamathi, A. M., Leake, B. and Gelberg, L. (2000) 'Sheltered versus nonsheltered homeless women: Differences in health, behavior, victimization, and utilization of care', Journal of General Internal Medicine, 15(8), pp. 565–572. doi: 10.1046/j.1525-1497.2000.07007.x This study would not be included in the evidence reviews of this guideline because the study design does not match the inclusion criteria in the review protocols.

				frequency of injecting. Thus, for some people, rough sleeping was a safer option than temporary housing with regards to managing their drug use (48). The onset and/or escalation of drug misuse amongst residents is widely reported, the risk of communicable disease transmission high, and deterioration in mental health common (49). Living conditions in H&S vary, and large H&S have been particularly linked with poor health and well-being (50). Of concern is that large H&S are intimidating – especially for those with mental health difficulties or vulnerable to exploitation (51). Crisis therefore advocates moving towards a housing-led approach to homelessness as is already the case in Scotland and Wales. At the very least, and as the pandemic has highlighted, self-contained accommodation even if provided in hostels and shelters, has significant advantages over congregate accommodation. We would recommend that the NICE guidance is strengthened in this section to state that self-contained accommodation should be the default offer to people experiencing homelessness, unless it is identified that self-contained accommodation may be inappropriate or someone requires specific, specialist support that cannot be offered via self-contained accommodation.	Barrow, S. M. et al. (1999) 'Mortality among homeless shelter residents in New York City', American Journal of Public Health, 89(4), pp. 529–534. This study would not be included in the evidence reviews of this guideline because it does not match review protocol objectives/phenomenon of interest. Hwang SW (2000) 'Mortality among men using homeless shelters in toronto, ontario', JAMA, 283(16), pp. 2152–2157. doi: 10.1001/jama.283.16.2152. This study would not be included in the evidence reviews of this guideline because it does not match review protocol objectives/phenomenon of interest. Nordentoft, M. and Wandall-Holm, N. (2003) '10 year follow up study of mortality among users of hostels for homeless people in Copenhagen', BMJ, 327(7406), p. 81. doi: 10.1136/bmj.327.7406.8. This study would not be included in the evidence reviews of this guideline because it does not match review protocol objectives/phenomenon of interest. Briggs, D. et al. (2009) 'Injecting drug use and unstable housing: Scope for structural interventions in harm reduction', Drugs: Education, Prevention and Policy, 16(5), pp. 436–450. doi: 10.1080/09687630802697685. This study was was identified in our literature search but excluded at the title and abstract stage because it does not match the review protocol phenomenon of interest. Busch-Geertsema, V., Edgar, W., O'Sullivan, E. & ... (2010) Homelessness and Homeless Policies in Europe: Lessons from Research,

					Available from: http://noticiaspsh.org/IMG/pdf/4099_Homeless_Policies_Europe_Lessons_Research_EN.pdf. This study would not be included in the evidence reviews of this guideline because the study design is not included in the review protocols. May, J., Cloke, P. and Johnsen, S. (2006) 'Shelter at the margins: New Labour and the changing state of emergency accommodation for single homeless people in Britain', Policy & Politics, 34(4), pp. 711–729. doi: 10.1332/030557306778553150. This study would not be included in the evidence reviews of this guideline because the study design is not included in the review protocols.
Crisis	Guidelines	22	11 - 15	In this section, there is a reference to a range of accommodation types and the guidelines distinguishes between self-contained and accommodation with on-site support. We suggest this section is amended to note that in some areas, Housing First services are available and enabling enable people with high and complex support needs to move into self-contained housing while still receiving intensive wraparound support.	Thank you for your comment. The committee discussed that Housing First is an effective intervention to reduce homelessness and agreed with many of the principles highlighted in the model, and have stated those in the recommendations. However, the committee agreed that the evidence did not show its suitability in improving access to, or engagement with health and social care, which was the objective of the review question. The committee discussed that there is huge variation in the fidelity of the housing first model and agreed not to specify it in the recommendations.

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Crisis	Guidelines	24	9 - 10	We strongly welcome this section that makes the case for long term support. However, in order for this to become common practice, this long-term approach must be reflected in approaches to commissioning. We would recommend the committee state that commissioning must reflect this need for long-term service provision and services should be commissioned on a medium-long term basis, to ensure these services' financial security.	Thank you for your comment. Commissioners are responsible for enabling care provision for people who need it regardless of contract lengths of individual providers. In the section on Commissioning and planning, the committee did recommend to consider the likely benefits of long-term contracts for providers. However, funding from central government may make this difficult but this is outside the remit of this guideline.
Crisis	Guidelines	30	20 - 22	We strongly welcome the second research recommendation around health and social care support related to housing. We would recommend that any research in this area includes Housing First, so that the evidence base on models of health and care support in Housing First programmes can be built upon.	Thank you for your support for this research recommendation. The committee have not made a change to this research recommendation because Housing First would already be included within the scope of the proposed research as it constitutes 'wrap around health and social care support that is integrated with housing'. This is perhaps made clearer in the detailed research recommendation, justification and PICO table, which can be found in appendix K of evidence review A&B.
Crisis	Guidelines	60	14 - 25	We welcome the committee looking at Critical Time Intervention, which we know can be an effective intervention in preventing or ending someone's homelessness. We would draw the committee's attention to the systematic review of CTI by Centre for Homelessness Impact (CHI), which found that when it came to discharge from institutions is CTI approaches can be effective in improving housing stability and reducing hospitalisations. It is important that we ensure we are looking at outcomes on transitions between settings, that we are focusing on evidence-based approaches that improve housing stability, given	Thank you for your comment and for providing this reference to a systematic review, which was identified in our search. The studies from the systematic review were checked against our protocol and included if relevant.

				that housing is a key indicator of health outcomes. Hanratty et al. (2020). Discharge programmes for individuals experiencing, or at risk of experiencing homelessness: a systematic review. Centre for Homelessness Impact.	
Crisis	Guideline	63	20 - 25	We welcome this research recommendation. We would recommend that any research on integrated approaches between health, social care, and housing considers whether joint commissioning between health, housing and social care, is itself associated with better provision of care and better housing/health related outcomes.	Thank you for your comment and your support for this recommendation. The committee have not made a change to this research recommendation because the issue you highlight would already be included within the scope of the proposed research. This is perhaps made clearer in the detailed research recommendation, justification and PICO table, which can be found in appendix K of evidence review A&B.

Crisis	Guideline Evidence A-B Evidence A-B	64 38 77	9 - 14 38 - 42 34 - 45	We are concerned about the committee citing evidence that links Housing First with increases in suicidal ideation and suicide attempts. This evidence is cited without placing the evidence in its wider context. We also believe the committee has misinterpreted the evidence cited. We would firstly like to draw the committee's attention to evidence that suggests that suicidality actually decreases upon entry into Housing First, as cited by Mackie et al (2017), albeit the reductions are similar to Treatment as Usual: Collins, S. E. et al. (2016) 'Suicidality Among Chronically Homeless People with Alcohol Problems Attenuates Following Exposure to Housing First', Suicide and Life-Threatening Behavior, 46(6), pp. 655–663. doi: 10.1111/sltb.12250. It must also be remembered that homelessness is itself associated with significant increases in suicide risk, with people experiencing homelessness over nine times more likely to commit suicide than the general population (57). As Mackie et al report, the quality and quantity of evidence associated with Housing First is far superior to other homelessness accommodation interventions (such as hostels and shelters), and all evidence points to significant improvements in housing stability and tenancy sustainment, effectively ending someone's homelessness. Importantly, the study cited by the committee on suicidal ideation and Housing First (Aquin et al,	Thank you for your comment, in response to which analysis of the two papers in question has been revisited and discussed with the guideline committee. Baseline data from Aquin 2017 was used to assess baseline differences between intervention groups when assessing the risk of bias arising from the randomisation process. Although the data from the paper indicates a drop from baseline in both arms, the guideline technical team sought to analyse between group effects rather than within group effects. In response to your comment the text in the evidence review has nevertheless been revised for greater clarity. Where the result on suicidal ideation is discussed, even greater emphasis has now been placed on the fact that there was no difference at earlier time points. It should now be clear that the result at one time point should not be seen in isolation. The author's more sophisticated modelling analysis is acknowledged, however these type of data are not usually extracted when aiming to conduct meta-analysis. For the outcome of suicide attempts, whilst the effect estimate is above the cut-off point determining clinical significance agreed a-priori (1.25), the 95% CI crosses the line of null effect (RR 1.3 [0.99 to 1.71]), therefore, we have removed the text from the Summary of the evidence section where previously it was stated

				2017) does not reach the conclusion that Housing First is associated with higher levels of suicidal ideation or suicide attempts than Treatment as Usual. Rather, the conclusion they reach is that research fails to find evidence that Housing First is superior to Treatment as Usual in reducing suicidal ideation and attempts. The researchers suggest that while Housing First should not be used solely as a mechanism to decrease suicidal behaviour, its previously demonstrated positive effects on quality of life and housing stability may set the stage for improved long-term follow-up and enhanced access to care. Similarly, both intervention and control groups experienced similarly significant drops in suicidal ideation over the course of the two-year study. This is a very different reading to the one in the NICE guidelines. The evidence on suicidal behaviour referred to is drawn from a Randomised Control Trial (RCT) in Canada (Aquin et al., 2017); the evidence on mortality from an RCT in France (Tinland et al., 2020). The claims regarding risk of harm are based on incorrect and misleading interpretations of this evidence. In short, the analysis presented focusses entirely on a few basic descriptive statistics showing point-in-time differences in outcomes for people receiving Housing First (known as the 'intervention' group) and those who are not (the 'control' or 'treatment as usual' group). Critically, no account is taken of the more sophisticated	that the result suggested there may be a harmful effect although there is uncertainty around the estimate. Upon further investigation of the outcome data on 'suicidal ideation' from Aquin 2017, discrepancies were noted in the reporting of people randomised to each arm (i.e. the denominator) and the percentage values reported in table 2, which might explain the difference in conclusions between analysis for the guideline and that of the study authors. The presented analysis in evidence review A/B follows Cochrane's preferred methodology of using the intention to treat principle, which shows the results as clinically important at 24 months only but not at earlier timepoints. However, the guideline technical team and the committee recognise the limitations of this approach, which assumed that people without an outcome measure would all not have the outcome. Discrepancies were noted in the reported data on mortality from Tinland 2019, who conclude no significance between the two arms. However, when the relative risk was calculated (authors do not report this), the result showed a significant difference (p=0.04) favouring treatment as usual over housing first. The authors report a p value of 0.056 but it is unclear how they calculated this value. In light of your comment, the narrative description of results in Somers 2017 has been reviewed and the technical team were able to extract additional data and add them to to the meta-analysis. Although the effect estimate of

				modelling analysis reported in the papers which assesses whether the outcomes documented are in fact a result of the intervention or are due to 'confounding' factors (such as someone's mental or physical health status at the point they start receiving Housing First, for example). The conclusions drawn by the papers' authors regarding whether there is in fact a relationship between the intervention and outcomes, and potential causality, have been ignored. Specifically, on the issue of suicidal ideation, Aquin et al. (2017) conclude from the Canadian study that "both intervention and control groups experienced similarly significant drops in suicidal ideation over the course of the 2-year study" (p.477). Any differences between the two (Housing First and Treatment as Usual) groups were not statistically significant, and in any case were largely accounted for by differences in participants' psychiatric state at baseline (i.e. the start of the trial). Even if there had been a statistically significant difference, that would have indicated that clients receiving Housing First experienced a slower reduction in suicidal ideation than those who did not. Regarding suicide attempt, Aquin et al. (2017) conclude on the basis of their regression modelling (which takes account of potential confounding factors) that there was "…no significant relationship between intervention status [i.e., whether an individual received Housing First or Treatment as Usual] and suicide attempts" (p.477).	the now pooled data is lower than for Tinland data alone, the result is statistically significant and clinically important, according to the methodology agreed a priori for this review. However, the limitations of this result are acknowledged in the report and with the wide confidence intervals, close to the line of no effect, the committee was unconvinced about there being an association between Housing First and suicidal ideation or mortality. This has been explained more clearly in the committee's discussion of the evidence section of the review. The committee discussed that Housing First is an effective intervention to reduce homelessness and agreed with many of the principles highlighted in the model. However, the committee agreed that the evidence did not show its suitability in improving access to, or engagement with health and social care, which was the objective of the review question. The committee discussed that there is huge variation in the fidelity of the housing first model and agreed not to specify it in the recommendations although many of the principles of the model are reflected in the recommendations. It is important to note that although the committee noted the results from the analysis of outcome data on suicidal ideation, this was not a finding that informed recommendations and therefore this text has been removed from the guideline rationale section. The findings did

				The committee have also cited concerns about Housing First and mortality. On this issue, more deaths were recorded amongst Housing First than Treatment as Usual clients (23 vs. 11) in the French study, but this difference is not statistically significant (Tinland et al., 2020). It is also notable that in a later paper documenting more detailed analyses of these same figures (which was published very recently hence was not included in the evidence review) the researchers conclude that "Due to important limitations, we cannot conclude on Housing First effect on mortality" (Tinland et al., 2021, p.2). These limitations included the small number of deaths overall which severely limited the statistical power of analysis, the fact that a few people in the Housing First group died before receiving Housing First, and potential that deaths in the Treatment as Usual group may have been under-reported. That said, the authors make some useful observations regarding the timing and cause of deaths amongst Housing First clients, including: more than one third occurred during the first six months after being housed, and half were due to overdose, suicide or accident other than overdose (with the others caused by cancer, cardiovascular or liver disease, infection, or other natural causes). Outputs from these two RCTs (and many other studies beside) emphasise that: a) homeless people (and especially the subpopulation targeted by Housing First) are at disproportionate risk of both suicidal behaviour and premature	however prompt an interesting discussion around the strong feelings of isolation, loneliness and stress that can be experienced after a move to independent accommodation. In the committee's experience this can be an isolating step for someone recently experiencing homelessness and the evidence highlighted the crucial importance of providing emotional and practical support throughout and following the move. Committee members with lived experience of homelessness corroborated this and agreed that emotional and practical support are crucial in these circumstances

				death as compared with the general population; and b) their vulnerability to these things persists after access to independent housing (even when supported by an intervention like Housing First). This being so, Tinland et al. (2021, p.10) recommend greater promotion of harm reduction for homeless people affected by addiction (including the use of naloxone), more effective primary prevention of homelessness, and earlier intervention for those who experience homelessness. Aquin et al. (2017, p.480) emphasise that clinicians should remain cognisant of the high prevalence of suicidality amongst the homeless population and not reduce their index of concern for suicidal behaviour when engaging with the participants of Housing First programmes. We would strongly urge the committee to look again at this section, and to carefully consider how to report upon Housing First and suicidality in a measured way, that balances the various pieces of evidence on suicidality, and also balances the evidence on suicidality with the evidence on Housing First's wider benefits regarding health outcomes and tenancy sustainment. We would recommend that the committee ideally remove these lines from the guidelines. References: Aquin J, Roos L, Distasio J et al. (2017) Effect of Housing First on suicidal behaviour: a	

				randomised controlled trial of homeless adults with mental disorders. The Canadian Journal of Psychiatry, 62(7): 473-481. Open access from https://journals.sagepub.com/doi/full/10.1177/0706743717694836. Somers J, Moniruzzaman A, Patterson M, et al. (2017) A randomized trial examining Housing First in congregate and scattered site formats. PLoS ONE, 12(1): e0168745. Open access from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0168745. Tinland A, Loubière S, Boucekine M, et al. (2020) Effectiveness of a housing support team intervention with a recovery-oriented approach on hospital and emergency department use by homeless people with severe mental illness: a randomised controlled trial. Epidemiology and Psychiatric Sciences, 29, e169, 1–11. Open access from https://doi.org/10.1017/S2045796020000785. Tinland A, Loubière S, Cantiello M, et al. (2021) Mortality in homeless people enrolled in the French housing first randomized controlled trial: a secondary outcome analysis of predictors and causes of death. BMC Public Health. 21: 1294 Open access from https://doi.org/10.1186/s12889-021-11310-w.	

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Crisis	Guideline	64	19 - 24	We welcome the committee's acknowledgement that the wraparound support associated with Housing First is variable and sometimes lacking. However, we would recommend that the committee make it clear that this is not necessarily a problem with the Housing First model, but rather the accessibility of health and social care services. Most Housing First programmes in the UK operate using Intensive Case Management or case management approaches, rather than Assertive Community Treatment. This is primarily because we have a free at point of access healthcare system, that in theory everyone should be able to access. However, as noted in Crisis' report 'Home for All: the case for scaling up Housing First in England' (2021), Housing First programmes, especially the three government pilots have reported significant barriers when Housing First workers have attempted to support clients to access mainstream NHS services. Access to mental health services has been reported as especially challenging. We would recommend that these guidelines state that mainstream NHS health and social care services have a vital role to play in Housing First provision, and that commissioners and providers of these mainstream services must ensure they are accessible for Housing First clients. We would also recommend that NICE guidelines state that Housing First programmes	Thank you for your comment, which has been discussed with the committee. The comment refers to the section 'how recommendations may affect practice or services', which generally discusses the resource impact that a recommendation may have. As such, the discussion around the variability of wraparound services is not necessarily only a problem with the Housing First intervention, but a larger problem within health and social care services. Thank you for your suggested recommendations about increasing the involvement of health and social care services in Housing First provision. The committee discussed that Housing First is an effective intervention to reduce homelessness and agreed with many of the principles highlighted in the model. However, the committee agreed that the evidence did not show its suitability in improving access to, or engagement with health and social care, which was the objective of the review question. The committee discussed that housing was not within the remit of this guideline and therefore they could not recommend or comment on improvements or changes to the Housing First program.

				explore the need for healthcare professionals to sit directly on Housing First teams, as is the case in various programmes such as Greater Manchester, where four dual diagnosis workers have been hired in order to overcome some of the barriers to healthcare. Joint commissioning between health, social care, and housing is especially important in this context.	
Depaul UK	Guideline	20	8	We suggest that a sentence is added to the guideline, suggesting that intermediate care settings may be delivered jointly by primary care trusts and specialist homelessness support agencies. Depaul jointly delivers a homelessness Out of Hospital Project with the Salford Inclusion Health Team, with funding from the NHS and Greater Manchester Combined Authority. This service shows the potential benefits of joint integrated delivery. Depaul delivers the accommodation and supports the residents, while the Inclusion Team provides health care and links residents in with other health services. This has delivered good health outcomes for residents, while making efficient and cost effective use of homelessness/primary care resources and expertise. Many of the people who have benefitted from the service have had multiple and complex support needs. It is a nine bed project, which has provided accommodation, support and care to 25 people	Thank you for your comment. There was no evidence identified about who delivers intermediate care and the committee did not think this specification was needed in the recommendation. Thank you for providing an example of a successful initiative on intermediate care for people experiencing homelessness, that is encouraging to hear.

				since the first resident moved entered the project in June. Working as both a step-up and step-down project, it has supported people who are Covid positive to isolate after leaving hospital, as well as people with a wide variety of other health issues that could not be managed in the community but did not or no longer required an in-patient stay in hospital. Move-on from the project has been positive in the majority of cases, with most people moving-on into supported accommodation or private rented accommodation when their health allows it. Feedback on the project from local authority and health stakeholders has been universally positive. Depaul UK has prepared a short-impact paper on the project, which we would be pleased to share.	
DHSC - Office for Health Improvement and Disparities	General	General		The guideline could be more effective in homelessness prevention if there it recognised that there are those whose homelessness is identified whilst in hospital and prison settings, including those who become homeless for the first time whilst in these settings. This is reflected in relevant sections eg, on discharge, intermediate care, but not in the introductory section.	Thank you for your comment. The committee understands and agrees with you about the importance of prevention of homelessness, however, the focus of this particular guideline is on improving access to and engagement with health and social care for people experiencing homelessness, not on prevention of homelessness. The scope of the guideline, which was published in December 2020, specifically excludes people staying in institutions in the long-term and therefore people leaving prison or hospital who are at a risk of becoming homeless is not a focus of this guideline. That said, in light of your comment, it has now been made explicit

					in the guideline that it does include people who are newly homeless.
DHSC - Office for Health Improvement and Disparities	General	General		Preferable to refer to 'social care and support' throughout the document, not just social care; social care implies care such as help to get washed, dressed, eat; these are not the only activities that enable people to live independently and the Care Act 2014 provides for these wider activities. These needs are reflected in the accompanying 'care **and support'** statutory guidance https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance	Thank you for your suggestion, which the committee discussed. They concluded that it is already well established, not least on the basis of the Care Act 2014, that the concept of social care includes 'support' as a key element and they therefore did not make any additional references to 'care and support' than already appeared in the draft guideline.
DHSC - Office for Health Improvement and Disparities	Guideline	General		**Q1 - Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.** Workforce development – frontline workers and commissioners – would have the biggest impact, but there is a significant shortfall in the health and care workforce, and in local authority commissioning for people experiencing homelessness. The homelessness workforce is experienced in supporting individuals whose health and care needs are often not assessed or met: more investment in this workforce so that they are recognised for their competence in supporting people by the health and care workforce (and may progress into professional roles in these	Thank you for your comment. The committee agree that there will need to be some workforce development. They acknowledge that there is variation in practice. Still, the committee was of a view that most agencies regularly train their staff but agreed that training on some issues relevant to homelessness, such as legal duties and powers, is not common practice for all services. The committee envisaged that such additional training could be delivered alongside existing staff training programmes in various low-cost ways, for example, by remotely using pre-recorded sessions, and could coincide with existing training. There are also various publicly available and free-of-charge materials and resources already available. The committee have also acknowledged that recruitment may be

				sectors) is needed. Health Education England, Skills for Care and Skills for Health could all play a part in supporting integration in this respect. Tools to support the workforces to integrate – to 'wrap around' the person – are needed to underpin consistent quality responses. As an example, enabling the adoption of a common approach to assessment, recognised by all professionals working with someone experiencing homelessness, for those identified as at risk and in likely need of safeguarding would be beneficial (akin to the approach taken to children and young people – the early help assessment). This requires a national approach in policy and funding. As a whole the guideline will have greater impact if other NICE guidelines referenced are updated to link to this new guideline.	challenging in some areas. However, the committee believed that it might be easier to recruit staff to junior roles and provide on-the-job training. The committee agree that issues around staff availability may impact the implementation of this guidance, and your comment will be passed to the NICE team, which plans implementation support. The committee agree that more investment in this workforce is required. However, NICE is not involved in funding decisions. But it is hoped that this guideline, including guidance for commissioners, will impact service design and delivery, discussions around workforce development, and additional funding, as needed, will be negotiated to implement the recommendations. Also, the effective use of NICE guidance will hopefully reduce variation in practice across the country. It is a general practice to cross-refer to other NICE guidance, and any future NICE guidelines or guideline updates will refer to this guidance as appropriate.

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DHSC - Office for Health Improvement and Disparities	Guideline	General		**Q2 - Would implementation of any of the draft recommendations have significant cost implications?** Suggest this is something OHID in role as topic adviser could provide additional input on. Page 34 lines 20 onwards asserts that there would not be a significant resource impact but it's unclear how this is evidenced, for whom this is true and how this relates to the availability of resources to direct towards delivering this guideline alongside other priorities in localities, health and care organisations. Line 23 recognises that practice is variable: for this to stop being the case requires the development and adoption of workforce competencies and tools to develop and underpin practice. If this is to be done at a local level the likelihood it variation will continue, not to mention the huge duplication in investment. There are cost implications associated with all of the recommendations, from educating and training the health, care and homelessness workforces, to developing and increasing capacity in local commissioning, to conducting quality health needs assessments and delivering integrated assessments of an individual's health, care and support and housing needs, to the workforce spending longer periods of time with individual's in order to develop relationships.	Thank you for your comment. The recommendations on general principles reflect good practice points that the committee discussed and identified based on their expert experience. The committee was of the view that these things should be happening across all services for people experiencing homelessness. However, the committee have acknowledged that practice is variable, so this may represent a change in practice for some services. The committee agree that the availability of resources may be an issue, and where possible, this has been discussed along with associated cost implications. For example, longer contact times may mean lower caseloads, meaning that services will have to recruit more staff. The committee acknowledged that this might be challenging in some areas. Economic analyses were also conducted as part of the development of the guideline and these suggested that lowering caseloads could be cost effective. However, the committee's view was that the availability of trained staff should not be a barrier; for example, services may find it easier to recruit staff to junior roles and provide on-the-job training. Similar considerations are made throughout the guideline. The guideline also highlights that generally, such investments would represent value for money. Your comment will be forwarded to the NICE team, which plans implementation support. The committee also agree that there may be other priorities for funding. However, NICE is not

					involved in sectorial funding decisions. Also, as suggested, it was acknowledged in the committee discussion of the evidence section of review A&B that if outcomes are poorer due to local variations, a variation in provision and funding may be needed to achieve equitable outcomes. In response to your comment on the development and adoption of workforce competencies and tools to develop and underpin practice, the committee make recommendations to commissioners on planning and commissioning at a more strategic level, e.g. by commissioning groups coming together to form partnerships. The committee also made recommendations on staff support and development, which should ensure staff competencies are at a level suitable for their professional role.

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DHSC - Office for Health Improvement and Disparities	Guideline	General		**Q3 - What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)** **National resources and support rather than an expectation that localities have the resources to shift to the model described.** A programme of support for localities to develop their approaches to integration would be useful; the Care Act 2014 was supported by an implementation programme but this did not focus on people experiencing homelessness. Would be helpful if there was a recommendation for research to understand how best to enable housing circumstances to be effectively captured by health and care professionals so that this triggers an appropriate response eg, referral to LA housing options, and enables local assessments of needs, and informs national policy making	Thank you for your comment. The committee made recommendations for commissioners at a more strategic level which will hopefully influence the support at a higher level, e.g. Integrated Care Systems or by these coming together to form partnerships. Your comment will also be passed your comment to the NICE team, which plan implementation support. The committee made a research recommendation looking at structural and systems factors that help or hinder the commissioning and delivery of wraparound health and social care integrated with housing which may answer the research question you have posed. The committee also believe that if implemented effectively, this guidance that aims to improve the integration of health and care for people experiencing homelessness will hopefully trigger the type of responses and pathways you describe. The committee also recommend that health and social care providers improve the recording of homelessness status for care provision and audit, which will hopefully be informing national policymaking too.

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DHSC - Office for Health Improvement and Disparities	Guideline	General		**Q4 - 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.** COVID-19 remains a threat for everyone, and for people experiencing homelessness, vaccinated or otherwise. Understanding an individual's health and the associated risk of serious illness from COVID-19 is important for all professionals working with an individual – including in ensuring that housing is suitable eg, it is self-contained. The guideline could say more on the need for integrated assessments of health, care and housing needs to recognise this. COVID-19 has meant that a hospital stay is not necessarily the opportunity it was to intervene; there are pressures across the system that mean there's a greater focus to move people on from admissions (to UEC and in-patients) quickly; the Discharge to Assess or 'Home First' model is recommended and this is likely to remain the case post Health and Care Bill enactment. It is more essential that services exist to prevent hospital attendance and admission (where this isn't appropriate) and for intermediate care options to be available to prevent discharge to the street and to allow appropriate time for an individual's needs to be assessed holistically.	Thank you for your comment. The guideline focuses on health and social care thesection on assessing people's needs focuses on these instead of assessment of their housing needs. However, the committee have revised the recommendations to state that the assessment should take into consideration people's housing and benefits situation. There are also recommendations around recognising the need for a range of accommodation types suitable for the varied needs of people experiencing homelessness, such as self-contained accommodation. The committee also recommend using a multidisciplinary approach to enable a comprehensive and holistic assessment of their needs. A multidisciplinary approach could include housing options officers or homelessness prevention officers, and would include considering housing needs. There are recommendations to support access to services, e.g. outreach, low-threshold services, drop-in services that will hopefully prevent hospital attendance and admission in the first place. The committee also made recommendations on intermediate care and supported discharge. They hope that these recommendations will address some of the concerns you raise and improve the care for people experiencing homelessness, whether at a time of global pandemic or not. Your comment will be passed to the NICE team, which plan implementation support.

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DHSC - Office for Health Improvement and Disparities	Guideline	General		There's no reference to the transition from prison to the community, nor any indication that this was excluded from the scope of the guideline. This transition would significantly benefit from the recommendations made in the guideline and to not recognise this would be a missed opportunity to address a well-known problem. There's one reference to 'custody' in the document and this also isn't sufficiently defined (comment made elsewhere in this response).	Thank you for your comment. People staying in institutions (such as prison) in the long term were not covered by the guideline, as stated in the scope of this guideline published in December 2020. However, the committee recognise that people experiencing homelessness may end up in custody (i.e. imprisonment) and when released end up homeless again. The evidence reviews or this guideline did not provide evidence with which the committee could make recommendations exclusively about this situation. However in recognition that this is often a very challenging transition they included it in the general section on 'transitions between different settings, which is intended to cover a range of transitions including leaving custody.
DHSC - Office for Health Improvement and Disparities	Guideline	General		The guidelines support vertical integration for people experiencing homelessness but misses the many opportunities that exist to integrate health, care and support **and** housing/homelessness (horizontal integration). For example the section on 'assessing people's needs' doesn't recommend that assessments should cover all these aspects, nor involve the homelessness workforce in this process (this is a well known barrier). Section 1.9 on housing with health and social care support doesn't cover the gaps (Page 22 line 1) Page 41 Line 26 onwards describes challenges presented by the different health and care legislation but fails to acknowledge the challenges presented by the differences between	Thank you for your comment. The focus of this guideline is on improving access to and engagement with health and social care services among people experiencing homelessness and not on housing provision or allocation. However, the guideline does aim to promote integrated planning and working across health, social care and housing. The committee has revised the recommendations on for example assessing people's needs to state that the assessment of their health and social care needs should be done in the context of their housing and benefits situation. The recommendations also say that the multidisciplinary assessment should include people who have detailed knowledge of the person's health and social care needs and the committee have now made it explicit that these may include people working in homelessness or

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				health, care and housing legislation, for example definition of vulnerability.	housing services. They have revised the text to state that health, social care and housing services have different legislative frameworks without going into detail about what these different frameworks are.
DHSC - Office for Health Improvement and Disparities	Guideline	General		To maximise impact of the guideline, recommendations and content generally should be reviewed to ensure language/definitions 'speak' to the way in which health and care services are/should be delivered for the general population. For example 'personalised care' (https://www.england.nhs.uk/personalisedcare/) is only mentioned once in the document, yet it's a way of working that would significantly benefit the population of people experiencing homelessness. Another example is 'care co-ordination' – a facet of personalised care, the guideline instead refers only to care navigation and key/case workers.	Thank you for your comment. The language used in the guideline has been carefully considered. The committee that wrote the recommendations consists of a mixture of people working in social care, homelessness hostels, outreach, mental health, primary and secondary care and people with lived experience of homelessness. The #HealthNow peer network were also consulted on the draft guideline and specifically asked about the language of the recommendations. Some revisions to the language were made based on their and other stakeholder's comments. Definitions for many of the terms used in this guideline have also been added in case they are unfamiliar to some readers or we want to clarify what the meaning of the term is in the context of this guideline.
DHSC - Office for Health Improvement and Disparities	Guideline	General		King's Fund Going Above and Beyond report	Thank you.

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DHSC - Office for Health Improvement and Disparities	Guideline	General		In relation to the communication and information approaches identified **1.1.8**, the Region supports the intentions within this proposal. However, we would recommend that this communications approach should be centred in the integrated personalised care model. This would emphasis stronger collaborative and person centred care and collaboration to address a person's needs. (comment from Gina Skipwith, OHID)	Thank you for your comment. The whole guideline is centred in an integrated model of service design and provision, which take into account the individual's needs and circumstances. The committee do not think this needs specifying here.
DHSC - Office for Health Improvement and Disparities	Guideline	General		**1.2.8** Planning and commissioning – due to the ongoing challenges seen with GP registration associated with homeless individuals, we recommend that this section is given a higher profile with a stronger national message to support reducing the issues (comment from Gina Skipwith, OHID)	Thank you for raising this. Although the committee did not make a change to this specific recommendation, they did make changes to other recommendations in response to yours and other stakeholder comments. In particular, they stated that when people experiencing homelessness are given information about how to access primary health services, this should include their right to GP registration, even without a permanent address. As well as the recommendation you mention, the committee had also already made a recommendation directed at primary care service providers that they should ensure people without an address can register with a GP practice and that this is in line with NHS policy. The committee feel that on balance they have made the point in the strongest terms they could.

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DHSC - Office for Health Improvement and Disparities	Guideline	General		**1.2.5** Planning and commissioning – the tackling of homelessness along with other broader health inequality challenges through a population health management approach should be emphasised as part of the guidance (comment from Gina Skipwith, OHID)	Thank you for your comment. The committee agree with you and have added reference to social determinants of health to the recommendations, recognising that commissioners have a broader duty to address health inequities and contribute to the delivery of the wider health equity agenda.
DHSC - Office for Health Improvement and Disparities	Guideline	General		**1.3.2** The multi-disciplinary approach is supported. Is there any opportunity within the guidance to showcase joint appointments between health and local authority sectors within this space? Within the multi-disciplinary working approach, is there also an opportunity to emphasise that local authority/public health colleagues within systems need to be at the forefront of these teams with the health services being a key partner in tackling this issue moving forward? (comment from Gina Skipwith, OHID)	Thank you for your comment. Integrated working could mean joint appointments, if considered appropriate, however, this has not been specified in the recommendations. The committee's view was that public health personnel from the local authority might not always be relevant in the homelessness multidisciplinary teams which offer case management and wrap around support directly to people. However, they would certainly often take part in local homelessness health and social care needs assessments.

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DHSC - Office for Health Improvement and Disparities	Guideline	3	8	None of the subsequent definitions of homelessness include people who are in prison or hospital and will become homeless on release/discharge.	Thank you for your comment. The population of the guideline was determined based on a scoping exercise including stakeholder consultation (the scope was signed off and published in December 2020). It was agreed at the time that people at risk of homelessness were not included in the population definition of this guideline, and indeed excluded people staying in institutions in the long-term. The exception being people who have a history of homelessness and continue to be at high risk of returning to homelessness due to ongoing complex health and social care needs. Also, people who have recently left institutions and are now homeless are included in the population of this guideline. The population of the guideline was agreed after careful consideration to manage the scope of the guideline.
DHSC - Office for Health Improvement and Disparities	Guideline	3	009 - 014	The use of 'are' in the definitions suggests that the guidelines may not be relevant to those who are 'at risk' of these circumstances – this would include people who may become homeless for the first time whilst in prison or hospital	Thank you for your comment. The committee recognise the risk of homelessness for people in prisons or hospitals. However, the guideline's scope (published in December 2020) defines the population of this guideline and indeed does not include people at risk of homelessness, with the exception of those with a history of homelessness with a high risk of returning to homelessness due to ongoing complex health and social care needs. The scope specifically states that the does not cover people staying in institutions in the long-term. The population of the guideline was agreed after careful consideration to manage the scope of the guideline.

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DHSC - Office for Health Improvement and Disparities	Guideline	3	22	Preferable to refer to 'social care and support needs', not just social care; this implies care such as help to get washed, dressed, eat; these are not the only activities that enable people to live independently. The Care Act 2014 provides for these wider activities, and this is reflected in the accompanying 'care **and support'** statutory guidance https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance	Thank you for your comment. The committee think that it is established that the concept of 'social care' already includes support as a core element and therefore they have agreed not to add "support".
DHSC - Office for Health Improvement and Disparities	Guideline	4	21	Barriers do not include the thresholds applied (related to available funding) once eligible needs have been determined (someone may have eligible care needs, but limited resources locally may mean these are not met). These funding thresholds are also a contributory factor in individuals' not being able to access an assessment; professionals decide that an individual's needs will not be high enough to warrant public funded services.	Thank you for your comment. The committee discussed this but did not think revising the text is needed. The committee understand that resource pressures may mean that not all needs for care and support meet eligibility thresholds. The guideline recommends the inclusion of local authority social workers as part of the homelessness MDT and as such, part of the assessment of need and the use of the Care Act in determining care and support needs. The MDT approach the committee recommend aims to bring an approach to assessment that is informed by the intersection of needs framed in legislation such as the Care Act and a person's homelessness.
DHSC - Office for Health Improvement and Disparities	Guideline	4	23	Could add reference to thresholds alongside to 'strict eligibility criteria' Barriers do not include the thresholds applied (related to available funding) once eligible needs have been determined (someone may have eligible care needs, but limited resources locally may mean these are not met). These funding	Thank you for your comment. The committee discussed this but did not think revising the text is needed. The committee understand that resource pressures may mean that not all needs for care and support meet eligibility thresholds. The guideline recommends the inclusion of local authority social workers as part of the

				thresholds are also a contributory factor in individuals' not being able to access an assessment; professionals decide that an individual's needs will not be high enough to warrant public funded services.	homelessness MDT and as such, part of the assessment of need and the use of the Care Act in determining care and support needs. The MDT approach the committee recommend aims to bring an approach to assessment that is informed by the intersection of needs framed in legislation such as the Care Act and a person's homelessness.
DHSC - Office for Health Improvement and Disparities	Guideline	5	11	The Housing Act 1996 is the primary homelessness legislation; this has been amended by subsequent legislation eg, the Homelessness Reduction Act 2017. Would be better to reference the Housing Act 1996 and/or 'homelessness legislation; and link to https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/overview-of-the-homelessness-legislation	Thank you for your comment. The suggested change has been made.
DHSC - Office for Health Improvement and Disparities	Guideline	5	23	Integration is not an end in itself: be helpful to reinforce in this line that it is a means to improved outcomes for people experiencing homelessness with health, care and support needs. Eg, 'integrating services as much as possible as a means to improved outcomes for individuals'	Thank you for your comment, the text has been revised as suggested.

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DHSC - Office for Health Improvement and Disparities	Guideline	6	16	PIE and trauma informed care are not the same thing and both should be considered together – suggest replace 'or' with 'and'	Thank you for your comment, the recommendation has been revised to say "and" instead of "or".
DHSC - Office for Health Improvement and Disparities	Guideline	7	10	Section 1.1.7 could do with explicitly referencing self-neglect: it's mentioned in the detailed section but not evident in any recommendations	Thank you for your comment. Whilst self-neglect is often used and is a term used within legislation, it was considered a term that can be perceived as judgmental and therefore its use in this recommendation was avoided. It is however mentioned in the rationale section. The committee agreed to make reference to it in a revised recommendation in the Safeguarding section.
DHSC - Office for Health Improvement and Disparities	Guideline	9	1	Add 'and social care'	Thank you for your comment, this has been added.
DHSC - Office for Health Improvement and Disparities	Guideline	10	21	**P. 10 line 21 'consider using long-term contracts for providers'** – this is entirely dependent on the length of the grants awarded for the services. Short term grants do not enable service planning or any job security causing difficulties in recruitment, therefore we would be advocating longer term grants to enable long-term contracts for providers for more stability within services(comment from Gina Skipwith, OHID)	Thank you for your comment. The committee agree that this can be a problem and can be a significant barrier to service provision and care continuation. They revised the recommendation slightly, which will hopefully help to address this issue by stressing the likely benefits of long-term contracts.

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DHSC - Office for Health Improvement and Disparities	Guideline	11	16	**P. 11 line 16 1.1.9 'Consider reducing caseloads and lengthening contact time for health and social care practitioners working with people experiencing homelessness to enable them to use approaches that sustain engagement with services '** – caseloads are increased across the service due to limited capacity and resources therefore very difficult to reduce the caseloads and contact time whilst improving service delivery and enhanced recovery with a flexible agile approach for this vulnerable complex group without increasing waiting lists/service pressures further(comment from Gina Skipwith, OHID)	Thank you for your comment. The committee agree and have explained in the rationale that lower caseloads will mean that services will have to recruit more staff, which might be challenging. This also implies that more funding will be required. However, NICE is not involved in funding decisions. Economic analysis was undertaken to support this recommendation, which indicated that lower caseloads represent value for money. The committee hope that commissioners, planners, and providers will take note of this and appreciate that smaller caseloads and longer contact time are essential to facilitate trusting relationships, improve engagement with health and social care, and ultimately lead to improved outcomes and sustained outcomes recovery in this underserved population. Your comment will be passed to the NICE team, which plans implementation support.
DHSC - Office for Health Improvement and Disparities	Guideline	11	19	This section on models of multidisciplinary service provision does not specifically reference the role of a lead professional/care co-ordinator/key worker; this is evidenced for other populations but possibly not picked up in this guideline as it's also not inclusive of the role of the homelessness workforce, and it's here that these workers are typically found. Without an individual who is recognised by the individual experiencing homelessness as the person who will support and advocate for them, enabling co-ordination of assessment and services, the MD approach isn't necessarily effective.	Thank you for your comment. The committee agreed with your point and changed a recommendation in this section, stating that person-centred case management should be offered by a designated practitioner within the multidisciplinary team to ensure continuity of care for as long as it is needed by the person.

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DHSC - Office for Health Improvement and Disparities	Guideline	12	28	Be more specific than 'homelessness leads': presumably mean local authority homelessness leads	Thank you for your comment. A definition of "homelessness leads" has now been added to the Terms used in this guideline section to avoid confusion. It does not mean local authority homelessness leads but people working in mainstream health and social care services who as part of their role lead on homelessness issues within their service.
DHSC - Office for Health Improvement and Disparities	Guideline	13	2	'allied social care' should be 'allied health'	Thank you for your comment. The term has been removed as it is not widely recognised. Allied health professionals are included in the "healthcare professionals" bullet. The wording in the list has been revised for clarity.
DHSC - Office for Health Improvement and Disparities	Guideline	13	18	Define 'homelessness leads'	Thank you for your comment; a definition to the Terms used in this guideline section has been added.
DHSC - Office for Health Improvement and Disparities	Guideline	15	8	There's no reference in the list of recommended approaches, or in the rationale section, as to the role of health and care, or other, personal budgets.	Thank you for your comment. The items in this recommendation are the different ways in which engagement with health and social care could be improved or enabled. The issue of personal budgets did not emerge from the evidence or from the committee's own knowledge so it is not listed here as one of the suggested strategies. That said, the list only provides examples of such strategies and is not intended to be exhaustive.

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DHSC - Office for Health Improvement and Disparities	Guideline	16	1	Either add 'or care co-ordination' and/or make this an explicit recommendation/definition – this is how the NHS can refer to what is defined on page 26 line 8 where there is a lead professional/key worker (this is recommended elsewhere in the guideline document)	Thank you for your comment. However, here the committee specifically mean care navigation and not care coordination. In this recommendation, they only describe options for the design and delivery of services in a way that reduces barriers to access and engagement, i.e. the committee do not attempt to describe the pathway.
DHSC - Office for Health Improvement and Disparities	Guideline	16	19	There are no recommendations that suggest how someone may be identified and assessed as frailthere is's an assumption that people know to do this (so that then they can be considered as such).	Thank you for your comment. This guideline is not aiming to give detailed guidance about how to assess frailty and the expectation is that the multidisciplinary teams conducting a comprehensive assessment of the person's health and social care needs will have the needed expertise.
DHSC - Office for Health Improvement and Disparities	Guideline	16	20	'social care and support'; also suggest that you say 'long term health and care packages, including residential care and supported housing' – it's common for continuing health care to not be considered as relevant to this population, or for long term accommodation based-care	Thank you for your comment. The recommendation has been revised as suggested.

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DHSC - Office for Health Improvement and Disparities	Guideline	17	6	The Housing Act 1996 is the primary homelessness legislation; this has been amended by subsequent legislation eg, the Homelessness Reduction Act 2017. Would be better to reference the Housing Act 1996 and/or refer to 2'homelessness legislation' and link to https://www.gov.uk/guidance/homelessness-code-of-guidance-for-local-authorities/overview-of-the-homelessness-legislation	Thank you for your comment. In this recommendation, the committee wanted to highlight duties specific to the Homelessness Reduction Act 2017 such as the Duty to Refer. Elsewhere in the guideline where a more general point is made, your suggested wording has been used and a link provided to the suggested website.
DHSC - Office for Health Improvement and Disparities	Guideline	17	10	**P. 17 line 10 1.5.12 'Consider moving people up waiting lists for health and social care appointments if they are experiencing homelessness, taking into account that they may need higher levels of support and have disadvantages, including the risk of premature death'** all people should be seen in chronological order or on clinical need so need to ensure that although vulnerable this cohort of people still need to managed in line with others for an overall equitable service i.e. not moved up a waiting list just because they are homeless(comment from Gina Skipwith, OHID)	Thank you for your comment. However, individuals would be at the highest clinical risk if they are also experiencing homelessness because homelessness accelerates the deterioration of their conditions or escalates their clinical risk. The wording of the recommendation has been revised to make the point clearer. This recommendation is also in line with the NHS Constitution overarching principle of all NHS services being available to all, especially people experiencing homelessness who are most vulnerable to poor outcomes. This is also in line with Core20PLUS5, an NHSEI approach developed by the Health Inequalities Improvement Team to support NHS Integrated Care Systems to reduce health inequalities.

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DHSC - Office for Health Improvement and Disparities	Guideline	19	General	There's no reference in the section on 'assessing peoples' needs' to the importance of assessments also seeking to understand an individual's housing needs alongside health and care needs. This gap will significantly reduce the impact of recommendations if not addressed; there is plenty of evidence that supports this as a problem.	Thank you for your comment. This section specifically focuses on assessing people's health and social care needs. However, the committee recognise that their housing situation will have an impact on these. The committee have revised the recommendation to include consideration of the individual's housing and benefits situation. There are also recommendations on a comprehensive and holistic assessment and made some further additions to reflect that to fully integrate with other services, including housing, health and social care services, may need input from other services or vice versa. There is also a whole section on housing in relation to health and social care support.
DHSC - Office for Health Improvement and Disparities	Guideline	19	2	Housing professionals also have relevant duties – to support true integration this should be reflected in these guidelines	Thank you for your comment. This guideline focuses on health and social care needs and services and therefore the committee have not specified duties of housing professionals here.
DHSC - Office for Health Improvement and Disparities	Guideline	19	13	Homelessness professionals/those working in homelessness services are missing from those who should be involved in the assessment process; the lack of recognition of such workers by the health and care professions is problematic, but often this workforce has the most knowledge given the longevity of relationships	Thank you for your comment. We agree and have added this to the recommendation.

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DHSC - Office for Health Improvement and Disparities	Guideline	19	22	Explicitly reference the homelessness workforce in this section – the importance of their role mustn't be under-estimated	Thank you for your comment. As suggested, a reference to those working in homelessness and housing services has been added.
DHSC - Office for Health Improvement and Disparities	Guideline	20	5	'Time limited' – no reference to how long this should be, but evidence suggests that the period of time needed in intermediate care for people experiencing homelessness is longer than for the general population (the NICE guideline referred to suggests that for most people, 6 weeks is the usual intervention period. The recently published NIHR funded homeless hospital discharge evaluation brings into question that 6 – 8 week period, with the most effective model offering 12 weeks https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr09170#/full-report	Thank you for your comment. The committee considered the NIHR report when developing recommendations on intermediate care. The key in the comparison you refer to was whether the model was clinically or housing-led and whether there was access to intermediate care and less to the duration of the intermediate care. In the other included studies that mainly focused on cost-effectiveness, the duration of intermediate care varied from as little as 5 days to as long as 12 weeks and depended on the need. Therefore, the committee felt that it was inappropriate to specify the duration of such support and that it should be flexible. Also, such services are currently rare for people experiencing homelessness and offering a standard model of 12 weeks to everyone would have significant resource implications and would be challenging to implement. The definition of intermediate care has also been added to the section listing the terms used in this guideline which gives an indication about the time-limited nature of this intervention.

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DHSC - Office for Health Improvement and Disparities	Guideline	21	6	Could be more specific than 'custody' ie, police, prison and probation.	Thank you for this comment, the committee did not think it is necessary to be more specific as with the other examples are not particularly specific either.
DHSC - Office for Health Improvement and Disparities	Guideline	21	8	Or 'lead professional'	Thank you for your suggestion. The committee did not make this change because they felt that lead practitioner and key practitioner have similar implications. However they did edit another recommendation placing greater emphasis on the role of a designated practitioner in the provision of case management within multidisciplinary teams.
DHSC - Office for Health Improvement and Disparities	Guideline	21	10	Services, amenities and community groups: people need to be supported to connect to more than just services (as recognised by the role of NHS social prescribers or link workers) https://www.england.nhs.uk/personalisedcare/social-prescribing/	Thank you for your comment. The committee think services covers this sufficiently, and would generally include for example amenities and peer support.
DHSC - Office for Health Improvement and Disparities	Guideline	21	19	Reviewing and learning from – reviewing on its own achieves nothing	Thank you for your comment, on the basis of which this recommendation has been revised..

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DHSC - Office for Health Improvement and Disparities	Guideline	21	24	Is there scope to add in reference to more recent and relevant guidance on improving hospital discharge for people experiencing homelessness ie, the Support Tool https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/Transforming-out-of-hospital-care-for-people-who-are-homeless.pdf (also accessed via the HICM website, and referenced in NHS hospital discharge guidance)	Thank you for highlighting this. It has now been referenced in the rationale section of the guideline which describes the basis on which these recommendations were made.
DHSC - Office for Health Improvement and Disparities	Guideline	22	4	'matches' isn't the right language; the assessment of health, care and support and housing needs should be an integrated assessment – matches implies two separate assessments of need. Comments have been provided about this in on the section on assessing people's needs and generally	Thank you for your comment. The recommendation was not implying two separate assessments. This was reworded to make it clearer.
DHSC - Office for Health Improvement and Disparities	Guideline	25	5	Would include 'housing and homelessness practitioners' in those who would benefit from training – don't assume they've the understanding of health and care needs	Thank you for this suggestion. The committee instead addressed this by adding a definition of 'social care staff' to the guideline, which states that the way it's used in this guideline, the term does cover people working in hostels and homelessness services.
DHSC - Office for Health Improvement and Disparities	Guideline	25	12	Would add mental capacity and self-neglect – or include as a separate bullet	Thank you for your suggestion. The committee agreed not to specify these because they are already covered by the items 'understanding the health and social care needs of people experiencing homelessness' and 'legal duties and powers'.

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DHSC - Office for Health Improvement and Disparities	Guideline	26	8	Either add 'or care co-ordination' and/or make this an explicit recommendation/provide the definition– this is how the NHS can refer to what is defined, particularly where there is a lead professional/key worker (this is recommended elsewhere in the document) https://www.england.nhs.uk/personalisedcare/supported-self-management/care-co-ordination/	Thank you for your comment. The committee specifically mean care navigation with this term and have defined what is meant by it in the context of this guideline, it is not the same as care co-ordination.
DHSC - Office for Health Improvement and Disparities	Guideline	27	15	None of the subsequent definitions of homelessness include people who are in prison or hospital and will become homeless on release/discharge. The use of 'are' in the definitions suggests that the guidelines may not be relevant to those who are 'at risk' of these circumstances – this would include people who may become homeless for the first time whilst in prison or hospital	Thank you for your comment. The population of the guideline was determined based on a scoping exercise including stakeholder consultation (the scope was signed off and published in December 2020). It was agreed at the time that people at risk of homelessness were not included in the population definition of this guideline, and indeed excluded people staying in institutions in the long-term. The exception being people who have a history of homelessness and continue to be at high risk of returning to homelessness due to ongoing complex health and social care needs. The population of the guideline was agreed after careful consideration to manage the scope of the guideline.

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DHSC - Office for Health Improvement and Disparities	Guideline	28	4	The background and resources cited here are not fully accurate or up-to-date. PHE (OHID) topic advisor can provide additional contacts (if they do not submit consultation responses)	Thank you for your comment. Based on the committee members' advice the resource has now been changed to the Homeless Link website's resource on Psychologically Informed Environments, although the information provided is similar to the resource that was previously linked.
DHSC - Office for Health Improvement and Disparities	Guideline	30	13	Research recommendations: Can it be recommended that we need to understand how best to enable housing circumstances to be effectively captured & recorded by health and care professionals so that this triggers an appropriate response eg, referral to LA housing options, enables local assessments of needs, and informs national policy making	Thank you for your comment. The committee did discuss that data on the needs and service use of people experiencing homelessness can come from records where homelessness status has been captured. However they also acknowledged that recording such information on health and social care records can cause fear of stigmatisation but ultimately they felt that this was outweighed by the benefits of accurate data that can improve services. They therefore recommended that commissioners work with health and social care providers to improve recording of housing status for the purpose of care provision, planning and audit, recognising that local solutions to this may vary. Having made this recommendation the committee did not feel there was a need for future research to attempt to inform further, more specific recommendations in this area.

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DHSC - Office for Health Improvement and Disparities	Guideline	34	15	Please use 'people experiencing homelessness' instead of 'homeless people'	Thank you for spotting this mistake, which has now been rectified.
DHSC - Office for Health Improvement and Disparities	Guideline	34	28 - 30	This line refers to reducing caseloads as being 'cost effective': this may be the case for the individual in question, but reducing caseloads can also mean that others' are unable to access a service at all, for whom there will be a cost.	Thank you for your comment. Even though lower case holding will require additional resources to deliver it and given a fixed budget, disinvestment from other interventions and services elsewhere will be required. This displacement will inevitably result in health decrements for other types of individual. However, the additional cost that has to be imposed on the system to forgo 1 quality-adjusted life-year of health through such displacement is within the accepted NICEs threshold of £20,000 per quality-adjusted life-year and would be seen as an efficient approach which is in line with the aim of maximising population's health (quality-adjusted life-years) given a fixed budget. The committee also acknowledged that some workforce expansion might be required. In addition, the committee identified many other benefits (e.g. forming trusted relationships, people feeling more comfortable and more engaged with services/care) which could not be quantified in the economic analysis. Including these other benefits could mean that lower case holding may be cost-saving, increasing the numbers that can access services.

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DHSC - Office for Health Improvement and Disparities	Guideline	35	31	Please replace 'learning difficulties' with 'learning disabilities' https://www.nhs.uk/conditions/learning-disabilities/	Thank you for spotting this mistake, which has now been rectified.
DHSC - Office for Health Improvement and Disparities	Guideline	36	2	Am surprised there was no evidence to suggest that it's also about a person's preferences (particularly important for individuals who, for example, are victims of abuse and for whom communication may place the individual at greater risk).	Thank you for your comment. The recommendations make it clear that communication should be tailored according to the person's preferences as well as their needs. The 'Why the committee made recommendations' section you are referring to failed to make this clear so it has now been added to the text.
DHSC - Office for Health Improvement and Disparities	Guideline	39	3	Is there a recommendation that housing status needs to be captured by health & care services, and for the workforce to supported to enable this (includes systems being capable of capturing this data)?	Thank you for your comment. The guideline includes a recommendation (1.2.4) about commissioners working with health and social care providers to improve recording of homelessness status for care provision and audit.
DHSC - Office for Health Improvement and Disparities	Guideline	39	4	Presumably we mean 'health care and care' records? Would be helpful to define	Thank you for your comment on the basis of which this has now been clarified in the text.

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DHSC - Office for Health Improvement and Disparities	Guideline	42	14	Disagree that health needs assessments (I assume we're referring to JSNA type assessments) are widely done – they're not, they're also often not good quality and are very rarely updated.	Thank you for your comment. The committee was of the view that Joint Strategic Needs Assessments are generally widely done as they are statutory. However, they agreed that homelessness issues are not included thoroughly, and currently, homelessness health and social care needs assessments are not always conducted. The text was rephrased to make this clearer. It is also hoped that the recommendations in this area will improve the quality of such assessments and ensure that local needs assessments are kept up to date and relevant.
DHSC - Office for Health Improvement and Disparities	Guideline	44	10	The guidelines should be clear what is meant by Housing First – this term is not always as described eg, a MDT approach; more often in England it is simply a case worker enabling access to universal services. This is not the model developed in Canada and US.	Thank you for your comment. The evidence mentioned in the comment comes from Canadian Housing First studies about intense case management or assertive community treatment by a multidisciplinary team for people with moderate to severe mental health problems experiencing homelessness, which is the context in which Housing First is described here. This has been clarified by adding "Canadian" in the rationale section of the guideline and the discussion section of the evidence review.
DHSC - Office for Health Improvement and Disparities	Guideline	46	7	'Homelessness leads' – it's really not clear who/what role this refers to (for the definitions section?); it seems to vary between someone who is leading for commissioning and someone who is the individual's care co-ordinator/lead professional. I think in this section you mean the latter – and it would be helpful if the language used in relation to the NHS and Long Term Plan could be adopted so that non-specialist services understand that we mean to include people	Thank you for your comment. A definition of what is meant by homelessness leads has now been added to the 'Terms used in this guideline'. Homelessness leads are not leading commissioning nor are they necessarily the person's care coordinator or lead professional but are health or social care practitioners in mainstream services who as part of their role lead on homelessness issues within their service. The recommendation on homelessness

				experiencing homelessness in services, rather than exclude. Particularly relevant to MDTs and care co-ordination is the planned anticipatory care approach https://www.england.nhs.uk/primary-care/primary-care-networks/network-contract-des/ G629and Anticipatory Care EOI Form.docx - Health Education England https://www.hee.nhs.uk › sites › default › files › Ant...	leads outline what their responsibilities should be.
DHSC - Office for Health Improvement and Disparities	Guideline	51	9	It's not just the eligibility criteria but the thresholds of care associated with available funding; someone can meet the criteria for care and support but these needs are as high as others' and are therefore not prioritised from within available funding. Assumptions are made about eligibility for funding that prevent an individual having an assessment (this is not just experienced by people experiencing homelessness, but all populations).	Thank you for your comment. The committee discussed this but did not think revising the text is needed. The committee understand that resource pressures may mean that not all needs for care and support meet eligibility thresholds. The guideline recommends the inclusion of local authority social workers as part of the homelessness MDT and as such, part of the assessment of need and the use of the Care Act in determining care and support needs. The MDT approach which is recommended aims to bring an approach to assessment that is informed by the intersection of needs framed in legislation such as the Care Act and a person's homelessness.

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DHSC - Office for Health Improvement and Disparities	Guideline	56	25	There is evidence relating to children and young people at risk and likely in need of safeguarding that is relevant here (common assessment framework/early help framework). https://learning.nspcc.org.uk/safeguarding-child-protection/early-help-early-intervention	Thank you for your suggestion. Unfortunately, the framework you highlight would not fit the review protocols for the systematic reviews underpinning this guideline.
DHSC - Office for Health Improvement and Disparities	Guideline	57	25	Evidence relating to the Children and Young Person's Early Help Assessment shows that this approach addresses the issue of an individual telling their story multiple times; it could be applied to the adult population. https://learning.nspcc.org.uk/safeguarding-child-protection/early-help-early-intervention	Thank you for your comment. It is not entirely clear to us what exactly in this approach addresses the issue of an individual having to tell their story multiple times. However, overall the guideline's recommendations align with the idea of early intervention by emphasising easy access to health, care and support services, including proactive approaches like outreach, provision of preventative/public health interventions, and thorough assessment of the person's needs, and tailoring care and support based on these needs.
DHSC - Office for Health Improvement and Disparities	Guideline	58	25	And housing needs (must be part of the integrated assessment)	Thank you for your comment. The committee agreed that this section is about assessing the person's health and social care needs, not their housing needs. However, they agreed to make it explicit in the recommendation that the assessment should be done in the context of the person's housing and benefits situation.

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DHSC - Office for Health Improvement and Disparities	Guideline	59	21	Please review recently published NIHR funded evidence https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr09170#/full-report	Thank you for providing this reference, which we have included in the health economic evidence of review A/B.
DHSC - Office for Health Improvement and Disparities	Guideline	61	30	There is no recommendation re: reviewing policies around prescribing methadone in hospital as a means to prevent self-discharge – can this be considered?	Thank you for your comment. The recommendation which this text relates to was revised based on consultation feedback but essentially, the guideline recommends that clinical teams working with hospital discharge teams, and where present, homelessness MDTs should have procedures to minimise self-discharge and when this happens review and implement learning from the case. Self-discharge against medical advice can happen for many reasons but sometimes it relates to people not receiving adequate methadone dose in the hospital. Therefore, the recommendation would cover this scenario and teams should minimise self-discharge by reviewing their procedures.
DHSC - Office for Health Improvement and Disparities	Guideline	64	3	A specific research recommendation that would be useful would be to understand the relationship between isolation and loneliness, homelessness and repeat homelessness; we understand that there is a significant impact on an individual's health and wellbeing of loneliness (irrespective of their housing circumstance); policy-wise the general public recognise loneliness and isolation and should be supportive of action to address this in those whose home circumstances are precarious	Thank you for your suggestion. Unfortunately, due to the guideline scope, none of the evidence reviews were designed to locate evidence about the relationship between homelessness and loneliness so it cannot be said with any confidence that such evidence does not exist. Since research recommendations are made in order to plug gaps identified by evidence reviews underpinning NICE guidelines, the committee were therefore unable to recommend future research in this area because they cannot be certain such a gap exists.

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DHSC - Office for Health Improvement and Disparities	Guideline	68	14	There is plenty of evidence that says that the homelessness workforce would like additional training & development in health and care, particularly as they're reporting increasingly complex needs amongst those they support; can this evidence be considered? Eg, by Homeless Link, the Frontline Network etc (OHID TA can provide)	Thank you for your comment. A definition of social care staff has now been added to the 'Terms used in this guideline' to clarify that this means front line social care practitioners that may work in residential care, hostels and homelessness services.
DHSC - Office for Health Improvement and Disparities	Guideline	68	23	Include 'housing providers' also	Thank you for your comment. A definition of social care staff has been added to the 'Terms used in this guideline' to clarify that this means front line social care practitioners that may work in residential care, hostels and homelessness services.
East London NHS Foundation Trust	Guideline	General	General	These guidelines are very welcome particularly as they include a wide definition of who is defined as homeless, a recognition of the multiple causes of homelessness including health inequalities and discrimination and a firm statement that homelessness is a public health issue. Also pleased to see mental and physical health issues given prominence throughout. The responses here are informed both by the practices within ELFT and by the UK wide Psychology in Homelessness Network.	Thank you.

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East London NHS Foundation Trust	Guideline	General	General	Understandably the guidelines are written in language that is familiar to health services. However most homeless people will be supported by a range of organisations outside of healthcare. The language in the guidelines should be readily understandable or translated into the language of social care and the voluntary sector.	Thank you for your comment. The committee that wrote the recommendations consists of a mixture of people working in social care, homelessness hostels, outreach, mental health, primary and secondary care and people with lived experience of homelessness. The #HealthNow peer network were also consulted and specifically asked about the language of the guideline. Some revisions to the language based have been made on the basis of theirs and other stakeholder's comments but we do not think the language used is specific to health care but is widely used in homelessness sector as well. Furthermore, definitions have been provided for many of the terms used in this guideline.
East London NHS Foundation Trust	Guideline	General	General	Whilst it is appreciated that access to statutory services should be everyone's right; we need to take into account that not all statutory services operate in psychologically informed or trauma informed ways and therefore even if a person experiencing homelessness accessed a service it may not be delivered in the most effective ways. In addition the guidelines give an overall impression that people experiencing homelessness will be invited into services rather than services assertively outreaching and developing community-based provision as appropriate. Therefore there should be recommendations that services must be psychologically and trauma informed, work with local communities, be co-produced and have ways of measuring this.	Thank you for your comment. The committee believe that all the issues you raise are very well covered by the existing recommendations. References to psychologically informed environments could not have been made in stronger terms because the committee did not feel they had the basis to do this. However due to it's widely accepted importance in this context they prioritised PIE as an area for future research (see 'research recommendations') so that future updates of this guideline might make stronger recommendations in this area.

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East London NHS Foundation Trust	Guideline	General	General	Whilst it is recognised that guidelines are not policy there could be much stronger recommendations throughout the document using the word ‘must’ rather than ’consider’ to indicate that actions are important.	Thank you for your comment. Without robust evidence, the committee were unable to make strong recommendations on some issues, therefore the word 'consider' is used in some cases. The Developing NICE guideline: the manual chapter 9.2 gives more information about the wording of the recommendations and how the wording reflects the strength of the recommendations. The word ‘must’ is only used in instances where there is a legal duty or where the consequences of not following a recommendation would be extremely serious.
East London NHS Foundation Trust	Guideline	General	General	Throughout the document, there is an opportunity to include more precise and clear language around race, discrimination and cultural issues. More is needed to avoid the guidelines being tokenistic towards issues of race and discrimination. We know that black people are three times as likely to experience homelessness Black people are more than three times as likely to experience homelessness - Shelter England Recommendations to record diversity data and outcomes based on diversity data should be made.	Thank you for your comment. The committee carefully considered issues around inequalities, discrimination and specific needs of different groups. Whilst race, ethnicity and different cultural issues are a part of this discussion, the committee also agreed that there are many other characteristics and experiences, often overlapping and intersecting, that should be considered. For example, women's experience of homelessness might be markedly different to that of men's, the underlying causes might be different and there may be specific issues related to access and engagement, which are relevant to women particularly. Adding the inequalities and experiences that race or ethnicity brings to this will further specify the needs. So the committee addressed this by including in the recommendation references to services needing to be inclusive, addressing health inequalities and being responsive to diverse needs of people. This was done in various places in the guideline instead of necessarily specifying a particular

					experience. For example, in the 'Planning and commissioning' section, the committee made a recommendation to consider providing services and support aimed at the needs of particular groups of people experiencing homelessness and list examples of groups (not an exhaustive list), including women, young people, older people, disabled people, LGBT+, people with no or limited recourse to public funds, people from different ethnic or religious minorities. In the 'General principles' section, a recommendation about promoting engagement was revised to specifically refer to the services aiming to address health inequalities, being inclusive and paying attention to the diverse experiences of people using the service. In the 'Staff support and development' section the committee made a recommendation about training for all health and social care staff, including homelessness as part of equality and diversity training, including the responsiveness to the impact of discrimination and stigma and of intersectional, overlapping identities.
East London NHS Foundation Trust	Guideline	General	General	Working with people experiencing homelessness with no recourse to public funds is a major issue that needs to be explicitly addressed in the guidelines to ensure that all people have access to healthcare, social supports and housing options in timely ways .	Thank you for your comment. The committee agree with you about the importance of this issue and certainly had this group in mind when making recommendations about people experiencing particular disadvantage. However, in response to your comment they have added further detail to the guideline so that more specific references are made.

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East London NHS Foundation Trust	Guideline	General	General	Many current NICE guidelines are referred to throughout these guidelines without an evaluation of whether or not the guidelines meet the needs of people experiencing homelessness which might send commissioners and service providers down an unfruitful rabbit hole.	Thank you for your comment. The committee sign posted to other NICE guidelines after careful consideration of the way in which they would provide additional detail alongside this guideline and help to achieve improvements in access to and engagement with health and social care for people experiencing homelessness.
East London NHS Foundation Trust	Guideline	3	25	It is not known what is meant by the word 'neurobehavioural differences' – is reference being made to the high numbers of people who may be described as 'neuroatypical'? It is known that there is an over representation of people who may be described as neuroatypical experiencing homelessness.	Thank you for your comment. The wording has been revised to 'neuroatypical' as suggested.
East London NHS Foundation Trust	Guideline	8	9	**Recommendation 1.1.10** Given the high prevalence of acquired brain injury and neurodiversity both diagnosed and undiagnosed within the homeless population and this has an impact on how individuals receive and understand information, there should be a recommendation that services and individuals are trained to screen for brain injury and neurodiversity and adapt information and how it is given accordingly. Useful resources for services include NeuroTriage and Autism_Homelessness_Toolkit.pdf and Brain-injury-Toolkit-June-2018-1.pdf (groundswell.org.uk)	Thank you for your comment. The guideline makes recommendations about assessing the person's health and social care needs and also about providing communication and information based on the person's needs, preferences and circumstances. The committee have not made a specific point about acquired brain injury or neurodiversity here but have acknowledged these to be common in the context section.

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East London NHS Foundation Trust	Guideline	9	5	Recommendation 1.2.1 Current commissioning arrangements are fragmented and invite competition rather than collaboration between services and funding is often short term when we know the population have long term needs. Working with the inevitable competition within and between services to achieve the most effective, efficient, satisfying outcomes is a core skill of Clinical Psychologists who are trained to work with systems and offer organisational consultancy. Ensuring that Commissioners have access to high quality organisational consultancy when working with providers should be recommended. In addition most current KPI's promote exclusion of people most in needs as targets tend to be about contacts. KPI's should measure responsiveness, flexibility and person-centred outcomes from services. For an example of innovative commissioning within homelessness see Victoria Aseervatham shares her thoughts about what matters in commissioning and explains how… | by Collaborate CIC | Collaborate To ensure services are meeting self-defined goals of service users making use of Goal Attainment Scales is recommended.	Thank you for your comment. It is hoped that this guideline will help to improve collaborative commissioning and planning across sectors and agencies. Organisation consultancy is not something that featured in the evidence and is not specific to this topic area, which is why it hasn't been commented on it. It is expected that KPIs will be updated based on the guideline focusing on the outcomes such as you mention as they align with the guideline.

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East London NHS Foundation Trust	Guideline	10	4	Access to services. Service users constantly fall between services despite multiple applicable NICE guidelines and recommendations for good practice Overview | Coexisting severe mental illness and substance misuse: community health and social care services | Guidance | NICE Overview | Borderline personality disorder: recognition and management | Guidance | NICE Overview | Coexisting severe mental illness and substance misuse | Quality standards | NICE consensus-statement-final.pdf (mind.org.uk) When assessing access services should state clearly if they are meeting current recommendations not to exclude people who are experiencing homelessness and have multiple needs.	Thank you for your comment. The committee agree with you about the significance of this problem having considered evidence during the development of the guideline that siloed working and minimal coordination resulted in people being dealt with by numerous individual providers rather than being supported holistically with consideration of all their intersecting needs. These findings were corroborated by the committee's experience, which is why they recommended that as part of the homelessness health and care needs assessment, a judgement should be made about whether and to what extent people with experience of homelessness have access to and engagement with current services. They also made a number of other recommendations throughout the guideline to ensure joined up working to address the complexity of needs and they specified ways in which this could be achieved. On this basis the committee feel that the guideline addresses your concerns.

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East London NHS Foundation Trust	Guideline	10	28	Recommendation 1.2.6. should include people who are veterans and people with intellectual disabilities and physical disabilities - as an example of groups of people who have specific service and support needs. People with intellectual disabilities and veterans are over-represented within homelessness populations. An example of good practice for mental health support of veterans is The Veterans Mental Health and Wellbeing Service - London and the South East (veteransservicelse.nhs.uk) Anecdotally there seems to have been an increase in the number of homelessness people experiencing addictions becoming amputees and there is little psychological support available to prepare for amputation and post amputation services are hard to access. Given it is difficult to acquire robust data on how many people become amputees as a result of homelessness, a recommendation to record this data should be made in order to plan service provision accordingly.	Thank you for your comment. The list of groups included in this recommendations are examples and it is not aiming to be an exhaustive list and may well include veterans if based on the local homelessness health and social care needs assessment this is a group that is present in the local homeless population. Based on your and other stakeholders' comments 'disabled people' has been added to the list as clearly a group which is overrepresented in the homelessness population and may need special consideration in terms of services and support. Otherwise, the committee addressed issues around being responsive to individual needs, including inclusion and diversity needs more generally in various parts of the guideline.
East London NHS Foundation Trust	Guideline	11	20	**Recommendation 1.3.1** Provision of specialist mental health teams are welcome as we know that traditional mental health services such as CMHT's struggle to engage with people who are homeless and tend to exclude people with multiple needs such as mental health and addictions. Providing services that are psychologically informed and trauma informed in the way they operate is key and should be evaluated. Specialist services should co-ordinate and provide care without arbitrary time limits imposed.	Thank you for your support for this recommendation.

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East London NHS Foundation Trust	Guideline	12	1	**Recommendation 1.3.2** A recommendation to have robust protocols on place for gathering and sharing information across teams/agencies should be in place should be included.	Thank you for your comment. This has been added to the recommendations as suggested.
East London NHS Foundation Trust	Guideline	12	15	The recommendation in 1.3.2 to '*wrap around health and social care needs*' - currently, can be tricky for people with offending backgrounds to access both mainstream/forensic mental health services, especially for psychological interventions; and can be restricted for people with other legal needs such as people seeking asylum. Both these vulnerable groups should be explicitly listed in this recommendation.	Thank you for your comment. The committee agree with your point but they think that the recommendation already largely covers the needs that would be experienced by people with offending backgrounds, including the reference to mental health and psychological needs. However they did add to this recommendation to further address your point so it now refers to referral for legal advice in addition to all the other areas of need.
East London NHS Foundation Trust	Guideline	12	30	Recommendation 1.3.3 For an evidence based service model review see Service-Review-Mental-Health-and-Rough-Sleeping (pathway.org.uk)	Thank you for this information, which will be shared with NICE colleagues responsible for guideline implementation.
East London NHS Foundation Trust	Guideline	13	7	Recommendation 1.3.4 Recommendations for teams to be engaged in reflective practice are welcome and a definition of reflective practice based on Gibbs Reflective Cycle seems to have been used. However, there needs to be a distinction between reflective practice, case discussion and case formulation and team formulation (Team formulation: applications of current models to reduce restrictive practice (acpuk.org.uk)) given. In addition there needs to	Thank you, but this is not a guideline on reflective practice and the committee have not made further specifications to this recommendation.

				be some guidance on the skills and experiences needed for reflective practice facilitators.	
East London NHS Foundation Trust	Guideline	14	1	**Recommendation 1.4** 'Peers' and 'peer support' are undefined for an example of a definition see Stephanie Barker on peer support and homelessness: understanding what makes it work - Groundswell for examples on how to make best use of lived experience see Best Practice Guidance - Lived Experience (pathway.org.uk) Many staff within services have lived experience of homelessness, mental health, addiction and neurodiversity – so services should be clear how this rich experience is made use of and supported when working with peers and peer supporters.	Thank you for your comment, on the basis of which the committee agreed to add a definition of 'peer' to the 'terms used in this guideline' section.

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East London NHS Foundation Trust	Guideline	16	12	Recommendation 1.5.4 Whilst the general principle to include access to all mainstream services is a good one, recommending that people experiencing homelessness who have multiple health needs attend services for common mental health problems is likely to result in the person experiencing homelessness being excluded as IAPT services for example are generally not set up to offer an outreach approach or to work with people with multiple needs and risks. People experiencing homelessness tend to be found in primary care, voluntary and community settings and have needs that would fulfil the criteria for secondary care. In England the NHS Long Term Plan (2019) specifically seeks to address the needs of rough sleepers. The NHS England Transformation agenda for mental health also provides further examples of how to reduce the barriers to access services and the need to be categorised with one need or another. East London NHS Foundation Trust is an early implementer of the transformation agenda see ELFT - Mental Health Transformation Programme and we would be willing to share learning from this work.	Thank you for your comment. This recommendation links to a particular section on improving access to services in the NICE guideline on common mental health problems. These recommendations align with the recommendations in this guideline. For example, including supporting the integrated delivery of services across primary and secondary care, focusing on entry and not exclusion criteria, having multiple means (including self-referral) to access the service, providing multiple points of access that facilitate links with the wider healthcare system and community in which the service is located, assessment and interventions outside normal working hours, considering a range of support services to facilitate access and uptake of services such as assistance with travel and advocacy services, and being respectful of, and sensitive to, diverse cultural, ethnic and religious backgrounds. There are circumstances where these measures are not effective and other approaches specific to circumstances that some people experiencing homelessness are better, for example assertive outreach. However, this does not mean the approaches recommended in the referenced section is not applicable to the wider population covered by this guideline.
East London NHS Foundation Trust	Guideline	17	11	**Recommendation 1.5.13** The recommendation to provide assertive outreach is particularly welcome.	Thank you.

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East London NHS Foundation Trust	Guideline	19	1	Recommendation 1.6 Assessing people's needs. Reference to and recommendations for 'Trusted Assessments' should be made and examples given of good practice to reduce the need for multiple assessments of the same needs. developing-trusted-assessment-schemes_essential-elements-280717.pdf (adass.org.uk) Given the high prevalence of acquired brain injury, trauma and physical health conditions many people experiencing homelessness may be poor historians and appropriate access to health records is essential to mitigate against disability and death.	Thank you for your comment. No reference to "Trusted Assessments" has been made but the committee have revised the recommendation on assessing the health and social care needs of the individual to specifically refer to avoiding unnecessary or potentially distressing repetition of history that is already on record. This was already discussed in the rationale and impact section. Elsewhere in the guideline, the committee also added to a recommendation about multidisciplinary teams about having protocols and systems in place for information sharing.
East London NHS Foundation Trust	Guideline	19	8	**Recommendation 1.6.2** there are often disputes amongst professionals and agencies over the person experiencing homelessness' ***rights to autonomy and self-determination***, usually focusing on differences of opinion re mental capacity and moral arguments. This usually indicates that systems feel stuck with knowing what to do in terms of engaging the person experiencing homelessness or lack resources to address the presenting needs. This can lead to a person not receiving any service and needs escalating to a point of crisis and increasing risk. A recommendation to hold face to face meetings, externally facilitated if need be at the earliest opportunity, no more than a week from identifying being stuck should be made.	Thank you for your comment. The committee realise that assessment of, for example, mental capacity is not always straight forward, however, it must be assumed that the multidisciplinary team is able to work together constructively to support the person. Need for face-to-face meetings or external facilitators should be a consideration locally as needed.

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East London NHS Foundation Trust	Guideline	20	5	**Recommendation 1.7.1** Re intermediate care, an explanation of what 'intermediate care' is and a definition of 'intensive' needs to be included.	Thank you for your comment. As suggested, the definition of intermediate care has been added to the section listing the terms used in this guideline.
East London NHS Foundation Trust	Guideline	20	5	**Recommendation 1.7.1** 'time-limited' work with this client group is the opposite to many of the recommendations in these guidelines re 'open door' and open-ended contact. Contact should be for as long as needed and based on health, social, housing, inclusion and wellbeing need(s).	Thank you for your comment. 'Time limited' was removed from the recommendation. The definition of intermediate care has been added, which acknowledges that such services provide time-limited support but that the actual duration will vary depending on needs.
East London NHS Foundation Trust	Guideline	21	1	**Recommendation 1.8.1** Transition between services. There are good, clear guidelines on the specific expectations on how transitions should be made. This would be enhanced by a statement that people experiencing homelessness may make transitions between services but the care and support provided is likely to remain multi agency and across settings.	Thank you for your support for these recommendations. The committee did not add this specific statement because they felt that the issue of maintaining a multidisciplinary approach to addressing complex needs is one of the overriding aims of the guideline and represented in a range of recommendations. There is a section of the guideline dedicated to models of multi-disciplinary services provision, which starts with the recommendations to provide care through specialist homelessness multidisciplinary teams across sectors and levels of care, tailored according to local needs.

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East London NHS Foundation Trust	Guideline	21	6	**Recommendation 1.8.1** Transition between services. Recommendations for 'time-limited intensive support' are not in keeping with a psychologically informed, trauma informed approach and open-door policies as recommended explicitly elsewhere in the guidelines. A lot of clinician time is spent keeping people out of services or moving them on when they do not wish to be moved on or discharged. Letting people come and go as need dictates, much like using a GP service, is a better alternative and in keeping with the idea of neighbourhoods coming from the NHS England Long Term Plan and Transformation agenda .	Thank you for your comment. The committee acknowledge your point but the basis for the recommendations about transitions between services was partly the effectiveness evidence comparing 'critical time intervention' with usual care among people experiencing homelessness. Critical time intervention is defined as a time-limited intensive support during a transition period. The evidence related to discharge from psychiatric inpatient care and moving from a homeless shelter to the community and it showed benefits in terms of mental health service use, housing status and reduced psychiatric re-hospitalisation, although no difference in quality of life was reported. The committee therefore agreed that the general approach and key principles of critical time intervention should form the basis of recommendations on support for key transitions. The time period in the studies was 9 months, but the committee agreed that the length of time needed for intense support during transition would depend on the circumstances and needs of the person and this is reflected in the recommendations whch emphasised the importance of a gradual lowering of intensity of support, as appropriate. In this sense, the committee agree the recommendations about transitions are evidence based and not at odds with the general principles of the guideline which state that trauma informed approaches including PIE should be considered.

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East London NHS Foundation Trust	Guideline	22	1	Recommendation 1.9 Housing with health and social care support. Given the growing evidence base for implementing psychologically informed environments and services particularly within housing for people experiencing homelessness, and the needs for trauma informed care and approaches, specific recommendations that Housing services should demonstrate that they are providing a psychologically informed, trauma informed and neurodiversity informed environment should be explicitly made Adults with complex needs who are homeless: evidence review (publishing.service.gov.uk)	Thank you for your comment. The guideline has made recommendations around psychologically informed environments and trauma informed care in several places. No specific recommendation has been made about these within the housing services. The focus of the guideline is not on housing services but on improving access and engagement with health and social care in people experiencing homelessness.
East London NHS Foundation Trust	Guideline	23	4	**Recommendation 1.10.1** The recommendation to have a designated safeguarding lead for people experiencing homelessness is particularly welcome.	Thank you for your support for this recommendation.
East London NHS Foundation Trust	Guideline	23	18	**Recommendation 1.10.6** A recommendation to hold a serious incident review every time a homeless person dies would also be welcome in the definition of when a Safeguarding Adult Review should be held.	Thank you for your suggestion. Local authorities do have the discretion to conduct safeguarding adults reviews (as per the Care Act 2014) in every such event but if this guideline recommended in stronger terms that they 'should' be done, this would have considerable resource implications. For this reason and without stronger underpinning research evidence, the committee chose not to place further emphasis on the conduct of safeguarding adult's reviews than the Care Act already does.
East London NHS Foundation Trust	Guideline	24	8	**Recommendation 1.11 Long-term support** The recommendation for long term support is welcome and should be linked explicitly to	Thank you for your comment. The recommendation already mention 'open-door'

				services having a measurable open-door policy that is well defined.	services explaining what this can mean and it was not considered necessary to add to this.
East London NHS Foundation Trust	Guideline	24	9	Recommendation1.11.1 an explicit statement about organisations struggling to engage with people experiencing homeless should be made. It is argued that services are often not ready to engage or expect to engage people experiencing homelessness and Maslow's Hierarchy of Needs is a perpetuated myth which serves to avoid assertively outreaching and attending to all needs see [PDF] The role of clinical psychology for homeless people | Semantic Scholar	Thank you for your comment. The committee think the guideline addresses this already without explicitly stating it in this recommendation. The guideline focuses on ways in which services themselves can lower barriers for people to access and engagement with services recognising that 'disengagement' is often due to services being difficult to engage with.
East London NHS Foundation Trust	Guideline	24	17	Recommendation 1.11.2 Given that relational difficulties between services and service users often contribute to lack of access to services, ensuring consistency of practitioners over time is key. The Open Dialogue approach is highly effective in improving quality of life for people experiencing psychosis and core components are working as a community and for individual staff not knowingly starting work with a service user if they know they would be moving on within a year Open Dialogue | A website for the international Open Dialogue community (open-dialogue.net)	Thank you for your comment. The committee recognises the importance of continuity of care and in addition to the recommendation; you are referring to have also addressed continuity of care in the recommendations about homelessness multidisciplinary teams. The guideline also makes other recommendations in relation to improving relational difficulties between services and people experiencing homelessness, such as involving peers or advocates, psychologically informed environments and trauma informed care, tailoring communication according to individual needs and preferences, and building a relationship of trust. The Open Dialogue approach is not something that was located within the evidence reviews nor in discussions and has not been commented on.

East London NHS Foundation Trust	Guideline	25	1	**Recommendation 1.11.4** An open-door policy should be a must rather than something to consider. The success of the majority of these guidelines depends on not getting caught up in cycles of rejection that time-limited services will inevitably invoke.	Thank you for your comment. No evidence was identified on this specifically so no strong recommendation was made; however, overall the guideline very much recommends different ways to remove barriers for engagement and re-engagement.
East London NHS Foundation Trust	Guideline	25	5	Recommendation 1.12.1 Recommended training for staff is welcome. Given the needs of this population staff would also benefit on training in safeguarding, the mental capacity act and how to assess in relation to this population, human rights and psychologically informed environments. aneemo - LMS online training courses, health and social care courses has award winning free and paid for training. The free to access Rough Sleeper Mental Health Awareness course is suitable for all staff working with people experiencing homelessness, not just when working with rough sleepers.	Thank you for this suggestion. The committee have not made this change because their intention was to ensure this list referred to areas for training in quite broad terms, rather than listing specific areas and risking missing any out of such a list. However on the basis of yours and other stakeholder comments, they have added more detail to the section of the guideline, which explains the basis for and elaborates on the recommendations. This now refers to legal literacy and understanding of duties and powers in relation to homelessness, mental capacity and safeguarding. In terms of your point about psychologically informed environments, this has now been added to the recommendation itself.
East London NHS Foundation Trust	Guideline	25	19	**Recommendation 1.12.3** Reflective practice should be mandatory for all staff given the rates of trauma in the population and the risk of vicarious trauma and higher rates of anxiety and depression in staff teams Good%20practice%20guide%20-%20%20Psychologically%20informed%20services%20for%20homeless%20people%20.pdf (soton.ac.uk) pies-literature-review.pdf (mentalhealth.org.uk) PTSD Symptoms, Vicarious Traumatization, and Burnout in Front Line Workers in the Homeless Sector - PubMed	Thank you for your comment but this is not a guideline on reflective practice and therefore no further specifications have been made to this recommendation., nor is it within the committee's remit to mandate training.

				(nih.gov) An exploratory study on the factors affecting the mental health and well-being of frontline workers in homeless services — University of Edinburgh Research Explorer	
East London NHS Foundation Trust	Guideline	25	19	**Recommendation 1.12.3** Robust definitions of reflective practice are needed as are the skills, experiences, supervisions and supports needed for facilitators. Evaluation of effectiveness of reflective practice should be mandatory.	Thank you for your comment but this is not a guideline on reflective practice and therefore no further specifications have been made to this recommendation.
Enabling Assessment Service London	General	General		References Cockersell, P. (2016). PIEs five years on. Mental Health and Social Inclusion. Cole, S., Johnstone, L., Oliver, D. N., & Whomsley, S. (2011). Good practice guidelines on the use of psychological formulation. British Psychological Society. Hollingworth, P., & Johnstone, L. (2014, May). Team formulation: What are the staff views. In Clinical Psychology Forum (Vol. 257, No. 5, pp. 28-34). Kurtz, A. (2019). How to Run Reflective Practice Groups: A Guide for Healthcare Professionals. Routledge. Proctor, B. (2010). Training for the supervision alliance: Attitude, skills and intention. In Routledge handbook of clinical supervision (pp. 51-62). Routledge. Reeves, E. (2015). A synthesis of the literature on trauma-informed care. Issues in mental health	Thank you for your comment and for providing these references. The references you cite have been checked for relevance to this review and reasons for exclusion are provided after each reference. Cockersell, P. (2016). PIEs five years on. Mental Health and Social Inclusion. This review investigates the effectiveness of the psychologically informed environments (PIEs) approach to working with homeless people, which was not the objective/phenomenon of interest for our evidence review. Cole, S., Johnstone, L., Oliver, D. N., & Whomsley, S. (2011). Good practice guidelines on the use of psychological formulation. British Psychological Society. This document describes guidelines for psychological formulation. This study design was not included in our evidence review. Hollingworth, P., & Johnstone, L. (2014, May).

				nursing, 36(9), 698-709. Wilson, A., Hutchinson, M., & Hurley, J. (2017). Literature review of trauma-informed care: Implications for mental health nurses working in acute inpatient settings in Australia. International Journal of Mental Health Nursing, 26(4), 326-343. Purtle, J. (2020). Systematic review of evaluations of trauma-informed organizational interventions that include staff trainings. Trauma, Violence, & Abuse, 21(4), 725-740. Schneider, C., Hobson, C. W., & Shelton, K. H. (2021). 'Grounding a PIE in the sky': Laying empirical foundations for a psychologically informed environment (PIE) to enhance well-being and practice in a homeless organisation. Health & Social Care in the Community. Wallbank, S. (2012). 7 Supervision and well-being. Clinical Supervision In The Medical Profession: Structured Reflective Practice: Structured reflective practice, 82. Watkins, C. E. (2012). Psychotherapy supervision in the new millennium: Competency-based, evidence-based, particularized, and energized. Journal of Contemporary Psychotherapy, 42(3), 193-203. Westaway, C. (2016). The Experiences of Men who have had Multiple Moves Within Projects for People who are Homeless. Hawkins, P., & McMahon, A. (2020)Supervision in the Helping Professions (UK Higher Education OUP Humanities & Social Sciences Health & Social Welfare)	Team formulation: What are the staff views. In Clinical Psychology Forum (Vol. 257, No. 5, pp. 28-34). This study evaluates staff experiences of formulating in teams, which was not the objective/phenomenon of interest for the reviews in this guideline. Kurtz, A. (2019). How to Run Reflective Practice Groups: A Guide for Healthcare Professionals. Routledge. This reference is for a book. Books were not included in the reviews in this guideline. Proctor, B. (2010). Training for the supervision alliance: Attitude, skills and intention. In Routledge handbook of clinical supervision (pp. 51-62). Routledge. This reference is for a book. Books were not included in the reviews in this guideline. Reeves, E. (2015). A synthesis of the literature on trauma-informed care. Issues in mental health nursing, 36(9), 698-709. This study examines existing research on trauma-informed care for survivors of physical and sexual abuse. This population group was not included in the reviews in this guideline (unless experiencing homelessness). Wilson, A., Hutchinson, M., & Hurley, J. (2017). Literature review of trauma-informed care: Implications for mental health nurses working in acute inpatient settings in Australia. International Journal of Mental Health Nursing, 26(4), 326-343. This study examines the challenges experienced by mental health nurses in embedding TIC into acute inpatient settings, which was not the objective/phenomenon of interest for the reviews in this guideline.

					Purtle, J. (2020). Systematic review of evaluations of trauma-informed organizational interventions that include staff trainings. Trauma, Violence, & Abuse, 21(4), 725-740. This systematic review focused on the effects of organisational interventions that included a "trauma-informed" staff training component, which was not the objective/phenomenon of interest for the reviews in this guideline. Schneider, C., Hobson, C. W., & Shelton, K. H. (2021). 'Grounding a PIE in the sky': Laying empirical foundations for a psychologically informed environment (PIE) to enhance well-being and practice in a homeless organisation. Health & Social Care in the Community. This study explores staff and client well-being and practice needs in a homeless prevention organisation, which was not the objective/phenomenon of interest for the reviews in this guideline. Wallbank, S. (2012). 7 Supervision and well-being. Clinical Supervision In The Medical Profession: Structured Reflective Practice: Structured reflective practice, 82. This reference is for a book. Books were not included in the reviews in this guideline. Watkins, C. E. (2012). Psychotherapy supervision in the new millennium: Competency-based, evidence-based, particularized, and energized. Journal of Contemporary Psychotherapy, 42(3), 193-203. This is a narrative article, which explores psychotherapy supervision for staff, which was not the objective/phenomenon of interest for the reviews

					in this guideline. Westaway, C. (2016). The Experiences of Men who have had Multiple Moves Within Projects for People who are Homeless. This qualitative study explored the experiences of people experiencing homelessness who had moved around homeless projects. This was not the phenomenon of interest for the qualitative review in this guideline, which explored what works well or what could be improved with access to, engagement with, and delivery of health and social care. Hawkins, P., & McMahon, A. (2020)Supervision in the Helping Professions (UK Higher Education OUP Humanities & Social Sciences Health & Social Welfare). This reference is for a book. Books were not included in the reviews in this guideline.
Enabling Assessment Service London	Guideline	5	4	We value the observation that more effort and targeted approaches are needed for people experiencing homelessness. We also wonder whether what is informing this statement is the need for a more relational, socially situated, and reflective approach. In line with a trauma informed approach these are the principles that would help health and social care practitioners respond to the histories of complex/developmental and compound trauma that people are likely to have experienced.	Thank you for your comment. The committee believe the guideline covers these issues by referring to trauma-informed care, psychologically informed environments, person-centred case management, support tailored according individual needs, and being responsive to people's individual and diverse needs, including being inclusive and addressing health inequalities, taking into consideration social determinants of health.

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Enabling Assessment Service London	Guideline	5	14	It is encouraging to see the inclusion of PIE and TIC informed frameworks within the guidance. Given the emerging published research (Schneider, 2021; Cockersell, 2015; Reeves, 2015; Wilson et al, 2017; Purtle, 2020) and our own practice-based evidence and learning, we would advocate for the influence of these frameworks to be more integrated and positioned with more certainty. These frameworks are approaches to systems change that consider the prevalence and impact of trauma and map out the pathway for systems change in order to meet these needs (FLLSL-Lit-Review_FINAL-September-2020.pdf). A more integrated approach across the guidance about how these frameworks should influence best practice would be valuable. We acknowledge the requirement for further research, which could be identified within the recommendations for research.	Thank you for your support. The committee is in agreement with you about the need for further work on the evidence base for psychologically informed environments as a contribution to trauma informed care for people experiencing homelessness. For this reason they made a recommendation for future research into the effectiveness and acceptability of PIE for improving access to and engagement with health and social care.

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Enabling Assessment Service London	Guideline	11	16	We endorse the inclusion of the reduction of caseloads in order to facilitate more reflective and intensive engagement. We would like to highlight that in our experience the risk of re-traumatisation for people experiencing homelessness accessing health and social care services is high and often the mechanism behind cycles of eviction and abandonment (Westaway,2016). Resisting re-traumatisation is one of the key elements of a trauma informed approach (SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach). We would therefore like to advocate that the risk of re-traumatisation is made more strongly across the guidance with clear approaches to protect against this, such as the provision of a robust supervision framework for both health and social care practitioners and housing staff. • Literature highlights that health and social care practitioners, and we would argue housing staff, have needs beyond group reflective spaces. Proctor's (2010) description of supervision clearly highlights that there are three different functions of supervision/staff support. These are: Formative (skills development), Normative (performance management) and Restorative (supportive). It is very difficult for all these functions to be met within any single model of supervision/reflective space. Consistent 1:1 reflective space (often referred to as clinical supervision), and formulation based complex case discussions, can have a significant impact on competency and therefore the safety and	Thank you for your comment. The committee agree with you and in the assessing people's needs section recommend that unnecessary and potentially distressing repetition of a history that is already on record should be avoided. Trauma-informed care is recommended in this guidance, and there are also a number of recommendations on integrated working, information sharing, staff training and development, continuity of care, building trusted relationships etc., which should help to address the issue of re-traumatisation. The committee also acknowledged that providing care and support as outlined in some of the recommendations might have a resource impact, e.g. lower caseloads to allow staff to form trusting relationships with people experiencing homelessness, improve engagement with health and social care etc. The committee understand that this may require additional funding. However, NICE is not involved in funding decisions. It is hoped that commissioners, planners, and providers will take note of this guidance and support its implementation. Your comment will be passed to the NICE team, which plans the implementation support.

				quality of practice (Hawkins & McMahon, 2020), therefore reducing the risk of re-traumatisation. • Furthermore, the function of formulation based complex case discussions is different to more process based reflective practice (Cole et al, 2011). Emerging evidence indicates that staff experience different benefits/outcomes from these different spaces. Reflective practice being more beneficial for developing a sense of belonging and protecting against burnout and formulation based complex case discussions facilitated the development and implementation of trauma informed practice (unpublished service evaluation). What remains crucial is that reflective and supervisory needs are defined and spaces are created, boundaried and reviewed in order to meet these needs. - Considering the above point is crucial that commissioning consider include the provision of funding for staff support as core delivery component within contracts. Without this what we observe from our experience is a high degree of staff turnover, which perpetuates the cycle of inconsistent relationships which people experiencing homelessness have already navigated.	

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Enabling Assessment Service London	Guideline	11	General re 1.3	• In principle we support the guidance that specialist MDT are developed in localities, however we would like to highlight the risk of over emphasising one model of service delivery. In practice we observe that the development of specialist MDTs will not be manageable in all areas. Therefore, we would like to see included in the guidance other examples of models for service provision that are seen as best practice. For example, it may be useful to further explore the practice-based evidence for others ways of gathering multidisciplinary staff through partnership working and alliances. Furthermore, we are interested in bringing out in the guidance further the importance of multi-agency, partnership and cross locations working and the value in training staff in mainstream mental health services to develop their practice in multiagency networking. This would of course require support from commissioners. • We would also like to invite more clarity in the guidance around the role of specialist mental health teams and the evidence/expert opinion around how these sorts of teams are. For example, there are good practice examples of mental health professions being co-located in accommodation services, or in reaching into staff teams in a consistent and organised manner. Such arrangements have the benefits of not only being able to offer a more flexible and relationally focused (trauma informed) service to people experiencing homelessness but crucially to develop relationships with accommodation	Thank you for your comment. The committee made the recommendations about multi disciplinary homelessness teams on the basis of the evidence they reviewed, which was corroborated by their own expertise. They discussed that people experiencing homelessness often have overlapping and intersecting care needs, which require the expertise and skills of different professionals to assess, plan and manage care jointly. Unfortunately the qualitative evidence described health and care systems as siloed, complex and fragmented, with little coordination between agencies and providers and therefore failing to meet such intersecting and often complex needs. For these reasons the committee made a range of recommendations to try to address these problems through joint working and multidisciplinary approaches. They deliberately did not recommend specific models of multidisciplinary working but instead described the important principles and essential elements, including that examples of good practice should be shared between homelessness leads in different areas. The committee did not feel there was the basis - from either the evidence or their own expertise -to recommend a specific model of multidisciplinary working and acknowledge that approaches will vary according to local arrangements. They also recognised that the emphasis on homelessness multidisciplinary team working in areas where there are low numbers of people experiencing homelessness will not be apprpriate and that in these cases

				providers and offer expertise through formulation based complex case discussions (where staff can help accommodation staff make the links between past trauma, present behaviour and appropriate mental health support planning). This is an example of how the staff support component of the PIE framework is developed and the principles of TIC, for example developing safety, are put into practice by health and social care practitioners.	links with multidisciplinary teams in nearby areas should be established and homelessness leads designated in the appropriate mainstream services.
Enabling Assessment Service London	Guideline	13	10	– We endorse the inclusion of reflective practice within the guidance. We would also like to see this term deconstructed so that the emerging evidence (e.g. Kurtz, 2019) can guide readers into the recommend options and considerations when designing and implement reflective spaces. As noted above we also recommend, from our practice-based evidence, that there is a distinction between a group reflective space based on processing the impact of the work, (the personal/professional interface) and reflective conversations based around formulating an understanding of a specific person and associated action plan/response, referred to as complex case discussions or group/team formulation (Hollingworth and Johnston, 2014).	Thank you for your comment but this is not a guideline on reflective practice and therefore the committee have not made further specifications to this recommendation.

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Enabling Assessment Service London	Guideline	19	6	We would like to see a stronger emphasis on the relationship between the assessment and formulation of people's experiences. In our practice-based experience one of the key outcomes of 'enabling assessment' are how they facilitate the wider network around a person to build capacity and confidence in better understanding and responding to peoples needs (Hollingworth and Johnston, 2014; EASI, Enabling Assessment Service London, Service Evaluation of input into Westminster, 2016). We would particularly emphasise the value of a 'trauma informed' formulation that considers what has happened to someone, developmental and socially rooted experiences of trauma and adversity and the linkage between these relational contexts and the challenges experienced in the here and now. - We would also like to offer that there is existing best practice is some areas, such as Bristol, where processes for interagency 'trusted assessments' processes are agreed so that key information does not need to be repeated by the person accessing services. This can protect against re-traumatisation and support a more asset/strengths-based approach when building a relationship with someone.	Thank you for your comment. The recommendation on assessing people's needs specifically refer to understanding the historical context of their situation including past traum. Elsewhere in the guideline trauma-informed practice is emphasised as an approach that could improve people's experience as well as improve their access and engagement with services. Importance of building a trusted relationship and strength-based approaches have also been emphasised in the General principles section of the guideline. However, based on your and other stakeholders' comments the committee have revised the recommendation to specifically mention that unnecessary and potentially distressing repetition of history which is already on record should be avoided.
Enabling Assessment Service London	Guideline	21	General	In our practice-based experience transitions can be a key trigger point for people accessing services and an area of challenge for organisations. we would like to emphasise that our expert opinion is that transitions need to be considered within a reflective practice setting,	Thank you for your suggestions. The committee did not feel that the evidence reviews underpinning the guideline provided the basis on which to make such detailed recommendations about how exactly such transitions should be handled. They felt that instead it would be a

				holding In mind how they are prepared for and crucially how information is shared. we are mindful that services (potentially both health and social care practitioners and housing workers) may have worked hard to establish the beginning of a relationship with someone and they may be at the tipping point of feeling safe enough to engage In an enabling assessment/formulation process, when they are moved to another more permanent housing option. - we invite more emphasis within the guidance that this is a key opportunity to engage In trauma informed practice, and therefore a relational approach to transitions. Tangible examples of this would be Considering how the person can safety end existing relationships and transfer that safety to relationships In the new location. Reflecting on how trust, choice and control might be maintained or navigated. crucially information needs to be shared and a level of co-responsibility across different health and social care teams/housing services retained. holding a pre-transition network meeting would be advisable. Cross location safety/proactive planning would be a key demonstration of trauma informed practice. this all requires health and social care practitioners to have enough time built into their work plan to work In the relational and reflective manner.	matter for local commissioners and providers to agree how to ensure, for example, that all handovers of care responsibilities are planned and coordinated, and relevant information is shared if agreed. Also, how exactly pre-emptive, structured support before, during and after transitions would be offered.
Enabling Assessment Service London	Guideline	22	General	--We would like to see a stronger description of the value of health and social care professionals working with the network around people experiencing homelessness and the value of building capacity within homelessness	Thank you for your comment. The committee believe this is covered in the guideline as the guideline recommends a multidisciplinary team approach but the committee have made it more explicit but specifically mentioning outreach and

				accommodation services through drawing on multidisciplinary, systemic and trauma informed frameworks.	homelessness practitioners in the list of people that could be involved in the homelessness multidisciplinary team. Trauma-informed care has also been mentioned in several parts of the guideline.
Enabling Assessment Service London	Guideline	23	General	We are mindful that consideration and assessment of people's mental capacity is both complex and often pivotal when making decisions about safeguarding. There would be value in referencing the concept of 'executive capacity' and the importance of capacity assessments by health professionals incorporating the evidence that housing and support staff might have in relation to someone's ability to execute decisions There may also be value in highlighting the problem of moving too fast to question capacity when someone's decision does not coincide with what professionals believe would be best, balanced against what was identified in the House of Lords Select Committee in its post-legislative scrutiny of the MCA 2005 in 2014: 'The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been	Thank you for your comment. None of the evidence reviews located data about adult safeguarding in the context of homelessness. The committee therefore drafted recommendations based on testimony provided by expert witnesses, who highlighted the importance of health and social care staff being supported to understand the legal duties and powers related to safeguarding. Although the recommendation does not specifically mention issues such as executive capacity and the Mental Capacity Act principles including presumption of capacity and unwise decisions, these would necessarily be covered by any training or professional development provided to practitioners to help them understand and apply relevant laws. The committee therefore decided not to make specific references to all relevant legislation in the recommendation itself but they are clear that the Mental Capacity Act and statutory guidance are among the laws relevant to homelessness and safeguarding and would therefore be covered.

				deliberately misappropriated to avoid taking responsibility for a vulnerable adult. (para 105)'	
Enabling Assessment Service London	Guideline	25	General	We endorse the inclusion and valuing of training. We would also like 'what' should be included in such training more specifically identified. We suggest that one of the publicly available K&S frameworks for trauma informed practice could be referenced. https://transformingpsychologicaltrauma.scot/media/5lvh0lsu/trauma-training-plan-final.pdf and Trauma-Informed System (bristolsafeguarding.org). We recommend this is relevant for both health and social care professionals and housing workers. We also wish to highlight that training needs to be followed/partnered with a scaffold of supervision and ongoing reflective learning spaces. In our experience this would involve a mixture of 1:1 reflective/clinical supervision space, complex case/group formulation and discussions, and group reflective practice. These types of spaces should be decided depending on assessment of need (potentially linked to a knowledge and skills framework) and commissioned accordingly. Group reflective space alone cannot meet the supervision needs of staff working with people who have experience complex trauma/multiple and severe disadvantage. Staff have different learning styles and need more or less 1:1 space for learning to be safe and within the 'window of tolerance'.	Thank you for your comment. The committee did not want to be prescriptive of the details of the trainings and listing general training areas was considered sufficient. Thank you for providing an example of training resources. The committee have included some links to resources in the rationale and impact section, however, they are not able to include a comprehensive list and have focused on training specific to homelessness. In terms of reflective practice, this has been addressed in the recommendations; however, the guideline is not a guideline on reflective practice so no details around this have been covered.

				Compassion fatigue/vicarious trauma is a risk for health/social care practitioners and housing workers. It is a potential driver of less effective practice and re-traumatisation. Robust supervision structures are key for ongoing professional sustainment and competency (Watkins, 2011; Wallbank, 2012)). Whoever is delivering/facilitating these sessions requires appropriate training and access to supervision themselves. Additionally, within suitable structure in place themselves, health and social care practitioners can be well placed to facilitate these types of supervision spaces within accommodation/housing teams. 1.12.3 In line with the above comments, we invite consideration that guidance of supervision for staff worded more strongly – all health and social care practitioners AND housing staff should have access to 1:1 reflective/clinical supervision, alongside group reflective and formulation spaces for the purposes of safe and effective practice	

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Enabling Assessment Service London	Guideline	30	16	We welcome more research into the effectiveness of PIE, however we would like to see this broadened to include trauma informed practice. We also question why this is focused on the model of clinical psychology led PIE services and suggest that a research design which considered different models/practical applications within a breath of contexts would be more useful in identifying best practice moving forward	Thank you for your comment, which the committee discussed. The rationale for specifying that the experimental intervention in the research recommendation on PIE should specifically be 'clinical psychology led' is largely to do with the importance that the committee place on the fidelity of the intervention under investigation. They are aware that other similar models purporting to be "PIE" do exist but do not necessarily involve clinical psychologists and when this is the case, the model cannot be legitimately labelled "PIE" because of the intrinsic contribution of clinical psychology, which covers all aspects of the psychologically informed environment. The committee felt that since they are recommending future research on PIE, they should ensure this is clinical psychology led because otherwise it will not legitimately be PIE and it is this high fidelity PIE for which the committee wish to generate evidence of effectiveness in order to provide the basis for firmer practice recommendations in future updates of this guideline.
Faculty for Homeless and Inclusion Health and Pathway Charity	General			Overall comment -we welcome this guidance and commend the committee for the thorough consideration of the available evidence.	Thank you for your comment and for providing feedback on the draft guideline.

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Faculty for Homeless and Inclusion Health and Pathway Charity	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?	Thank you for your comment. Unfortunately, it is not within the remit of NICE guideline committees to recommend the development of future guidance but your comment will be passed to the NICE commissioning team for consideration.
Faculty for Homeless and Inclusion Health and Pathway Charity	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.	Thank you for your comment; a definition of 'social care staff' has now been added to the 'terms used in the this guideline'.
Faculty for Homeless and Inclusion Health and Pathway Charity	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"	Thank you for your comment. The population of the guideline was carefully considered and determined based on a scoping exercise including stakeholder consultation. The scope which defines the population was signed off and published in December 2020. The population does include people who are temporary residents of domestic violence safehouses (or other temporary accommodation) but excludes people in institutions in the long-term, such as prison.

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Faculty for Homeless and Inclusion Health and Pathway Charity	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…."	Thank you for your comment. Outreach services is covered in this guideline and even has its own section. Specifying it in this recommendation was not considered necessary.
Faculty for Homeless and Inclusion Health and Pathway Charity	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."	Thank you for your comment. Consideration of social determinants of health have been added to a recommendation in general principles and planning and commissioning. Social determinants of health are also discussed in the context section and referred to these throughout the guideline and rationale sections.
Faculty for Homeless and Inclusion Health and Pathway Charity	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."	Thank you for your comment, the suggested change has been made.

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Faculty for Homeless and Inclusion Health and Pathway Charity	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.	Thank you for your suggestion. The committee agree with you about the lack of palliative care to meet the needs of this population. They addressed your comment by adding to the recommendation to say that wraparound health and social care support should encompass palliative care needs. They also added a new recommendation about palliative care to the section of the guideline on long-term support.
Faculty for Homeless and Inclusion Health and Pathway Charity	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.	Thank you for your comment; the suggested change has been made.
Faculty for Homeless and Inclusion Health and Pathway Charity	Guideline	13	16 & 23	We would suggest "homelessness **health** leads" to differentiate this role from a housing specific post.	Thank you for your comment. The committee do not think this addition is needed or necessarily appropriate. The role is leading on issues related to homelessness within a health or social care service. The role does not only involve issues around health but might also involve issues around legal duties around homelessness, social care issues, or liaison with housing services.

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Faculty for Homeless and Inclusion Health and Pathway Charity	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.	Thank you for your comment. As suggested, this was reiterated in the recommendation by adding psychologically informed environments and trauma informed care to the bulleted list.
Faculty for Homeless and Inclusion Health and Pathway Charity	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."	Thank you for your suggestion. This recommendation now makes reference to residential care and supported housing.
Faculty for Homeless and Inclusion Health and Pathway Charity	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".	Thank you for your comment, this has been revised as suggested.

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Faculty for Homeless and Inclusion Health and Pathway Charity	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"	Thank you for your comment. As suggested, the committee added that comprehensive assessment should be undertaken by taking into account the person's housing and benefits situation.
Faculty for Homeless and Inclusion Health and Pathway Charity	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.	Thank you for your comment. The committee agree with you and have revised the recommendation as suggested. This was already discussed in the rationale section.
Faculty for Homeless and Inclusion Health and Pathway Charity	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"	Thank you, this has been added.

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Faculty for Homeless and Inclusion Health and Pathway Charity	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”.	Thank you for your comment, the recommendation has been revised as suggested to include those working in homelessness and housing services.
Faculty for Homeless and Inclusion Health and Pathway Charity	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).	Thank you for your comment. As a general principle, references to resources that have not been reviewed by the committee and which are not accredited by NICE are not made in the recommendations. The evidence you refer to was indeed reviewed and to an extent informed the committee's decision making.
Faculty for Homeless and Inclusion Health and Pathway Charity	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.”	Thank you for your comment. This was something the committee discussed thoroughly when making this recommendation and again after receiving this comment. The committee deliberately agreed to keep it generic, there are various models and options for housing that could be applicable to different individuals depending on their specific needs but the focus of this guideline is not on housing.

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Faculty for Homeless and Inclusion Health and Pathway Charity	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."	Thank you for your comment. The committee agreed to edit one of the other recommendations in this section of the guideline in order to incorporate the point you make. In the recommendation aimed at commissioners and providers to help health and social care staff understand the laws relating to people experiencing homelessness and who are in need of safeguarding, they added that this should include indications of abuse and neglect, including self neglect and how to make a safeguarding referral
Faculty for Homeless and Inclusion Health and Pathway Charity	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."	Thank you for your comment. The committee agreed to add a recommendation based on your and other stakeholders' comment about provision of palliative care for those for whom death is not unexpected in the next 6 to 12 months. We have also revised the definition of recovery-oriented language to reflect that not everyone will recover.
Faculty for Homeless and Inclusion Health and Pathway Charity	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…"	Thank you for your suggestion. The committee felt this was already addressed by the draft recommendation but have nevertheless amended slightly to try to make the meaning much more explicit. It now recommends training on homelessness as part of equality and diversity training, including responsiveness to the impact of discrimination and stigma and of intersectional, overlapping identities.

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Faculty for Homeless and Inclusion Health and Pathway Charity	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."	Thank you for your comment. In the 'Why the committee made the recommendations' section, it is made clear that safeguarding is included.
Faculty for Homeless and Inclusion Health and Pathway Charity	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."	Thank you for your comment, on the basis of which the definition has now been revised.
Faculty for Homeless and Inclusion Health and Pathway Charity	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?	Thank you for your suggestion. The committee recognise this approach as the basis for Housing First and similar approaches to providing wrap around health and social care to provide support that is flexible to people's changing needs and which helps to sustain appropriate accommodation. The committee reviewed evidence on this approach to care and support and used it together with their own expertise on this issue, to make recommendations with the intention of improving responsiveness to complex and fluctuating needs and maximising outcomes from housing with health and social care support. They also made a research recommendation to try to understand the possible structural and systems factors which

					help or hinder the commissioning of this approach to care and support for people experiencing homelessness. The committee therefore did not believe that a further research recommendation was needed to cover these issues.
Faculty for Homeless and Inclusion Health and Pathway Charity	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”	Thank you for your comment. The text in the 'Impact' section has been revised to state that local data recording methods may need to be adjusted.
Faculty for Homeless and Inclusion Health and Pathway Charity	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”.	Thank you for your comment. The recommendations on this have been slightly rephrased. Even though your wording has not been explicitly used, the recommendation is to record homelessness status in a way that can be used for planning and audit to improve services. We also acknowledged in the rationale section that this might require adjusting existing data recording methods to record homelessness status in a meaningful way.

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Faculty for Homeless and Inclusion Health and Pathway Charity	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"***	Thank you for your comment. The effectiveness evidence for this topic showed little benefit overall, however the health economic evidence showed that homelessness multidisciplinary teams (not necessarily hospital-based) represent value for money and are potentially cost saving. This has been stated in the rationale and impact section for the recommendations on homelessness multidisciplinary teams. We also included the suggested wording.
Faculty for Homeless and Inclusion Health and Pathway Charity	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	Thank you for your comment. The evidence you mention was indeed reviewed by the committee and to an extent informed their decision-making. There are elements in the Pathway model that align with the recommendations, however, the Pathway model has not been mentioned in the recommendations as such; thus, no reference to the Pathway website has been made.
Faculty for Homeless and Inclusion Health and Pathway Charity	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.	Thank you for your comment. Some economic evidence was identified where intermediate care was provided successfully in hostels. Also, based on their experience the committee, , believed that intermediate care could be delivered effectively in the community settings, including hostels. It was not the intention to suggest that intermediate care provided in hostels is cheaper. The rationale has been reworded to ensure that such hostels should be

					suitable, which should help address the challenges you have identified.
Faculty for Homeless and Inclusion Health and Pathway Charity	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"	Thank you for your comment. The cost-effectiveness analysis compares alternative courses of action in terms of their costs and outcomes. So generally, the term 'cost effectiveness' implies that outcomes were considered. Also, the suggested wording would not be completely accurate. The Pathway model refers typically to the clinically-led teams. However, the evidence was leaning towards housing-led teams. Also, the committee did not feel that the evidence was sufficient to recommend a particular team composition and only suggested what homelessness multidisciplinary teams may want to include.
Faculty for Homeless and Inclusion Health and Pathway Charity	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.	Thank you for your suggestion. The committee received a number of suggestions for additional resources so they agreed to address these by making an additional, general reference to 'further resources in Health Education England's inclusion health education mapping and review.'
Faculty for Homeless and Inclusion Health and Pathway Charity	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?	Thank you for your suggestion. The committee made a general addition to this section to address several stakeholder comments. They did not make additional reference to these networks but given that the training modules by the Faculty for Homeless and Inclusion Health are specifically cited they expect people will be able to follow links from there to take the opportunity to join the network.

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Faculty for Homeless and Inclusion Health and Pathway Charity	Evidence Review A -B	53		**Table** 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.	Thank you for your comment. Even though clinically involved MDTs increased planned care for patients after discharge, this was not reflected in any additional benefits, e.g. quality-adjusted life years or cost reductions due to, e.g. reduction in morbidity and mortality. This is only the summary of the cost-effectiveness findings and only one piece of information that the committee has used in their decision making. The committee does make recommendations on multidisciplinary working and the composition of such teams. However, it does not make explicit recommendations as to whether these should be clinically or housing-led. The committee do not look at the cheapest option but instead, the most cost-effective option and that includes comparing all alternatives in terms of their costs and outcomes. The committee discussion of this evidence is summarised in the section titled 'The committee's discussion and interpretation of the evidence'.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	General		Whilst understanding the ambition to use language, which is hopeful and strength based, feedback is that the use of the phrase "drug and alcohol recovery needs" throughout the document, is suggestive that it is always possible to "recover" from drug and/or alcohol dependency.	Thank you for your comment. The committee agrees that recovery is not always possible. Finding terminology that is universally accepted is difficult but the wording has been amended to "drug and alcohol treatment needs".

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Greater Manchester Mental Health NHS Foundation Trust	Guideline	4		Pg 4 ‘siloed’ and ‘rigid’; these seem to be used an undefined, pejorative terms and should be better explained or left out.	Thank you for your comment. The committee think that in this context these terms should be relatively well understood, describing the systemic and structural issues in services that create barriers for accessing and engaging with health and social care services among people experiencing homeless.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	6		Pg. 6 Recommendation. Whilst recommending those with lived experience are involved in co-production etc, does some thought need to be given on the recent relevance and aspire to include those still experiencing homelessness too?	Thank you for your comment. The term 'lived experience' covers people who are experiencing as well as those who have in the past experienced homelessness.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	8		Pg. 8 ‘non-judgemental’, consider a phrase such as ‘unconditional positive regard’ instead	Thank you for your comment. The committee think that 'non-judgmental' is a much more widely used and understood term than 'unconditional positive regard' and have therefore not changed the wording.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	8		The communication methods they list are all dependent on homeless people having a phone, a computer or an address..digital poverty is a big issue.	Thank you for your comment. Based on consultation feedback we have added "face to face" to the list. However, the committee have also added a point about considering the person's access to a phone or internet as well as addressing digital connectivity elsewhere in the guideline to improve people's access and engagement with health and social care.

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Greater Manchester Mental Health NHS Foundation Trust	Guideline	8	15	S1.1.11 Advocacy. This seems a sensible idea. Proper, trained advocate would be excellent.	Thank you for your comment. The committee was of the view that this needs to be broader and that some people experiencing homelessness might want a friend or support worker, who is not trained, to advocate for them. However, it could also be an independent advocate, i.e. someone who would be trained. The committee was concerned that many people could be cut out of services if limited only to qualified advocates. Also, there is no supporting evidence that using only suitably trained advocates is the right thing to do. The committee also slightly reworded the recommendation to make the above clearer.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	10	28	S1.2.6 kind of agree; women clearly have different challenges BUT earlier they criticise fragmentation. If we want 'Inclusion Health' homeless teams should just get their heads around the needs of women, rather than having a separate team. SIX minorities are listed but it's unrealistic to have six teams?	Thank you for your comment. The recommendation is not suggesting there to be different teams for each group listed (which are just examples) but to consider whether there needs to be a specific service or support provided to groups/individuals with specific needs. The guideline otherwise emphasises the importance of practitioners and teams working with people experiencing homelessness to be responsive to people's specific needs, including their inclusion and diversity needs.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	11	12	S1.2.8 people need to see a GP. This probably the single most important thing which would improve their health. Is just one point & perhaps an idea about the strategy to improve this would be good. They do say later that GPs have a duty etc but it isn't v practical advice. The attitudes of primary care staff need to change.	Thank you for raising this. Although the committee did not make a change to this specific recommendation, they did make changes to other recommendations in response to yours and other stakeholder comments. In particular, they stated that when people experiencing homelessness are given information about how to access primary health services, this should

					include their right to GP registration, even without a permanent address. As well as the recommendation you mention, the committee had also already made a recommendation directed at primary care service providers that they should ensure people without an address can register with a GP practice and that this is in line with NHS policy. The committee feel that on balance they have made the point in the strongest terms they could.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	12	1	S1.3.2, agree needs to be 'addiction treatment' needs	Thank you for your suggestion, which the committee have taken on board. The recommendation now refers to alcohol and drug treatment needs.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	12	1	General language is v patronising 'NEEDS'. We are imposing our views on these people somewhat.	Thank you for your comment. 'Needs' are seen in the context of people having needs that have not been met or that need addressing. The guideline does not impose any particular needs on individuals but recommends that a comprehensive assessment of the person's health and social care needs is done, involving the person themselves.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	15	9	S1.5.14 again 'addiction treatment'	Thank you for your suggestion, which the committee have taken on board. The recommendation now refers to alcohol and drug treatment needs.

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Greater Manchester Mental Health NHS Foundation Trust	Guideline	15	9	Later on in the section explaining why they made certain recommendations, they use the Hep C treatment analogy. The difficulty with this is that the Hep C agenda has its impetus from pharmaceutical companies. Before we have the oral anti-virals, the Hep C teams were far less proactive.	Thank you for your comment. The committee are not sure what is meant by 'the Hep C analogy'. Effectiveness evidence on outreach services was scarce; there was a study on outreach services for people with hepatitis C that showed it to be cost effective. This piece of evidence formed only a part of the reasoning for the committee to make a recommendation about outreach services, the committee were also informed by qualitative evidence and their knowledge and experience.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	15	9	Later on a suggestion that addiction services should ‘modify eligibility criteria’.They don’t say how. Surely self-referral is enough?	Thank you for your comment. Just to clarify, the reference to modifying eligibility criteria was not in itself a recommendation but instead a description of the way in which that recommendation might change practice. In other words, some addiction services may need to revise their criteria in order to fulfil the recommendation.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	15	9	Final thought is that they don’t mention the interplay with the criminal justice system and how short-term prison sentences seem to be further destabilising this population. Lots of my patients seem to be NFA immediately on leaving prison.	Thank you for your comment. People staying in institutions (such as prisons) in the long-term were not covered by this guideline. However, it is recognised that people experiencing homelessness may end up in custody in the short term. This is covered in the section on Transitions between settings where it is recommended that homelessness multidisciplinary teams or homelessness leads should support people experiencing homelessness through transitions between settings (such as custody) and consider providing time-limited intensive support. Based on the consultation feedback, the committee also revised the Planning and commissioning section

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					around commissioners of health, social care and housing services working together to also involve commissioners from other sectors such as criminal justice and domestic abuse as needed.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	15	25	**S.1.12** The need to improve competence and confidence across the workforce is also referenced in the Dame Carol Black review and applies to both MH staff being skilled in understanding alcohol and drug dependency and the staff within Addictions Services having a better knowledge of mental illness. This could be further referenced in section 1.12.	Thank you for your comment. The committee appreciate these are important points but this would probably better fall within the remit of the other NICE guideline on coexisting severe mental health illness (psychosis) and substance misuse already referred to and is not specific to homelessness. Therefore, no reference to the review you mention has been made.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	21	2	1.8.1 suggest this is rewritten as “residential or community drug and alcohol treatment.”	Thank you for your comment; the suggested change has been made.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	44		reference to Housing First might want to reflect the pilot site models include support for drug and alcohol problems as well as mental health.	Thank you for your comment. If you are referring to the UK Housing First pilot site studies, no effectiveness evidence matching the review protocol's inclusion criteria was identified but it is likely that further evidence will become available to inform future updates of this guideline. There is a reference to mental health in the section you highlight as evidence was identified for a Housing First approach for people with moderate to severe mental health problems experiencing homelessness.

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Greater Manchester Mental Health NHS Foundation Trust	Guideline	48		suggest “there are existing peer networks, for example, for people recovering from problem drug or alcohol use,” is rewritten as “people experiencing drug and/or alcohol dependency issues.”	Thank you for your comment, the suggested change has been made.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	61		may be an opportunity to recommend consideration be given to referral to specialist inpatient detox settings to improve outcomes (or at least liaison with?)	Thank you for your comment. It is not entirely clear what this is in reference to. However, referral to onward care or specialist services, such as inpatient detox, would be based on the multidisciplinary team's consideration based on the person's assessed needs. The role of the MDT is described in the section on The models of multidisciplinary service provision.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	61		GAMBLING There is some evidence of increased prevalence of history of problem gambling in this population. Consider using the term ADDICTION.	Thank you for your comment. The committee recognise that gambling addiction or history of it may be more prevalent in people experiencing homelessness, however, it was not something that featured in the evidence that was reviewed. The recommendations around assessing the individual's needs will cover a range of health and social care needs and would certainly include addiction, including gambling. The committee have therefore not made a specific reference to this in the guideline.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	68		The same language is not applied when discussing physical and mental health issues or problems and, in fact, the document uses the terms “problem drug and alcohol use”, “substance misuse” and, on page 68, describes “complicated health problems, such as addiction”.	Thank you for your comment. The language used when referring to drug and alcohol issues has been revised and the term 'drug and alcohol treatment needs' is now used.

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Greater Manchester Mental Health NHS Foundation Trust	Guideline	68		Consideration should be given to referencing the recently published Government commissioned Review of Drugs, Part 2, authored by Professor Dame Carol Black, who urges medical professionals and the public to consider and treat addiction like diabetes or rheumatoid arthritis. The public perception and stigma associated with addiction as being a “lifestyle choice”, can be perpetuated with the suggestion of a “failed” recovery. Recommend replacing “recovery” with “treatment” or “treatment and recovery”.	Thank you for your comment. It is not clear to which section of the guideline this comment is refers. The guideline does not suggest addiction is a lifestyle choice or make any reference to failed recovery. Based on feedback, the language used when referring to drug and alcohol issues has been changed and the term "drug and alcohol treatment needs" is now used.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	68		The reference on p.68 to “people’s preferences” may require further referencing with harm reduction approaches.	Thank you for your comment. People's preferences cover much wider issues than harm reduction. This issue has not been specified here.
Greater Manchester Mental Health NHS Foundation Trust	Guideline	68		Can it be made clearer that there is benefit, efficiency and improved outcomes to people experiencing homelessness having their needs met by fewer professionals? Examples would be where a psychiatrist from either a MH or Addiction Service is prevented from prescribing medication for both conditions, exacerbated by funding restraints and commissioning arrangements.	Thank you for your comment. This was not something that came up in the effectiveness evidence that was identified and reviewed for this guideline although in general the committee agrees with this. Therefore, the committee have made recommendations around care and support for people experiencing homelessness to be led by a homelessness multidisciplinary team, with person-centred case management by a designated practitioner within the MDT, providing continuity of care as long as needed. Importance of building trusted relationships and having a key practitioner coordinating care during transitions between settings has also been recommended by the guideline.

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Groundswell	Guideline	General	General	We welcome NICE producing guideline in relation to people experiencing homelessness and strongly support all of the recommendations outlined in the draft particularly those in relation to: involvement of peers; long-term support; focus on engagement with services; intermediate care; trauma informed and psychologically informed care; multi-disciplinary working; housing health and social care support; and outreach working. The recommendations, if implemented effectively would be the gold standard of care for people experiencing homelessness and would greatly improve health and social care outcomes for individuals. However, in order for the recommendations to be effectively implemented significant change in systems and investment would be required. Current short term contract lengths and targets that conflict with delivering person centred support place significant barriers on services adopting the recommendations of the guideline. All health and social care staff would need significant, standardised training in understanding and addressing the barriers to access and engagement for people experiencing homelessness. The move towards Integrated Care Systems should provide a platform to improve multi-disciplinary working between organisations however, barriers to this exist and will take time, resource and commitment to overcome them. The recommendation on the involvement of peers across the design and delivery of services is excellent however, in order for participation and involvement to be	Thank you for your comment and support for the recommendations in this guideline. It is hoped that the guideline will push required change in planning and practice to improve the lives of people experiencing homelessness. The committee believe all the issues you raise have been addressed in the guideline and where needed multidisciplinary working, training for health and social care practitioners, and support and career progression opportunities for peers, including reference to considering the likely benefits of long-term contracts with providers. The committee agreed some changes to the wording of the recommendations or the rationale sections where appropriate. For example, based on your and the #HealthNow peer network's feedback word "inclusive" has been added when referring to "employment opportunities" for peers.

				meaningful long term investment is needed to ensure peers are supported to be involved and are provided with a package of training and progression support. Services also need to review their recruitment and HR practices to remove barriers to volunteering and employment for people with lived experience of homelessness.	
Groundswell	Guideline	General	General	Responses to set questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. Investment in staff support and development. Support is delivered by people, so if they are motivated, happy and well trained they will do a good job. Plus if their teams are well resourced they will have time and energy to work in a multi-disciplinary way, joining up all the different aspects of support, like housing and health, to make a clearer, more consistent pathway of support of individuals that is more efficient and effective. 2. Would implementation of any of the draft recommendations have significant cost implications? Initial investment in building staff teams will reduce costs in the long run as providers will not be on a constant cycle of contract insecurity and	Thank you for your comment. In this context 'practice' means recommendations will have the most significant change in the way services or health and social care are delivered to people experiencing homelessness. The committee agree with the points you raise about investment in staff support and development and staffing resources and made recommendations on this. Economic analysis was also undertaken as part of the guideline development that showed that reducing caseloads (increasing staff) would potentially represent value for money and support the points you made. The committee agree with you that models of service provision vary in current practice and this is acknowledged in the guideline. In some areas with high rates of homelessness, there are no specialist homelessness multidisciplinary teams, or services are often focused on one aspect or are mainly medically led. However, there may not be a need to employ new staff but to

				short term recruitment drives which achieve little. Those using services will benefit from stable well trained teams which lead to improved outcomes and reduced homelessness. AS we move towards an integrated system we need to think about the cross-sector cost savings that would be seen as a result of the investment (i.e. criminal justice, housing, employment). 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) Services work in silos, peer support is a way to build bridges and trust between different parts of the system, like Homeless Health Peer Advocacy which enables housing providers to refer people for health appointments. 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. Covid-19 is a health issue that isn't going to go away, like the flu or cancer, so just be treated as normal business not a separate entity. This is particularly true of the vaccine rollout – we should stop trying to get everyone vaccinated as a one off piece of work but consider it as part of wider health promotion.	reorganise, collaborate with other agencies and form a team from existing professionals. Some evidence was also located that showed that such ways of working represented value for money and referred to some of the cross-sector cost savings you identified. This guidance aims to improve the integration of services, and it is hoped that overall the guidance will help improve care for people experiencing homelessness. Thank you for pointing out Homeless Health Peer Advocacy. This model is already referred to in the committee discussion of the evidence section of full evidence review A-B. It is encouraging to see that there are already initiatives that will support the implementation of some of the recommendations in this guidance. The committee made recommendations to commissioners and the design and delivery of services that reduce barriers to access and engagement and specifically considered a digital exclusion. It is hoped that overall, the guidance will help improve care for people experiencing homelessness, whether at a global pandemic or not.

				Through our work and the work of our #HealthNow and HHPA partners delivering frontline, peer-led services we know that health inequalities for people experiencing homelessness are greater than ever. The increased pressure on health and care services combined with the rapid move towards remote and digital delivery have resulted in people being unable to access the health and care they need when they need it. If anything it indicates the need for the recommendation to be published and adopted as soon as possible.	
Groundswell	Guideline	6	15	We feel that services should be strongly encouraged to be trauma informed and psychologically informed & use of the word 'consider' does not convey how important this recommendation is. Adoption of both approaches requires a change in thinking and significant training and support for staff in services at all levels. Both approaches require a long term commitment and change in policy and practice,	Thank you for your comment. The committee agree about the importance of psychologically informed environments and trauma informed care, however, they also agreed that there is some uncertainty around it and more research is needed on the topic to hopefully inform future updated of the guidance and made a research recommendation about it. Therefore, the committee was not able to make a stronger recommendation about it.

				implementation of them needs to be meaningful and not tokenistic.	
Groundswell	Guideline	9	014 - 018	Important to recognise that local research on health needs of people experiencing homelessness may already exist and rather than investing time and resource in repeating this can be used in consultation with local stakeholders (including people with personal experience of homelessness) to identify need and then coproduce services to address this in a similar way to the #HealthNow local alliances.	Thank you for your comment. The committee did not intend to imply that such information is not already available in some places but they are aware the population needs assessments are not conducted consistently and they are aiming to improve this. They made a slight amendment to this recommendation to emphasise that homelessness health and social care needs assessments should be maintained and kept up to date - not just conducted as a one off. The committee also feel that your comment is addressed in the recommendation to involve peers (experts by experience) in delivering and designing services and they have added to this, placing greater emphasis on the importance of the user perspective in actually influencing the service design and development. They also slightly amended this recommendation so that peers should also be involved in participatory research and data collection.

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Groundswell	Guideline	10	9	We recognise that recording of homelessness status can when used and recorded accurately improve access and provision of care and improve awareness and understanding about the health needs of people experiencing different forms of homelessness. However, consultation with people with experience of homelessness should be sought to ensure that: information is asked at an appropriate time and in an appropriate way; asking and recording of housing status is explained clearly; develop process for reviewing housing status; and process for how long information is recorded for (i.e. how long it remains on a person's medical record)	Thank you for your comment. The committee considered this carefully when drafting the recommendation originally and when revising it based on the consultation feedback. The committee recognises the issues raised, however, they did not want to go into the level of detail suggested but agreed to revise it to emphasise that the recording should be a way to improve the individual's care and support. They revised the recommendation to state that commissioners should work with providers to improve the recording of housing status (not homelessness status) so that services can best meet the individual's needs, and to use it for planning and audit to improve services.
Groundswell	Guideline	10	21	We feel very strongly that longer term commissioning of services is an essential requirement for delivering health and care services to people experiencing homelessness, particularly if they are to implement any of the recommendations in this guideline. Short-term commissioning places too much pressure on services in terms of time and resource and restricts the ability to build relationships with partners to promote integrated and multi-disciplinary working and trusting relationships with people experiencing homelessness.	Thank you for your comment. Yes, there are likely benefits of long-term contracts and the committee have revised the wording of the recommendation to emphasise this but the committee recognises that there needs to be flexibility to adapt to changing local needs and this has been discussed in the rationale section.
Groundswell	Guideline	11	1	Although not academically published research our work on Women, Homelessness and Health supports this recommendation. Along with partners we also delivered a conference on the same topic and feedback from discussions held with delegates was the need for services to be	Thank you for your comment and support for this recommendation. The committee agrees that services and responding to the needs of people experiencing homelessness should be gender-responsive, and also responsive to various other sometimes overlapping or intersecting experiences. This is why the committee has

				gender-informed & that the answer isn't just to provide women-only service provision.	included reference to being responsive to people's inclusion and diversity needs in different sections of the guideline.
Groundswell	Guideline	12	31	We strongly support the recommendation to include peers with personal experience of homelessness as part of the multi-disciplinary team. Our work providing peer-led health support demonstrates that this model improves trust between the person experiencing homelessness and health care services which promotes engagement and improves health outcomes.	Thank you for your support.
Groundswell	Guideline	13	013 - 026	We acknowledge that provision of specialist homeless and inclusion health services should be proportionate to need and support the recommendation that there are homeless leads within mainstream services – we would also recommend. We also believe homeless leads should have an additional responsibility to ensure training on homeless and inclusion health is provided within their services to ensure awareness raising, appropriate provision of care and link in to other support services this would not only support people currently experiencing homelessness but could support people at risk of homelessness to prevent them from becoming homeless.	Thank you for your support for these recommendations. The committee discussed your suggestion and agreed not to specify that homelessness leads should have responsibility for implementing training. They have made a detailed recommendation about training for health and social care practitioners including on the issues you mention. Although they anticipate that homelessness leads would have a role in organising this training they did not think they had the grounds to assign this responsibility, agreeing instead that plans for training and implementation would vary according local arrangements.

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Groundswell	Guideline	14	1	We strongly support the entire section on the role of peers. All aspects of the recommendation fully align with how we design and deliver our services at Groundswell and we hope our work and our reputation have influence this section despite our evidence not being recognised as it is not academic research. Kings College London and The London School of Hygiene and Tropical medicine are currently undertaking an evaluation of our Homeless Health Peer Advocacy (HHPA) service and we hope the outcome of this will contribute to the evidence base to support the role of peers in health and social care delivery. While we advocate for the development of both volunteering and paid roles designed for peers we also want to emphasise the value of having people with lived experience in all roles within health and social care. This may require organisations to review their recruitment processes to remove barriers for people with experience of homelessness and also recognise the value of lived experience in the same way as experience gained through employment.	Thank you for your comment. It is hoped that the recommendations on the role of peers will have an impact on practice. Some organisations may need to review their recruitment policies and the committee have revised the recommendations to include reference to "inclusive employment opportunities" to stress the importance of this.
Groundswell	Guideline	14	18	Through our experience in conducting peer research we strongly feel that peers contribute to the research process much more than simply data collection and recommend the use of the term participatory research or peer research	Thank you for your comment, in response to which the wording in the recommendation has been revised.

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Groundswell	Guideline	15	001 - 002	Important to consider range of ways that peers can be incentivised or supported to be involved i.e. paid employment, progression opportunities, vouchers or payment for sharing experiences for research or consultation. We are currently undertaking an economic evaluation of the progression programme we deliver as part of our peer-led service approach in partnership with New Economics Foundation which will be available in early 2022.	Thank you for your comment. The committee agreed that organisations might need to review their recruitment policies so they have revised the recommendations to include reference to "inclusive employment opportunities" to stress the importance of this.
Groundswell	Guideline	16	025 - 028	Would also recommend having staff trained as digital champions to help people experiencing homelessness develop the skills, confidence and motivation to engage with digital technology.	Thank you for your suggestion. The committee did not feel they had the basis on which to specifically recommend that staff are trained as digital champions but they did agree the recommendations would help to ensure that staff support people with online access to health and social care information and are supported to use online services. They did also make a training recommendation to ensure health and social care practitioners understand the health and social care needs of people experiencing homelessness, and their rights to access services.
Groundswell	Guideline	17	001 - 009	Fully support all of these recommendations however, through our work reducing health inequalities for people experiencing homelessness we acknowledge that comprehensive training in homelessness and inclusion health would be required for staff & clear processes & policies in place in order for the recommendations to be effectively implemented.	Thank you for your comment and your support for these recommendations. The committee agree that when policies and processes are in place and when staff are provided with the range of training set out in the training section of the guideline that these recommendations are feasible within the current practice context.

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Groundswell	Guideline	17	010 - 013	From our work delivering Peer Advocacy services in London our frontline staff also want to raise awareness on the barriers people face accessing some forms of diagnostic interventions which require pre-procedure preparation (such as nil by mouth). In order to support the patient to engage with the intervention and reduce the risk of missed appointments a person-centred plan should be put in place to support the patient to attend, this could include being admitted to hospital or in intermediate care facility for stabilisation prior to the appointment.	Thank you for your comment. The guideline makes a recommendation about intermediate care which could potentially be relevant in this case; otherwise the guideline recommends a person-centred case management approach a designated person within an MDT so the committee would expect considerations for appropriate preparations for diagnostic tests to be made by the team so that the person's attendance can be supported.
Groundswell	Guideline	19	006 - 012	While comprehensive assessments are important to ensure appropriate care and support is provided care needs to be taken when developing processes on how and when assessments should take place and how frequently. Feedback from our peers and our experience delivering frontline services has contributed to our understanding that assessments can be a barrier to accessing care and support if people are being asked to disclose too much information without building a relationship with the service and if people are repeatedly asked the provide the same information to multiple services and workers. Focus should be placed on ensuring robust data sharing processes are in place to allow information sharing between services and to promote partnership working.	Thank you for your comment. The committee agree with you and have revised the recommendation so state that unnecessary and potentially distressing repetition of a history that is already on record should be avoided. The committee also made recommendations about involving advocates or peer supporters in appointments. Advocates and peers supporters can help to ensure that the situation you are describing does not happen. In addition, there are recommendations around a more coordinated approach with appropriate information sharing, e.g. services have protocols and systems in place for sharing information.
Groundswell	Guideline	19	17	We strongly support the recommendation that the individual is involved in their health and social care planning.	Thank you for your support.

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Groundswell	Guideline	22	004 - 007	Based on previous conversations we have had in our #HealthNow peer network this recommendation is strongly supported by people with lived experience of homelessness. Need to recognise the impact that housing has on health & wellbeing and the ability to engage in services, supporting people to access the right type of accommodation and support and providing people with choice and control over where they live can significantly improve outcomes for people and support them to move successfully out of homelessness.	Thank you.
Groundswell	Guideline	22	016 - 019	Again from previous conversations with our network peers have stressed the importance of existing support services remaining in place wherever possible to support someone for a period of transition when moving in to new accommodation. This is particularly important when people are moving from supported accommodation into independent living.	Thank you for your comment. The importance of existing support services for people experiencing homelessness has been acknowledged in the section on transitions between settings, which states that emotional and practical support, should be provided for as long as it is needed.
Groundswell	Guideline	26	1	In consultation with our #HealthNow peer network we recommend that there should be a definition of what is meant by the term peer. The definition our peers suggested is – a person with lived experience of homelessness who are using the experience to benefit others through different means such as direct support, research, coproduction, media.	Thank you for your comment; a definition of the term 'peer' has now been added, based on the suggestion by the #HealthNow peer network.

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Groundswell	Guideline	30	13	Given the recommendation for the role of peers in the guideline but lack of academic research to support the effectiveness of peer-led approaches we also recommend research into this is conducted.	Thank you for your suggestion, which the committee discussed. On the basis of quantitative evidence, high quality qualitative evidence and corroborated by their own expertise, the committee were able to make firm recommendations in favour of the contribution of peer support to promoting access to and engagement with health and social care for people experiencing homelessness. For this reason they did not prioritise peer support for future research because research recommendations within NICE guidelines are intended to address weak evidence or a paucity of evidence with the hope of making stronger practice recommendations in future updates of a particular guideline. There were evidence gaps in certain areas of the scope of this guideline, and these were therefore prioritised for future research.
Heriot-Watt University	Guideline	General	General	We welcome the acknowledgement that homelessness is a public health issue as well as a housing issue (p.3, lines 26-27), and that there are both moral and economic imperatives to tackle it (p.4, lines 24-25). We endorse strongly recommendations regarding general principles including the promotion of: psychologically informed environments and trauma-informed care to foster engagement (p.6, lines 14-16); longer contact times to foster the development of sustained trusting relationships between health/social care staff and people experiencing homelessness (p.6, lines 19-21); strength- and asset-based approaches to care (p.7, lines 3-5); long-term commitment to care to promote	Thank you.

				recovery, stability and lasting positive outcomes (p.7, lines 6-9); and active re-engagement with people who disengage or refuse health and social care services (p.7, lines 10-14).	

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Heriot-Watt University	Guideline	General	General	We found the lack of reference to Housing First in the guideline's recommendations surprising given: firstly, recognition of the model's effectiveness in resolving homelessness experienced by people with severe mental health and/or substance misuse issues (see Evidence Review A-B); and secondly, very clear alignment between the model's core principles and many of the recommendations made in the guidance, including amongst others: • Promotion of psychologically-informed approaches (recommendation 1.1.3) • Promotion of strength-based approaches (recommendation 1.1.5) • Active support of re-engagement for people who disengage from services (recommendation 1.1.7) • Long-term provision of support (recommendation 1.2.5) • Reduction of caseloads (recommendation 1.2.9) • Endorsement of peer support (recommendation 1.4.1) [NB: used in some but not all HF programmes] • Non-use of penalties for missing appointments (recommendation 1.5.2) • Avoidance of policies which withdraw/close support after a standard duration (recommendation 1.5.2) • Support of people who have co-existing mental health issues and problem substance misuse (recommendation 1.5.5) • Delivery of support in non-traditional settings (recommendation 1.5.13)	Thank you for your comment, in response to which our analysis of the two papers in question has been revisited, and discussed with the guideline committee. The committee discussed that Housing First is an effective intervention to reduce homelessness and agreed with many of the principles highlighted in the model. However, the committee agreed that the evidence did not show its suitability in improving access to, or engagement with health and social care, which was the objective of the review question. The committee discussed that there is huge variation in the fidelity of the housing first model and agreed not to specify Housing First in the recommendations although many of the principles of this model are reflected in the recommendations. Thank you for providing two references, which have looked into and given reasons for their exclusion: Mackie,P., Johnsen, S., and Wood, J. (2017) Ending rough sleeping: what works? An international evidence review. Crisis: London. This study focuses on the important issue of ending rough sleeping. However, this was not the objective/phenomenon of interest for the reviews in this guideline. Lynne McMordie (2021) Avoidance strategies: stress, appraisal and coping in hostel accommodation, Housing Studies, 36:3, 380-396, DOI: 10.1080/02673037.2020.1769036. This study explores why some people experiencing homeless avoid temporary

				• Use of assertive outreach (recommendation 1.5.17) • Involvement of users in assessments and care planning (recommendation 1.6.3) • Provision of suitable accommodation to support access to and engagement with health and social care services and long-term recovery and stability (recommendation 1.9.1) • Provision of wraparound health and social care support that is flexible to the person's changing needs and circumstances (recommendation 1.9.2) • Provision of emotional and practical support for as long as needed after a move into independent accommodation (recommendation 1.9.4) • Provision of support for people to assess the risks associated with a new living arrangement, whilst also recognising their strengths and planning ways to mitigate the risks (recommendation 1.9.5) • Planning of long-term engagement to help meet the person's needs at their own pace (recommendation 1.11.1) • Priority given to building a relationship of trust (recommendation 1.11.2) We note that "the committee agreed that practical and emotional support should be provided for as long as it is needed" when people move into settled accommodation (p.64, lines 4-8). We would like to emphasise that this is exactly what HF does for the subpopulation it targets, this being homeless people with complex needs. We would argue on the basis of existing	accommodation, which was not the objective/phenomenon of interest for the reviews in this guideline. Beth Watts & Janice Blenkinsopp (2021) Valuing Control over One's Immediate Living Environment: How Homelessness Responses Corrode Capabilities, Housing, Theory and Society, DOI: 10.1080/14036096.2020.1867236. This study explores the importance of control over one's environment for people experiencing homelessness, which was not the objective/phenomenon of interest for the reviews in this guideline. Upon further investigation of these outcome data from Aquin 2017 on suicidal ideation, discrepancies in the reporting of people randomised to each arm (i.e. the denominator) and the percentage values reported in table 2 have been noted. The presented analysis in evidence review A/B follows Cochrane's preferred methodology of using the intention to treat principle, which shows the results for the outcome of suicidal ideation-reducing more slowly for Housing First- as clinically important at 24 months only but not at earlier time points. The limitations of this approach are acknowledged as it assumed that all people without an outcome measure did not have the outcome. We also recognise that the minimally important difference (MID) cut-offs used (GRADE default MIDs) are somewhat arbitrary but they were agreed a priori and therefore used in the

				(compelling) quantitative and qualitative evidence that formerly homeless people with complex needs are much better positioned to cope with "the emotional challenges of independent living" referred to in the guidance (p.64, line 9) if provided with the intensive, holistic, flexible and non-time-limited support that HF offers than are their counterparts who are housed with very limited or no support at all (Mackie et al., 2017, https://www.crisis.org.uk/ending-homelessness/homelessness-knowledge-hub/services-and-interventions/ending-rough-sleeping-what-works-an-international-evidence-review/). Further to this, Housing First provides homeless people with complex needs an opportunity to avoid hostels which a growing body of evidence suggests can themselves cause demonstrable harm and affect health and wellbeing detrimentally (McMordie, 2020, https://www.tandfonline.com/doi/full/10.1080/02673037.2020.1769036; Watts & Blenkinsopp, 2021, https://www.tandfonline.com/doi/full/10.1080/14036096.2020.1867236). We appreciate that the committee may have had strong reservations regarding Housing First in light of the evidence review's assertions regarding potential harms, which are described as including 'increased risk' of suicidal ideation, suicide attempt, and mortality (see our Comments 10 and 14). Those assertions are however based on an incorrect and misleading	evidence review as the limit of clinical importance. For the outcome of suicide attempts, whilst the effect estimate is above the cut-off point determining clinical significance agreed a-priori (1.25), the 95% CI crosses the line of null effect (RR 1.3 [0.99 to 1.71]), therefore, we have removed the text from the Summary of the evidence section where previously it was stated that the result suggested there may be a harmful effect although there is uncertainty around the estimate. In terms of the outcome of mortality, in light of your comment, the narrative description of results in Somers 2017 has been reviewed and the technical team were able to extract additional data and add them to the meta-analysis. Although the effect estimate of the now pooled data is lower than for Tinland data alone, the result is statistically significant and clinically important, according to the methodology agreed a priori for this review. However, the limitations of this result are acknowledged in the report, and with the wide confidence intervals, close to the line of no effect, the committee was unconvinced about there being an association between Housing First and mortality. This has been explained more clearly in the committee's discussion of the evidence section of the review. It is important to note that although the committee noted the results from the analysis of

				interpretations of the evidence cited (see our Comments 10 and 14). This being so, we would encourage the committee to consider making reference to at least the following in the guideline: a) Housing First's proven effectiveness in improving housing outcomes for homeless people with complex needs, and b) its strong consonance with many of the principles and practices promoted in the guidance.	outcome data on suicidal ideation, these were not decisive findings informing the recommendations and therefore this text has been removed from the guideline rationale section. The findings did however prompt an interesting discussion around the strong feelings of isolation, loneliness and stress that can be experienced after a move to independent accommodation. In the committee's experience this can be an isolating step for someone recently experiencing homelessness and the evidence highlighted the crucial importance of providing emotional and practical support throughout and following the move. Committee members with lived experience of homelessness corroborated this and agreed that emotional and practical support are crucial in these circumstances., Finally, the committee's discussion of the evidence in the evidence review has also been revised to respond to the 'a and b' suggestions at the end of your comment. The committee is content that this provides an accurate description of their discussions around this evidence and are grateful for your feedback.

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Heriot-Watt University	Guideline	General	General	No specific attention is given to palliative care for people experiencing homelessness. This seems to us to be a significant omission, especially in light of recent work which documents high levels of concern for homeless people with advanced ill health remaining in hostels due to a lack of alternative provision (see for example Schulman et al., 2018, https://journals.sagepub.com/doi/pdf/10.1177/0269216317717101).	Thank you for your comment and for the reference to Shulman 2018, which was included in our review. Data from this paper have contributed to several review findings, such as 'A1.14.2 Competing priorities', 'A2.2.1 Feelings of apprehension', 'A2.2.2 Feelings of fear', 'A2.7 The skills, training and values of practitioners', 'A3.1.1 Care experiences', 'A3.2 Responses to complex healthcare needs', 'A3.3 Consistency and care continuity', 'A3.5 Individualised care and support', 'A3.11 Experiences of stigma and discrimination', in Review C. Our literature search did not identify much evidence specifically about palliative care. The committee discussed this comment and they agree with you about the need to improve access to palliative care for people experiencing homelessness. On the basis of yours and other stakeholder comments, they made changes to some recommendations to try to address this. They also added a recommendation about palliative care to the section of the guideline on long-term support.
Heriot-Watt University	Guideline	009 - 011		We fully support recommendations regarding commissioning, including the imperative for health and social care and housing services to work together to plan and fund services (p.9, lines 5-9), the need to enable long-term support for those who need it (p.10, lines 15-16), and use of long-term contracts for providers (p.10, line 21) which is critical given evidence regarding the importance of sustained relationships with people who have complex needs. We also welcome the suggestions regarding reducing	Thank you for your support for these recommendations.

				caseloads and lengthening contact time for health and social care providers (p.11, lines 16-18), which our own recent work indicates is a key ingredient for success when supporting individuals with complex needs (see Johnsen et al, 2021, https://pubmed.ncbi.nlm.nih.gov/33397341/).	
Heriot-Watt University	Guideline	015 - 016		We support fully the recommendation that services be designed and delivered in a way that reduces barriers to access and engagement, and in particular inclusion of reference to outreach services, low threshold services, flexible opening and appointment times, and help to access care (e.g. transport support and digital connectivity) (p.15, lines 9-21). On this issue, we also strongly endorse recommendations to avoid penalising people for missed appointments (p.16, lines 2-7), and avoidance of policies that withdraw support and close cases after a standard duration of time (p.16, lines 8-11).	Thank you for your comment and support for the recommendations.
Heriot-Watt University	Guideline	17	015 - 017	We strongly support the recommendation regarding the provision of outreach care in non-traditional settings, such as on the streets, hostels and day centres. Some of our own recent research adds to a growing body of qualitative evidence that 'taking services to' people experiencing homelessness in exactly these types of settings, coupled with a more flexible approach to delivery where this is adopted, improves some individuals' willingness and	Thank you for your comment and support for the recommendation. The reference you provided has been checked. This study was published after the literature search date for the evidence review in this guideline and therefore was not included. This study would have otherwise met the inclusion criteria for the qualitative evidence review, however, based on its findings, all the themes have already been identified in the

				ability to engage with healthcare substantially (Johnsen et al., 2021, https://pubmed.ncbi.nlm.nih.gov/33397341/).	evidence review so its inclusion would not have changed the conclusions.
Heriot-Watt University	Guideline	18	014 - 021	We strongly support the recommendation regarding the use of assertive outreach, especially with people with co-occurring mental health issues and problem substance misuse. Evidence regarding the value of such an approach with this subpopulation is very compelling. That said, we would argue that this should ideally be used for all people who disengage with services, even if they have not received a formal diagnosis regarding mental health issues and/or exhibit problematic substance use given increased recognition of the impact of trauma on individuals' engagement with services (see for example Theodorou et al., 2021, https://www.emerald.com/insight/content/doi/10.1108/JMHTEP-02-2021-0016/full/html).	Thank you for your comment. The committee agree that assertive outreach might be useful for anyone who finds it difficult to engage with services, however, no evidence was identified on the effectiveness of assertive outreach so they were unable to make a stronger recommendation about this.
Heriot-Watt University	Guideline	22	001 - 010	We welcome the acknowledgement that the provision of suitable accommodation can support access to and engagement with health and social care services and long-term recovery and stability (p.22, lines 4-7); so too that wrap-around health and social care support that is flexible to a person's changing needs and circumstances and helps them stay in their accommodation.	Thank you.

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Heriot-Watt University	Guideline	25	005 - 014	We welcome inclusion of reference to the issue of training for all health and social care practitioners (line 5-6),yet would encourage NICE to go further in recommending that training in understanding the health and social care needs of homeless people should be provided (rather than just suggesting that consideration be given to its provision). Work under the broader 'Inclusion Health' agenda referenced at the beginning of the guideline (p.4) suggests that enhanced understanding of the needs of homeless people and other socially excluded groups amongst health and social care practitioners across the board would help to reduce the barriers to healthcare that these populations face (including within non-specialist services).	Thank you for your comment. The committee agree with you about the importance of training in this context but given a lack of strong evidence, they were unable to make a firmer recommendation. In the context of NICE guidelines, this therefore means they need to use such language as 'consider' as a reflection that research evidence demonstrating effectiveness or cost-effectiveness is lacking in this area. That said, the committee are confident that commissioners and providers will take seriously the need for training and staff development in light of the recommendations taken as a whole, including many 'strong' recommendations about the way in which care and support should be provided to address the complex needs of this population.
Heriot-Watt University	Guideline	25	019 - 021	We welcome the inclusion of recommendations regarding the provision of regular support, professional supervision and reflective practice opportunities for staff. Recent research indicates that these opportunities are especially valuable for frontline staff supporting people experiencing the most severe and multiple forms of disadvantage who often have insecure attachment styles and relate to other people in 'difficult' ways (see for example Theodorou et al., 2021, https://www.emerald.com/insight/content/doi/10.1108/JMHTEP-02-2021-0016/full/html). This kind of support is invaluable for protecting the wellbeing of staff and equipping workers to facilitate constructive interactions with individuals	Thank you for your comment and support for the recommendation.

				who are sometimes labelled ‘service resistant’ or ‘difficult to engage’.	

Heriot-Watt University	Guideline	63	013 - 019	We agree that the level of support that an individual requires to maintain their housing "depends on the person's needs" (p.63, line14). Some do indeed require specialist on-site support, as noted (p.63, line 15), but we would emphasise that it should not be assumed to be the case for homeless people with complex needs. Rather, international evidence on Housing First (HF) indicates that the vast majority of homeless people with complex needs who are offered ordinary settled scatter-site housing with non-time-limited holistic support are able to successfully maintain their tenancies, as is acknowledged in Evidence review A-B. High 2-year tenancy sustainment rates commensurate with those reported elsewhere (80%+) are being replicated in the UK, even in the context of the covid-19 pandemic (see for example Johnsen et al., 2021, https://researchportal.hw.ac.uk/en/publications/scotlands-housing-first-pathfinder-evaluation-first-interim-repor-2). It is also worth noting that whilst evidence on the effectiveness of HF in the UK is still accumulating, interim evidence from the current English city regions pilot and Scottish Pathfinder evaluations suggests that there are three particular groups for whom HF is not suitable: firstly, people who lack capacity to comprehend a standard tenancy agreement and/or the consequences of failing to adhere to its conditions (due to severe learning difficulties or alcohol related brain damage, for example);	Thank you for your comment. The committee agree with you that it should not be assumed that all homeless people with complex needs require specialist on-site support and they do not feel this is implied in that recommendation. However, specialist onsite is appropriate in some cases, sometimes a model like Housing First is appropriate, depending on individual needs. The committee are aware that there are several pilot studies ongoing on the Housing First model in the UK and hopefully these studies can inform future updates of this guideline.

				secondly, those who are so unwell that their healthcare needs exceed what can realistically be provided by HF; and thirdly, people who do not want HF (Johnsen et al., 2021, https://researchportal.hw.ac.uk/en/publications/scotlands-housing-first-pathfinder-evaluation-first-interim-repor-2). Alternative 24/7 intensive support interventions are needed for the first two of these groups given that they require a care-led rather than housing-led solution. Further thinking and evidence is required to identify the most appropriate intervention(s) for the third group. The same is true for the minority of individuals who have not been able to sustain tenancies even with HF support. (Johnsen et al., 2021, https://researchportal.hw.ac.uk/en/publications/scotlands-housing-first-pathfinder-evaluation-first-interim-repor-2).	

Heriot-Watt University	Guideline	64	006 - 011	We refute in the strongest possible terms the assertion that "…evidence from the Housing First studies … showed increased suicidal ideation and suggested a possible increase in suicide attempts with the Housing First approach" (p.64, lines 9-11). This is based on incorrect and misleading interpretations of evidence drawn from a Randomised Control Trial (RCT) exploring the effect of HF on suicidal behaviour in Canada (Aquin et al., 2017). Critically, the analysis presented focusses entirely on a few basic descriptive statistics showing point-in-time differences in outcomes, and even then key baseline prevalence figures (re suicidal ideation in particular) have been ignored. Further to this, no account is taken of the more sophisticated modelling analysis reported which assesses whether the outcomes documented are in fact a result of K653K653the intervention. Specifically, regarding suicidal ideation, Aquin et al. (2017) conclude that "both intervention and control groups experienced similarly significant drops in suicidal ideation over the course of the 2-year study" (p.477, emphasis added). Any differences between the two groups were not statistically significant, and in any case were largely accounted for by differences in participants' psychiatric state at baseline. Even if there had been a statistically significant difference, that would have indicated that clients receiving HF experienced a slower reduction in suicidal ideation than those who did not. Regarding suicide attempt, Aquin et al. (2017)	Thank you for your comment, in response to which analysis of the two papers in question has been revisited and discussed with the guideline committee. Analysis of the data from Aquin 2017 considered the baseline data provided by the authors in order to assess bias in the randomisation process, as it is not typical to use this data to calculate a relative risk. Although the data from the paper indicates a drop from baseline in both arms, the analysis for the guideline sought to analyse between group effects rather than within group effects. In response to your comment the text in the evidence review has nevertheless been revised for greater clarity. Where the result on suicidal ideation is discussed, even greater emphasis has now been placed on the fact that overall there was a decrease in suicidal ideation in both groups over time although the decrease was slower in the intervention group compared to the control group. The author's more sophisticated modelling analysis is acknowledged, however this type of data is not usually extracted when aiming to conduct a meta-analysis. For the outcome of suicide attempts, whilst the effect estimate is above the cut-off point determining clinical significance agreed a-priori (1.25), the 95% CI crosses the line of null effect (RR 1.3 [0.99 to 1.71]), therefore, we have removed the text from the Summary of the evidence section where previously it was stated

				conclude on the basis of their regression modelling that there was "…no significant relationship between intervention and suicide attempts" (p.477) (estimate = .10, SE = .16, P > 0.05). The guideline's assertion re HF 'increasing risk' of suicidal ideation and being suggestive of a possible increase in suicide attempts is unfounded. On this issue, Aquin et al. (2017) emphasise that homeless people (and especially the subpopulation targeted by HF) are at disproportionate risk of suicidal behaviour as compared with the general population, and that their vulnerability to this persists after access to independent housing (even when supported by an intervention like HF). This is not a reason to discredit HF as an intervention, not least when there is compelling evidence that it is highly effective at resolving the homelessness of some of society's most vulnerable members who are disproportionately susceptible to repeat homelessness (see Evidence Review A-B). Rather, as Aquin et al. (2017) argue, their study's findings highlight the imperative for clinicians to "continue to be cognizant of the high prevalence of suicidality amongst the homeless population and … not reduce their index of concern for suicidal behaviour when engaging with the participants of HF programmes" (p.480). We request that reference to the erroneous interpretation of evidence on suicidal ideation	that the result suggested there may be a harmful effect although there is uncertainty around the estimate. Upon further investigation of the outcome data on 'suicidal ideation' from Aquin 2017, discrepancies were noted in the reporting of people randomised to each arm (i.e. the denominator) and the percentage values reported in table 2, which might explain the difference in conclusions between the analysis for the guideline and that of the study authors. The presented analysis in evidence review A/B follows Cochrane's preferred methodology of using the intention to treat principle, which shows the results as clinically important at 24 months only but not at earlier timepoints. However, the guideline technical team and the committee recognise the limitations of this approach as well, as it assumed all people without outcome measurement would not have the outcome. The committee discussed that Housing First is an effective intervention to reduce homelessness and agreed with many of the principles highlighted in the model. However, the committee agreed that the evidence did not show its suitability in improving access to, or engagement with health and social care, which was the objective of the review question. The committee discussed that there is huge variation in the fidelity of the housing first model and agreed not to specify it in the recommendations although many of the principles of the model are

				and suicide attempt be removed from the guidance.	reflected in the recommendations. It is important to note that although the committee noted the results from the analysis of outcome data on suicidal ideation and mortality, these were not decisive findings informing the recommendations and therefore this text has been removed from the guideline rationale section and the limitations of the data have been described more clearly in the evidence review itself. It has also been made absolutely clear that notwithstanding these limitations, the issues prompted discussion around the strong feelings of isolation, loneliness and stress that can be experienced after a move to independent accommodation. In the committee's experience this can be an isolating step for someone recently experiencing homelessness and the evidence highlighted the crucial importance of providing emotional and practical support throughout and following the move. Committee members with lived experience of homelessness corroborated this and agreed that emotional and practical support are crucial in these circumstances.

Heriot-Watt University	Evidence review A - B	038, 077, 085		We refute in the strongest possible terms a number of assertions made in the evidence review regarding Housing First, including: • "Housing First also showed a harmful effect on suicidal ideation at 24 months (moderate quality evidence) and suggested that there may be a harmful impact on suicide attempts at around the same follow-up…" (p.38, lines 34-37). • "...the committee expressed concern about other findings from Housing First trials, such as increased suicidal ideation at 2 years (but not earlier) and mortality at 2 years…" (p.77, lines 35-37). • The committee also referred to the evidence of harm in a few effectiveness studies on HF, namely, increased mortality risk and suicidal ideation at 2 years" (p.85, lines 36-37) These assertions are based on incorrect and misleading interpretations of the evidence reviewed, including a Randomised Control Trial (RCT) in Canada (Aquin et al., 2017) and RCT in France (Tinland et al., 2020). Specifically, regarding suicidal ideation, Aquin et al. (2017) conclude that "both intervention and control groups experienced similarly significant drops in suicidal ideation over the course of the 2-year study" (p.477, emphasis added). Any differences between the two groups were not statistically significant, and in any case were largely accounted for by differences in participants' psychiatric state at baseline. Even if there had been a statistically significant	Thank you for your comment, in response to which the analysis for the guideline of the two papers in question has been revisited and discussed with the guideline committee. Baseline data from Aquin 2017 was used to assess baseline differences between intervention groups when assessing the risk of bias arising from the randomisation process. Although the data from the paper indicates a drop from baseline in both arms, the guideline technical team sought to analyse between group effects rather than within group effects. For the outcome of suicide attempts, whilst the effect estimate is above the cut-off point determining clinical significance agreed a-priori (1.25), the 95% CI crosses the line of null effect (RR 1.3 [0.99 to 1.71]), therefore, we have removed the text from the Summary of the evidence section where previously it was stated that the result suggested there may be a harmful effect although there is uncertainty around the estimate. Upon further investigation of the outcome data on 'suicidal ideation' from Aquin 2017, discrepancies in the reporting of people randomised to each arm (i.e. the denominator) and the percentage values reported in table 2 were noted, which might explain the difference in conclusions between the analysis for the guideline and the analysis by the study authors. The presented analysis in evidence review A/B

				difference, that would have indicated that clients receiving HF experienced a slower reduction in suicidal ideation than those who did not. Regarding suicide attempt, Aquin et al. (2017) conclude on the basis of their regression modelling that there was "…no significant relationship between intervention and suicide attempts" (p.477) (estimate = .10, SE = .16, P > 0.05). The guideline's assertion re HF 'increasing risk' of suicidal ideation and being suggestive of a possible increase in suicide attempts is unfounded. On the issue of mortality, more deaths were recorded amongst HF than TAU clients in the French study, but this difference did not yield statistical significance (P = 0.056) (Tinland et al., 2020). Our own analysis of the data focusing on substantial differences between the proportion of deaths, 6.5% HF against 3.1% TAU, yields an effect size (Cohen's h) of 0.16 which is below the conventional threshold of 0.2 for 'small effects'. That would mean that the difference is unlikely to be 'practically significant' or 'clinically meaningful' (Keefe et al., 2013, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3719483/). It is also notable that in a later paper documenting more detailed analyses of the study's mortality figures the researchers conclude that "Due to important limitations, we cannot conclude on HF effect on mortality" (Tinland et al., 2021, p.2, https://pubmed.ncbi.nlm.nih.gov/34215235/), These limitations included the small number of	follows Cochrane's preferred methodology of using the intention to treat principle, which shows the results as clinically important at 24 months only. However, the guideline technical team and the committee recognise the limitations of this approach as well, as it assumed all people without outcome measurement would not have the outcome. The guideline technical team noted discrepancies in the reported data on mortality from Tinland 2019, who conclude no significance between the two arms. However, when relative risk was calculated (authors do not report this), the result showed a significant difference (p=0.04) favouring treatment as usual over housing first. The authors report a p value of 0.056 but it is unclear how they calculated this value. Further details about the limitations of the Tinland 2019 have been added to the evidence review for clarity about some of the issues you raise, for example the small numbers in the analysis. In light of your comment, the narrative description of results in Somers 2017 has been reviewed and the technical team were able to extract additional data and add them to the meta-analysis. Although the effect estimate of the now pooled data is lower than for Tinland data alone, the result is statistically significant and clinically important, according to the methodology agreed a priori for this review. However, the limitations of this result are acknowledged in the report and

				deaths overall (n=34 across both arms) which severely limited the statistical power of analysis, the fact that a few people in the HF group died before receiving HF, and potential that deaths in the TAU group may have been under-reported. It should also be noted that another trial reported no difference in the prevalence of mortality between HF and TAU arms (Somers et al., 2017, https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0168745). We would request that the evidence review text be revised to correct or delete reference to the erroneous interpretations of data on suicidal ideation, suicide attempt and mortality.	with the wide confidence intervals, close to the line of no effect, the committee was unconvinced about there being an association between Housing First and suicidal ideation or mortality. This has been explained more clearly in the committee's discussion of the evidence section of the review. The committee discussed that Housing First is an effective intervention to reduce homelessness and agreed with many of the principles highlighted in the model which are reflected in the recommendations. However, the committee agreed that the evidence did not show its suitability in improving access to, or engagement with health and social care, which was the objective of the review question. The committee discussed that there is huge variation in the fidelity of the housing first model and agreed not to specify it in the recommendations. It is important to note that although the committee noted the results from the analysis of outcome data on suicidal ideation and mortality, these findings were not decisive factors informing the recommendations and therefore this text has been removed from the guideline rationale section. However, these findings played a part in prompting an interesting discussion around the strong feelings of isolation, loneliness and stress that can be experienced after a move to independent accommodation. In the committee's experience this can be an isolating step for someone recently experiencing

					homelessness and the evidence highlighted the crucial importance of providing emotional and practical support throughout and following the move. Committee members with lived experience of homelessness corroborated this and agreed that emotional and practical support are crucial in these circumstances.

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Homeless Friendly	Guideline	7	10	**1.1.7** No mention of people who fear the establishment	Thank you for your comment. The wording in this recommendation has now been revised and the committee think this is covered by people experiencing homelessness who "may find services difficult to engage with".
Homeless Friendly	Guideline	7	10	**1.1.7** No mention of people experiencing acute & enduring mental ill health	Thank you for your comment. The wording in this recommendation has now been revised and the committee think this is covered by people experiencing homelessness who "may find services difficult to engage with".
Homeless Friendly	Guideline	8	1	**1.1.9** Many people have a c/o address this should be acknowledged.	Thank you for your suggestion. The committee made some changes to this recommendation including that face to face as well as the other cited methods of communication be considered, if this is the person's preference and also that reminders and follow ups should be sent if people do not attend. The committee agreed it would not be necessary to mention that people have c/o addresses as this would be explained by the person in a discussion to ascertain their preferred communication method.
Homeless Friendly	Guideline	10	28	**1.2.6** We feel very limited on particular groups and that the following should be included: Dependency on alcohol, enduring mental health issues and people with physical disability examples being physical disability and learning disability	Thank you for your comment. This particular recommendation is giving examples of groups based on equalities considerations that may need specific services and support. The list of examples is not exhaustive but 'disabled people' has been added to the list based on consultation feedback from you and other stakeholders. The guideline refers to drug and alcohol treatment needs of people experiencing homelessness in various places. Similarly, mental health needs are addressed throughout so the committee think these are well covered.

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Homeless Friendly	Guideline	11	20	**1.3.1** These may not exist – would require statutory guidance to direct this. Plus acknowledgement of the need to fund these teams.	Thank you for your comment. The committee acknowledge that these teams do not already exist everywhere they are needed, which is why they made the recommendation. They felt that the recommendations on multidisciplinary teams may mean a change in service configuration. However, they also point out there may not be a need to employ new staff but to reorganise, collaborate with other agencies and form a team from existing professionals. Forming a multidisciplinary team may entail pulling together a team from different services working with the person or having a permanent integrated multidisciplinary team under single management within a service (that is, a coexisting co-located team). The committee agreed that having coexisting, co-located teams would represent a more substantial change but it is not within the remit of NICE guidelines to make specific comments or recommendations which canvass for more funding.
Homeless Friendly	Guideline	13	13	**1.3.6** Again may not occur due to services being precious about remaining in their location. Need to emphasis good practice dictates…..	Thank you for your comment. The recommendation you are referring to is not about offering services in a different location but about having a designated person in a local mainstream services on homelessness issues in areas where there is no need for a specialist homelessness multidisciplinary team and establishing links with homelessness multidisciplinary teams in nearby areas to share knowledge and get advice from.
Homeless Friendly	Guideline	15	6	**1.5** No actual mention of voluntary services (implied but not mentioned)	Thank you for your comment. The committee did not think it was necessary to specify the funding structure of the health and social care services

					involved in these various means of improving engagement.
Homeless Friendly	Guideline	19	1	**1.6** No mention of community assessments (go to the person)	Thank you for your comment. The committee have not specified where the assessments should take place. This was not something that was specifically reviewed or which came up in the evidence reviews, although the committee understand that this can be an important consideration. Overall, the guideline emphasises a person-centred approach tailored to the individual's needs. Furthermore, outreach is prominently featured in the guideline.
Homeless Friendly	Guideline	21	002 - 011	**1.18.1** No acknowledgement that the service may need to step up again if needed.	Thank you for your comment. 'As appropriate' would cover situations where the intensity of support may have to increase.
Homeless Friendly	Guideline	22	1	**1.9** No mention of Cuckooing this can be a real problem for when vulnerable people are offered tenancies.	Thank you for this comment. The committee understand this can be a real issue but this is not something that is within the remit of this guideline which focuses on improving access and engagement with needs-based health and social care.
Homeless Friendly	Guideline	25	5	**1.12.1** The use of the word consider is too vague and easy to dismiss ……. Provide training for all health and social care….	Thank you for your comment. Without robust evidence, the committee were unable to make strong recommendations on some issues, therefore the word 'consider' is used in some cases. The Developing NICE guideline: the manual chapter 9.2 gives more information
Homeless Friendly	Guideline	25	19	**1.12.3** gain the word consider allows for not action…….Provide regular and ongoing support (these words evidence a commitment)	Thank you for your comment. In the context of NICE guidelines, the word 'consider' does not allow for inaction but it does denote that the committee felt there was insufficient evidence, located in the reviews underpinning the

					guideline, to enable them to make a stronger recommendation.
Homeless Link	Guideline	6	15	After 'non-judgemental' insert 'gender sensitive' to ensure that experiences particular - although not unique - to being female such as having a history or sexual and/or domestic abuse, are taken in account and the services offered tailored accordingly.	Thank you for your comment. On the basis of yours and a number of other stakeholder comments the committee agreed to make some important changes to this recommendation. In the final version of the guideline, 'friendly' is now replaced with 'empathetic' and further additions were made to the recommendation about services needing to be inclusive, addressing health inequalities and being responsive to diverse needs of people.
Homeless Link	Guideline	7	14	Homeless Link members have told us that their clients are often required to return to the beginning of a support pathway, having dis-engaged. Members have told us that clients can decide not to re-engage if they are not offered the opportunity to engage at an appropriate point in a pathway. After, 'have capacity.' Insert, 'Where possible, enable people to re-engage with services where they left, rather than always requiring a return to a pathway entry point.'	Thank you for your comment. The committee agree that going back to the beginning of a pathway can cause further barriers for engagement and have revised the recommendation based on your suggestion.
Homeless Link	Guideline	8	6	After 'letter', insert 'face-to-face'. Face-to-face communication is often preferred by, and critical to, building trust with women and young people (36, 37)	Thank you for your comment, the suggested change has been made.

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Homeless Link	Guideline	11	13	After 'GP', insert ', access primary services when needed'. In the context of primary care services increasingly accessed via online means (Digital First Primary Care), commissioners must ensure that services do not erect digital barriers to access for people experiencing homelessness, who will often lack ready access to the internet.	Thank you for your comment. Digital exclusion and connectivity is covered in the section on Improving access to and engagement with services about ways to design and deliver services that reduces barriers to access and engagement.
Homeless Link	Guideline	13	16	After 'designate' insert, 'senior leaders as'. Having senior leader commitment will ensure service commitment to those experiencing homelessness.	Thank you for your comment. The committee did not consider the homelessness lead in a mainstream service would necessarily have to be a senior lead and thus have not made the change.
Homeless Link	Guideline	18	5	After 'with providers', insert an additional bullet point: 'women who fear using male-dominated services'. Women traumatized by abuse will often experience an understandable fear of trusting others, their trust having been profoundly and repeatedly betrayed by those who abused them. Distrust of men in particular is common. Many women who have experienced male violence will actively avoid traditional mixed sex homelessness provision from fear of (or lived experience of) exposure to further violence and exploitation.(39, 40)	Thank you for your comment on the basis of which the recommendation has been revised.
Homeless Link	Guideline	21	20	There should be no suggestion of discharge to the street. Instead, hospital staff should seek to obtain consent from patients due for discharge who have nowhere to staff to refer them to the local authority housing options team, as per s213B of the Homeless Reduction Act 2017.	Thank you for your comment. The committee agree with you that discharge to the street is something that should be avoided and they felt that this could not be addressed without mentioning it, not least because it clearly happens in some cases. The committee nevertheless edited this recommendation post consultation and it is now a lot firmer, stating that

					clinical teams, working with hospital discharge teams and specialist homelessness multidisciplinary team, where available, should have procedures to minimise self-discharge and prevent discharge to the street. The recommendation now also states that where a discharge to the street or self discharge do happen, there should be a review of the incident and learning from it should be implemented.

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Homeless Link	Guideline	64	009 - 014	Having reviewed the research cited in the draft guideline, we have can find no evidence that suicidal ideation nor suicide attempts are more common with the Housing First (HF) approach, as this paragraph implies. Whilst the study which refers to suicide ideation/suicide attempts ([53]) states that the study did not find that HF is more effective at reducing suicidal ideation/attempts that treatment as usual (TAU), it notes that "… both intervention [HF] and control groups [TAU] experienced *similarly significant drops in suicidal ideation* over the course of the 2-year study."(emphasis added) ([54]) The study also acknowledges that the HF intervention examined, "… did not have any evidence-based interventions focused on suicide behaviour." and "… HF is not a suicide-focussed intervention …" ([55]) It concludes that, "This research fails to find evidence that HF is superior to TAU in reducing suicidal ideation and attempts." ([56]) We believe that the paragraph in guideline we have highlighted wrongly implies that, "…increased suicidal ideation and […] increased a possible increase in suicide attempts with the Housing First approach. (emphasis added)" The research evidence cited does not suggest that HF is associated with increased suicide ideation or suicide attempts to any greater degree than TAU. Given this, we suggest that the sentence beginning "The emotional challenges…" and ending in "… the Housing First approach." should be deleted.	Thank you for your comment, in response to which the analysis for the guideline of the two papers in question has been revisited and discussed with the guideline committee. For the outcome of suicide attempts, whilst the effect estimate is above the cut-off point determining clinical significance agreed a-priori (1.25), the 95% CI crosses the line of null effect (RR 1.3 [0.99 to 1.71]), therefore, we have removed the text from the Summary of the evidence section where previously it was stated that the result suggested there may be a harmful effect although there is uncertainty around the estimate. Upon further investigation of the outcome data on 'suicidal ideation' from Aquin 2017, discrepancies were noted in the reporting of people randomised to each arm (i.e. the denominator) and the percentage values reported in table 2, which might explain the difference in conclusions between the analysis for the guideline and that of the study authors. The presented analysis in evidence review A/B follows Cochrane's preferred methodology of using the intention to treat principle, which shows the results as clinically important at 24 months only but not at earlier timepoints. However, the guideline technical team and the committee recognise the limitations of this approach, which assumed that people without an outcome measure would all not have the outcome.

					It is important to note that although the committee noted the results from the analysis of outcome data on suicidal ideation, this was not a decisive finding that informed recommendations and therefore this sentence has been removed from the rationale in the guideline. The findings did however prompt an interesting discussion around the strong feelings of isolation, loneliness and stress that can be experienced after a move to independent accommodation. In the committee's experience this can be an isolating step for someone recently experiencing homelessness and the evidence highlighted the crucial importance of providing emotional and practical support throughout and following the move. Committee members with lived experience of homelessness corroborated this and agreed that emotional and practical support are crucial in these circumstances

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Homeless Link	Guideline	64	019 - 024	HF is an international evidence-based approach that uses independent, self-contained, stable housing as a stepping stone to allow individuals experiencing multiple disadvantage to begin recovery and move away from homelessness. The approach provides intensive, flexible and open-ended support for as long as it's needed. For true, high-fidelity' HF, small caseloads are essential, as they enable the flexible and intensive support required by clients. Existing evidence has shown that HF successfully ends homelessness for at least eight out of every ten people across Europe (58). We believe the key features above should be included in the guideline to ensure that it is clear what constitutes true, high-fidelity HF, as distinct from other housing-led models.	Thank you for your comment, which the committee discussed. The committee discussed that Housing First is an effective intervention to reduce homelessness and agreed with many of the principles highlighted in the model. However, the committee agreed that the evidence did not show its suitability in improving access to, or engagement with health and social care, which was the objective of the review question. The committee discussed that there is huge variation in the fidelity of the housing first model and agreed not to specify it in the recommendations although many of the principles of the model are reflected in the recommendations. Thank you for providing the reference, which has been checked for suitability to include in the guideline reviews: Pleace N & Bretherton J (2013) The Case for Housing First in the European Union: A Critical Evaluation of Concerns about Effectiveness European Journal of Homelessness. This descriptive study does not match the inclusion criteria for our evidence review.
Leicestershire Partnership NHS Trust	Guideline	General	General	Referring to other guidelines: this may not help homelessness services because those guidelines do not always meet the needs of people experiencing homelessness (otherwise we wouldn't need this one). We should also already be able to take it for granted that health professionals are following the other guidelines.	Thank you for your comment. Indeed, it is stated in the guideline that more efforts, targeted approaches and resources are often needed to ensure that health and social care services for people experiencing homelessness are available, accessible and provided to the same standards and quality as for the general population. This guideline focuses on service provision and proposes different approaches that aim to improve the way services can meet the

					needs of people experiencing homelessness. There are, however, many other NICE guidelines on specific topics or particular sections or recommendations in other NICE guidelines that are valid and relevant for this population. For example, NICE has already produced a guideline on community engagement and referring to it in this guideline, which recommends involvement of peers in designing and delivering services is providing additional guidance on how this could be best done. Similarly, there are several NICE guidelines that give guidance on communication and information provision which are relevant. Instead of repeating these recommendations, the committee cross-referred to them whilst this guideline focuses on issues around communication that are specific to this population.
Leicestershire Partnership NHS Trust	Guideline	General	General	Missed groups: We felt there was very little mention of release from prison	Thank you for your comment. The scope of the guideline, published in December 2020, states that people staying in institutions in the long-term (including prisons) are not covered by the guideline. However, people who have recently left prison and are now homelessness would be covered. The committee have made some revisions to the guideline emphasising the importance of joint working and planning with prison and probation services. Custody is also mentioned in the section on Transfer between settings because it is well known that criminal justice involvement can be common among people experiencing homelessness and some may end up in a vicious cycle of incarceration and homelessness.

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Leicestershire Partnership NHS Trust	Guideline	General	General	Language: we felt that there was little mention of severe and multiple disadvantage which we were surprised about and which is often a barrier to services and leads to multiple experiences of exclusion	Thank you for your comment. Based on your and other stakeholders', including people with lived experience of homelessness, comments the wording has been revised in the guideline to refer to 'severe multiple disadvantage' instead of 'complex needs'.
Leicestershire Partnership NHS Trust	Guideline	General	General	PIE: Given the huge contribution PIE has made to homelessness services over the last 10 years, we felt that there was not enough emphasis on the emotional and psychological needs of people who experience homelessness and PIE	Thank you for this comment. Whilst the committee are in favour of trauma-informed practice or psychologically informed environments, no evidence on the effectiveness of was located. Therefore, there is some uncertainty around this and the committee agreed to make a research recommendation about it so that future research could inform and possibly strengthen future updates of this guideline.
Leicestershire Partnership NHS Trust	Guideline	General	General	Definitions: we felt that more of the terms should be explicitly defined, bearing in mind that these guidelines will be read by a broad audience outside of health and they can be interpreted differently by different organisations (eg 'homelessness leads/commissioners' could be interpreted by health as not-for-them; Multi-disciplinary team means different things in health to other settings)	Thank you for your suggestion. The committee agreed this would benefit the guideline so they have added a number of new terms to this section and edited some of those included in the draft. New terms include homelessness leads, intermediate care and severe multiple disadvantage.

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Leicestershire Partnership NHS Trust	Guideline	General	General	Equalities: In relation to people who are homeless with specific needs (eg sex workers, families, young people, LGBTQI+) please consider a recommendation about providing specialist support services or specialist settings for these groups because even if health and social care agencies are working to an 'assertive outreach' model, for some people (often those in the groups named) will not feel comfortable in mainstream homelessness services (eg Crisis 2006 evidence that women who are homeless are more often 'hidden' because they do not feel safe in homeless hostels and day centres.) reference: https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/homeless-women-striving-survive.pdf	Thank you for your comment. The committee agrees that consideration needs to be given to people with specific needs. This has been addressed in the guideline in various places and the committee has revised the recommendations based on consultation feedback to reflect this better. For example, in the 'Planning and commissioning' section, the committee made a recommendation to consider providing services and support aimed at the needs of particular groups of people experiencing homelessness and list examples of groups (not an exhaustive list), including women, young people, older people, disabled people, LGBT+, people with no or limited recourse to public funds, people from different ethnic or religious minorities. In the 'General principles' section, a recommendation about promoting engagement was revised to specifically refer to the services aiming to address health inequalities, being inclusive and paying attention to the diverse experiences of people using the service. In the 'Staff support and development' section the committee made a recommendation about training for all health and social care staff, including homelessness as part of equality and diversity training, including the responsiveness to the impact of discrimination and stigma and of intersectional, overlapping identities.
Leicestershire Partnership NHS Trust	Guideline	General	General	PIE: it should be clearer that PIE and TIC are not individual interventions to be enacted with people who are homeless, but are about systems change, they are interventions for the system	Thank you for your suggestion. The committee agree that the definitions provided in the section 'terms used in this guideline' do address your concerns. For example, the definition of the term 'Psychologically informed environment' clarifies

					that "It includes building organisational awareness of psychological and emotional needs; physical environment and social spaces; staff training and ongoing support; service evaluation and learning; and reflective practice." The definition of trauma informed care begins by saying that it is 'an approach to planning and providing services' so there is no reference in either definition to the delivery of a discreet intervention.
Leicestershire Partnership NHS Trust	Guideline	6	008 - 010	1.1.2: Agree that co-production is essential. However, adapting services according to feedback from frontline and grassroots agencies supporting people who are experience of homelessness is also crucial in recognition that people with lived experience of homelessness are not always in a position to give their feedback to services because of powerlessness. This allows services to respond to the needs of people who aren't using their services.	Thank you for your comment. The committee agrees that the involvement of frontline practitioners working with people experiencing homelessness is important in assessing local needs and planning and designing services. This has been covered in the Planning and commissioning section. The guideline also makes a recommendation about who might be involved in the homelessness multidisciplinary team and this has now been revised to include outreach and homelessness practitioners. The recommendations state that these multidisciplinary teams should directly contribute to local needs assessments and service quality improvement.
Leicestershire Partnership NHS Trust	Guideline	6	15	1.1.3 remove the word 'consider' before PIE and trauma informed. Unsure why this has been put in a tentative way when the other suggestions in the sentence are not.	Thank you for your comment. The word 'consider' is used in the context of NICE guidance to denote a weaker recommendation made because the committee lack the robust evidence on which to make it any stronger or more certain. Please note however that the fact the committee did not review convincing evidence about PIE led them to make a

					recommendation for future research on precisely that topic.
Leicestershire Partnership NHS Trust	Guideline	6	19	1.1.4 include more intensive staffing, so that longer contact time is possible. For our MH team, in the 1990s we piloted undertaking CPA and holding caseloads under secondary care but this effected flexible access and meant we were unable to keep up with the 'flow' of people who were homeless and the system was became stuck because the homeless team staff were taken up with secondary care tasks (eg CPA).	Thank you for your suggestion. It is outside the remit of NICE guidance to make recommendations about staffing ratios and resourcing so the committee were unable to make this change. However they did make a recommendation for future research into the effectiveness and cost-effectiveness of longer contact times so in future updates of this guideline there may be evidence based grounds on which to provide more detailed and stronger recommendations around this issue.
Leicestershire Partnership NHS Trust	Guideline	7	3	1.15 We agree, but PIE should also be mentioned here	Thank you for your suggestion. The committee did make a recommendation about PIE and this actually appears earlier in the guideline than the recommendation you mention. The committee also felt there is some uncertainty around the evidence for PIE and more research is needed on the topic to hopefully inform future updates of this guideline so they made a recommendation for future research on this issue.
Leicestershire Partnership NHS Trust	Guideline	7	10	1.17 We strongly agree	Thank you.

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Leicestershire Partnership NHS Trust	Guideline	8	3	1.1.9 include 'assertive'	Thank you for your comment, the committee do not think this is needed or necessarily appropriate here where being empathetic and non-judgemental is described.
Leicestershire Partnership NHS Trust	Guideline	8	5	1.1.9 explicitly explain that people move around a lot (so a letter sent to an address on their medical notes may not reach them) and may not have access to phone or may have problems with literacy and digital skills	Thank you for your comment. The committee have revised the recommendations in this section to be more explicit about taking into account people's access to phone or internet as well as adding an option of face-to-face to the different methods of communication. The rationale discusses that lack of a steady address can be a problem when communication is still often done via letter.
Leicestershire Partnership NHS Trust	Guideline	8	10	1.1.10 please expand on the 'circumstances' in the list given	Thank you for your comment. The committee agreed to specify in the recommendation that extra support should be provided to people with speech, language and communication difficulties. They also added that people's access to phone and internet should be taken into account.
Leicestershire Partnership NHS Trust	Guideline	8	14	1.1.10 include in the list 'access to appropriate technology' and digital literacy	Thank you for your comment. As suggested, the recommendation has been expanded to include the consideration of the person's access to a phone or internet.

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Leicestershire Partnership NHS Trust	Guideline	8	15	1.1.11 We think this point could be more even more encouraging of partnership working. For example, by adding that health and social care services can and should copy appointment letters to support agencies/advocates as a way of promoting engagement	Thank you for your comment. The committee have purposefully not added this level of detail to the recommendation about involving an advocate but this may be relevant to some.
Leicestershire Partnership NHS Trust	Guideline	8	22	1.1.12 ensure the information is available in settings that people who are homeless frequent, recognise that people who are homeless may not want to take away bulky leaflets and information if they are travelling light.	Thank you for your suggestion. The committee did not make the suggested addition because the recommendation is focussed on which topics and issues the information should cover, rather than how or where it should be delivered. The committee believe that the issue of providing support in places frequented by people experiencing homelessness is address in other recommendations, namely the whole section on outreach services.
Leicestershire Partnership NHS Trust	Guideline	10	11	1.2.5 We have found that the current model of commissioning pits organisations against each other through the competitive tendering processes which undermines a culture of collaboration and openness in the sector.	Thank you for your comment. It is hoped that this guideline will help to improve collaborative commissioning and planning and integrated working across sectors and agencies.
Leicestershire Partnership NHS Trust	Guideline	10	20	1.2.5 Outcomes measured should be meaningful to the person experiencing homelessness and not arbitrarily set by commissioners. Outcomes should be more than counting the number of people whose rough sleeping has ended.	Thank you for your comment. The committee did not think this should be specified in the recommendation but it would be expected that the outcomes measures would be meaningful i.e. include outcomes relevant and meaningful to the people experiencing homelessness.
Leicestershire Partnership NHS Trust	Guideline	10	28	1.2.6 add people with disabilities, neurodevelopmental difficulties and those with brain injury	Thank you for your comment. The list is not aiming to be exhaustive but based on your and other stakeholders' comment ‘disabled people’ has been added to the list.

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Leicestershire Partnership NHS Trust	Guideline	11	16	1.2.9 remove the word 'consider' and acknowledge this has resourcing implications. Explicitly acknowledge that specialist homelessness services cannot imitate mainstream services whilst also being specialist, flexible and responsive; they must have permission to be different to the mainstream.	Thank you for your comment. 'Consider' reflects the strength of the supporting evidence. Unfortunately, even though the committee agreed that smaller caseloads and longer contact time are essential to facilitate trusting relationships, improve engagement with health and social care etc., there was no supporting effectiveness evidence. Also, the supporting economic evidence was only exploratory, based on many assumptions, and showed that reducing caseloads may potentially be a cost-effective approach. As a result, the committee could not make a stronger recommendation on this. The potential resource impact has been acknowledged in the rationale, i.e. stated that lower caseloads will mean that services will have to recruit more staff. The committee envisaged that a lower caseload strategy could apply in various settings, e.g., a practitioner working within multidisciplinary outreach teams, and did not want to limit this to specialist homelessness services.
Leicestershire Partnership NHS Trust	Guideline	11	20	1.3.1: we think what you are describing is a multi-agency team, not a multidisciplinary team. it would be good to specifically define this and stick to one term.	Thank you for your comment. The committee decided to use the term "multidisciplinary team" and defined as including practitioners across disciplines and agencies. The definition of how the term is used in this guideline can be found in the Terms used in this guideline section.

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Leicestershire Partnership NHS Trust	Guideline	12	1	1.3.2: We strongly agree that a multidisciplinary (multi-agency) team is required, but we feel that the guidelines should address how issues relating to confidentiality could be addressed including a reminder that sharing information on the basis of risk trumps information governance frameworks. There is no guidance as to who should be responsible for these teams or whether anyone should be.	Thank you for your comment. As suggested, the recommendations has been amended to capture this so the recommendations now emphasise the role of protocols and systems in place to support information sharing in line with relevant legal frameworks.
Leicestershire Partnership NHS Trust	Guideline	13	7	1.3.4 If reflective practice is important for these teams, we think PIE could be referenced at this point as this gives a context and justification for the reflective practice and makes clear the purpose of RP.	Thank you for your suggestion. The committee do not agree that PIE should be specifically referenced here because the concept of reflective practice can be far broader than and distinct from PIE.
Leicestershire Partnership NHS Trust	Guideline	14	1	1.4.1 definition of who peers are needs to be more specific. what qualifies someone to be a 'peer' in homelessness service? We think it should include people who have recent past experience of homelessness, not only people who are currently homeless. It should be clearer that roles should be paid or recompensed. We feel that it is important to be explicit that a range of service users voices to be heard, not just the same few people, and services should be encouraged to listen to those people who don't come forward or who communicate in unusual or challenging ways.	Thank you for your comment, on the basis of which the committee agreed to add a definition of 'peer' to the 'terms used in this guideline' section and in one of the recommendations they have specified that peers be provided with 'inclusive employment opportunities', which doesn't just cover pay but other aspects as well.

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Leicestershire Partnership NHS Trust	Guideline	15	9	1.5.1 explicitly encourage health and social care staff to be co-located on site in homelessness settings.	Thank you for your comment. Co-location is covered by 'one-stop shops' for multiple services.
Leicestershire Partnership NHS Trust	Guideline	15	14	we agree that self-referral is essential, but also referral by any agency or person supporting someone who is homeless, not just qualified professionals or leaders in the field. This is supportive of a 'no wrong door' approach; for example, if any agency or person is approached by someone experiencing homelessness and they disclose they would like mental health support, that person or agency can make a referral to our team, they don't have to support the person to attend the GP or other agency to get a referral. With good multi-agency partnership working this is not too much responsibility for partner agencies.	Thank you for your comment. A situation you describe would be covered by low-threshold services, i.e. services that avoid restrictive eligibility criteria.
Leicestershire Partnership NHS Trust	Guideline	16	8	1.5.3 ensure that the door is open for re-referral if appropriate	Thank you for your comment. The committee felt that this was implied in the original drafting of this recommendation but to place greater emphasis on it they agreed to edit one of the recommendations in the general principles section. This now states that people should be able to re-engage with services at the same point as they left.

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Leicestershire Partnership NHS Trust	Guideline	16	12	1.5.4 is this guideline appropriate for people who are homelessness? our common mental health problems specialist had to work quite differently from the rest of the common mental health problems service. Our knowledge of this would lead us to recommend considering homeless specialists within primary mental healthcare services who are allowed to work in the flexible, assertive way that you are recommending elsewhere in the guideline.	Thank you for your comment. The committee think it is appropriate to link the NICE guideline on common mental health problems as the recommendations on improving access to services in the guideline certainly align with the recommendations in this guideline, including supporting the integrated delivery of services across primary and secondary care, focusing on entry and not exclusion criteria, having multiple means (including self-referral) to access the service, providing multiple points of access that facilitate links with the wider healthcare system and community in which the service is located, assessment and interventions outside normal working hours, considering a range of support services to facilitate access and uptake of services such as assistance with travel and advocacy services, and being respectful of, and sensitive to, diverse cultural, ethnic and religious backgrounds.
Leicestershire Partnership NHS Trust	Guideline	16	21	1.5.6 'irrespective of age and dependent on need'	Thank you for your comment. The committee think that it is clearly implied that this should be based on needs, irrespective of age.
Leicestershire Partnership NHS Trust	Guideline	16	28	1.5.8 day centres and hostels also need to have the staffing available to support people to access the online resources	Thank you for your comment. The committee believe that this point is covered by the recommendation although they are unable to make a specific comment about staffing levels as this is beyond the remit of NICE guidelines.

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Leicestershire Partnership NHS Trust	Guideline	17	21	1.5.14 we agree that it is very important to provide a specialist mental health team for people who are homeless	Thank you for your comment. This recommendation is about outreach services offering support to people with mental health needs so not directly about providing a specialist mental health team for people experiencing homelessness but the guideline does recommend multidisciplinary outreach care that responds to people with differing needs and elsewhere in the guideline that homelessness MDTs should have people with relevant expertise including mental health.
Leicestershire Partnership NHS Trust	Guideline	18	6	1.5.15 does 'outreach teams' mean street outreach? This another example of terminology needing to be extremely tight as different agencies will have different understandings of what terms mean. If it does mean street outreach, we agree that they should be multi-disciplinary. We are again wondering whether you mean multi-disciplinary or multi-agency?	Thank you for your comment. The term 'outreach services' has been defined in the 'Terms used in this guideline' section and it includes street outreach as well as outreach in other settings such as hostels and day centres. The recommendations have been revised and the first recommendation in the section now refers to “multidisciplinary outreach”. We have also defined 'multidisciplinary team' in the same section and say this includes people from different disciplines and agencies.
Leicestershire Partnership NHS Trust	Guideline	18	8	1.5.16 is very focussed on physical health and could equally apply to mental health, this is not clear.	Thank you for your comment, mental health assessment has been added to the recommendation.

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Leicestershire Partnership NHS Trust	Guideline	19	1	1.6 assessments need to take place in venues where people experiencing homelessness feel comfortable and using means of communication that are accessible to people experiencing homelessness, ensuring privacy and confidentiality.	Thank you for your comment. The committee did not think the place for the assessment needs to be specified but overall the guideline support a person-centred approach and conducting the assessment in a place where people feel comfortable may be part of that.
Leicestershire Partnership NHS Trust	Guideline	20	4	1.7 could the guidelines address the inequalities between physical health and mental health hospital discharge procedures? what does 'multidisciplinary team' mean in this section? do you mean multi-agency? more clarity needed. there should be an emphasis on this section that we would expect the same quality of support for people who are homeless leaving hospital or in step-up situations as we would expect for any other citizen. 'intermediate care service' requires a definition.	Thank you for your comment. This guidance aims to improve the integration of health and social care services, including care during transitions between different settings, for people experiencing homelessness. These settings include mental health services, and the recommendations are for practitioners in any setting supporting people experiencing homelessness. It is hoped that the successful implementation of these recommendations will reduce variation in practice and help address the inequalities in access and engagement and facilitate integrated care that may help address the disparities between physical health and mental health service provision, including hospital discharge procedures. The overarching principle throughout the guideline development was that all services should be available to all, especially people experiencing homelessness who are most vulnerable to many poor outcomes because homelessness accelerates the deterioration of their conditions. The committee believe this is reflected throughout the committee's recommendations, including the guidance on transitions between settings and intermediate care, whether step-up or step-down. The definitions of 'intermediate care' and

					'homelessness multidisciplinary team' are provided in the Terms used in this guideline section.
Leicestershire Partnership NHS Trust	Guideline	21	1	1.8 gives good, clear guidelines on the specific expectations for how transitions are managed - good points have been made in this section	Thank you.
Leicestershire Partnership NHS Trust	Guideline	21	12	1.8.2 information sharing needs to be 'agreed by the service user' specifically, unless there is a risk to self or others. It would be helpful here to have reference to governance structures that allow information sharing between agencies such as DPA and Children's Act, making it clear that, legally, risk management trumps confidentiality.	Thank you for your comment. The committee feel that it is already implied in the recommendation that the sharing of information needs to be agreed with the person. They have also avoided the use of the term 'service user' in the recommendations.
Leicestershire Partnership NHS Trust	Guideline	21	19	1.8.3 please be clear about what is the purpose of the 'review'. Release from prison is an important transition that is missed that if not handled appropriately can increase chance of homelessness. Ensure robust care planning for discharge from hospital including liaising with GP and communication between hospital and the receiving accommodation.	Thank you for your query. The committee have now amended this recommendation and merged it with another which is about preventing self-discharge and discharge to the street. It should now be clearer that 'review' implies a review of how and why the self-discharge or discharge to the street came about and that learning should follow from this to help prevent future occurrences. In terms of your other point about communication and information sharing to support transitions, the committee feel this is

					already addressed within this section of the guideline. To note, people staying in institutions (such as prisons) in the long-term are not covered by this guideline. However, people who have recently left prison and are now homeless are.
Leicestershire Partnership NHS Trust	Guideline	22	11	1.9.3 include accommodation for specific groups eg women, those with physical disabilities, those fleeing domestic abuse. We were surprised that PIE was not mentioned explicitly as something that can inform accommodation models and there have been various promising trials of 'PIE hostels' (see Dr Williamson's work in London and Dr Gallagher in Manchester)	Thank you for your comment. This was something the committee discussed thoroughly when making this recommendation and again after receiving this comment. The committee deliberately agreed to keep it generic and not make a list as risks leaving out some important groups. There are various models and options for housing that could be applicable to different individuals depending on their specific needs but the focus of this guideline is not on housing and the recommendation has been kept broad.
Leicestershire Partnership NHS Trust	Guideline	22	19	1.9.4 We agree that emotional and practical support should be recommended to be given "as long as it is needed", as often this can often be time limited. It could be made clearer whose responsibility this is and whether it is everyone's responsibility.	Thank you for your comment. This depends on the needs and long-term plan for the individual and the guideline does not comment on whose responsibility this is.
Leicestershire Partnership NHS Trust	Guideline	23	4	1.10.1 we strongly agree	Thank you for your support for this recommendation.

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Leicestershire Partnership NHS Trust	Guideline	23	10	1.10.3 we strongly agree	Thank you for your support for this recommendation.
Leicestershire Partnership NHS Trust	Guideline	23	17	1.10.6 we would like to see a recommendation of a serious case review for all deaths of someone who is homeless	Thank you for your suggestion. Serious case reviews were replaced in law by Safeguarding Adults Reviews with the implementation of the Care Act 2014 so when they discussed it, the committee assumed your point actually related to SARs. However they highlighted that local authorities do have the discretion to conduct safeguarding adults reviews in every such event but if this guideline recommended in stronger terms that they 'should' be done, this would have considerable resource implications. For this reason and without stronger underpinning research evidence, the committee chose not to place further emphasis on the conduct of safeguarding adults reviews than the Care Act already does.
Leicestershire Partnership NHS Trust	Guideline	24	9	1.11.1 we recognise that this section isn't about commissioning, but there is an overlap… how will long term commissioning be ensured? Commissioning for less than a year is unworkable and runs the risk of retraumatisation of people experiencing homelessness and the homelessness system as individuals leave their posts and services are lost.	Thank you for your comment. Commissioners are responsible for enabling care provision for people who need it regardless of contract lengths of individual providers. In the section on Commissioning and planning, the committee did recommend to consider the likely benefits of long-term contracts for providers. However, funding from central government may make this difficult but this is outside the remit of this guideline.

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Leicestershire Partnership NHS Trust	Guideline	25	5	1.12.1 The guidelines could be clearer here by including examples of legal frameworks that should be included in training such as mental capacity act, housing act, homelessness prevention act, human rights act and mental health act. Also training on the expectations of services working with people with NRPF. we were disappointed that there was no reference to PIE training here (PIE training is broader than Trauma informed care).	Thank you for your suggestion. The committee did not think the recommendation would benefit from this level of detail but they did add more detail to the more fulsome description in the rationale section, which explains the basis for these recommendations. In terms of PIE, the committee have now added it in to this recommendation along with trauma informed care.
Leicestershire Partnership NHS Trust	Guideline	25	15	1.12.2 this point should be a given. Are the NICE guidelines for coexisting severe mental illness and substance currently working for people experiencing homelessness? What else is needed over and above to make the NICE guidelines for coexisting severe mental illness and substance work for people who experience homelessness?	Thank you for your comment. Different NICE guidelines cover a variety of topics and making links between different guidelines on issues that are related is often helpful. Because co-existing mental health and substance use problems are common in people experiencing homelessness, the link with the NICE guideline on it seems appropriate. However, the committee agree that training for staff on specific issues related to homelessness and the needs and circumstances of people experiencing homelessness is needed which is why they made the recommendation 1.12.1.
Leicestershire Partnership NHS Trust	Guideline	25	19	1.12.3 The guidelines would benefit from an explanation of how reflective practice is different from supervision, and has a different function. it is important that reflective practice is provided by a qualified practitioner with adequate supervision of their own. This is a growing area in homelessness and there is a risk that damage will be done to staff teams and to the service users they are supporting if un-supervised facilitators are providing reflective practice. can you suggest models of reflective practice, explain	Thank you for your comment but this is not a guideline on reflective practice and therefore no further specifications have been made to this recommendation.

				what reflective practice is and what is involved (eg frequency)?	
Leicestershire Partnership NHS Trust	Evidence review A -B	General	general	We felt that this was focused on economic costs, as opposed to personal costs, and especially the multiple personal and circumstance-based factors leading to a consideration of "homelessness": at the very least, this should determine where future research priorities should be directed.	Thank you for your comment. The committee agree that multiple personal and circumstance-based factors lead to homelessness, and they have acknowledged the multitude of these factors, e.g. structural, societal and economic factors, such as poverty and deprivation. The committee also acknowledged complex and intersecting physical and mental health needs, drug and alcohol recovery needs, and social care needs that may be contributing factors for becoming homeless, as well as experiences of psychological trauma, adverse childhood events, neurobehavioral differences, and brain injury are also common in people experiencing homelessness. Given regional variations in services, the potential resource impact, and the need for additional funding to implement some of the recommendations, it was important to demonstrate that recommendations are cost-effective. These cost-effectiveness arguments were strengthened by outlining economic costs associated with homelessness. However, references are also made to personal costs throughout the guideline, e.g. increased

					morbidity and mortality, impact on quality of life, exclusion and discrimination.

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London Borough of Camden	Guideline	General		**Questions** Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. Impacts: • Delivering friendly, non-judgmental, flexible services with staff who have an understanding of trauma would have a significant impact on the experience of people accessing and engaging services. Delivering services in a flexible way including varied appropriate community settings, flexible appointment times, and taking into account each person's communication and information needs is also important. • Having a consistent key worker who can build a trusting relationship and who can support access and engagement with a range of services. • Reducing barriers to engagement with services. • Implementing an MDT type approach to care planning and reducing the number of individuals someone has to work with. • Improving access to and engagement with health and social care, in particular outreach and low threshold services, self-referral and drop-in services. • Not closing cases for missing appointments/lack of contact. • Not excluding people for having co-existing mental health issues and substance misuse. • Using trauma-informed approaches, developing specialist homelessness multidisciplinary teams, involving peers (experts by experience) in designing and delivering services, adapting policies to improve access and engagement with	Thank you for your comment. In this question, 'practice', refers to recommendations which will have the most significant change in the way services or health and social care are delivered to people experiencing homelessness. However, the committee agree with the impacts you have identified and they made recommendations in each of the areas you have highlighted. They agree that there is variation in the current availability and provision of health and social care support associated with housing; in some regions, accommodation with onsite support is limited, and there are issues around capacity and assessment. As a result, they made recommendations in these areas that will hopefully be taken up by services and reduce variation in practice. Some of the challenges that you highlight are acknowledged in the rationale and impact sections of the guideline and the committee discussion of the evidence sections in full evidence reviews. The committee also understand that there is a lack of evidence in some areas that you have identified and made research recommendations, e.g. wraparound health and social care and associated structural and systems factors that help or hinder commissioning and delivery of such care. Your comment will be passed on to the NICE team, which plans implementation support. The committee agree that additional funding may be required to implement guidance. They attempted to identify areas that will require additional resources or have cost implications

				services, and enabling long-term support for those who need it. Challenges: • Providing wrap-around health and social care – although this may improve with the development of ICSs, partnership working between health and social care is a challenge due to different funding and governance structures, IT systems, thresholds and criteria. It is also a challenge for care assessments to be completed and any subsequent care packages implemented. • Providing a range of accommodation types is also challenging due to LA housing stock and supported accommodation options. Care/Nursing homes are sometimes reluctant to accommodate people with existing substance misuse needs. • Offering a flexible service offer can be challenging for statutory services or primary/secondary care due to the constraints of staffing models e.g. no capacity to offer out of hours or in reach/outreach services. • Demonstrating tangible outcomes • A current challenge can be what services to deliver for people who do not have a severe diagnosed mental health issue, and health/social care accepting assessments by a non-medical/social care professional. • Areas that would be the most challenging to implement are those that require additional funding and/or changes in long-embedded professional practices. In many cases, the latter could be more of a challenge than the former.	and highlighted that generally, such investments would represent value for money. However, NICE is not involved in sectorial funding decisions. Thank you for sharing examples of good practice. The committee made recommendations in the areas that you have highlighted. It is encouraging to see that there are already initiatives that will support the implementation of the guidance. Thank you for sharing your views on the impact of the Covid-19 pandemic on people experiencing homelessness. The committee made recommendations to commissioners and some about the design and delivery of services that reduce barriers to access and engagement. This guidance aims to improve the integration of services. It is hoped that overall, the guidance will help improve care for people experiencing homelessness, whether at a global pandemic or not.

				Would implementation of any of the draft recommendations have significant cost implications? • Offering long-term support • Providing a range of accommodation options • Providing an MDT approach to care planning and service delivery (needs coordination of funding and operational delivery) • Working in a trauma informed way with reflective practice – involves costs around training, management commitment and support, time for reflective practice/external facilitation. The same applies to peer involvement. • Providing appropriate accommodation for young people with complex needs / people with severe mental health issues and substance misuse / high levels of care needs. • Implementation of many of the recommendations needn't have significant cost implications. In many cases, it would be more a question of using existing funding more intelligently and in a more joined-up way. It might, however, involve decommissioning certain services to release funds for commissioning new services that conform better to these guidelines. • What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) • Examples of good practice e.g. where GPs have successfully set up initiatives to register and engage with people experiencing	

				homelessness – e.g. the Camden Health Improvement Practise (CHIP) GP outreach programme • Examples of MDT implementation including return on investment analysis. • Examples of where health and social care have successfully delivered integrated care plans/discharge planning etc; e.g. case studies/ feedback from people with lived experience where they have been successfully supported to access the services they need. • Feedback from frontline staff on the impact of working in a trauma-informed way • 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. • Business Continuity planning for further pandemics, including how service delivery could still be operational, how services could still reach vulnerable people who might not have access to digital/virtual alternatives. • The pandemic showed us how integration can really work when there are no organisational barriers in place. Housing rough sleepers in hotels and the wrap around care by a multitude of professionals was astonishing, so we can do it effectively with the right resources.	

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London Borough of Camden	Guideline	9	14	Re: recommendation to conduct a local homeless HNA: it could also be useful longer term to develop guidelines / consistency in questions around HNAs to provide national consistent data sets. BM: It would be helpful if the guidance could specify which public body should lead on conducting the local homelessness health and care needs assessment.	Thank you for your comment. This would not be within the remit of this guideline although the committee agree that consistent and standardised data collection would be helpful. The assessments should be done collaboratively in an integrated way and the committee did not want to name one body responsible for it. Local authorities are responsible for the Joint Strategic Needs Assessments but the guideline cannot and should not give a mandate for who exactly should be leading on the local homeless health and social care needs assessments.
London Borough of Camden	Guideline	10	13	Re: strategically planning and delivering care across larger areas; would be useful to also recognise here that flexibility / reciprocal arrangements are also required across local authorities housing local connection criteria for providing suitable step down and move on accommodation across larger areas	Thank you for your comment. The committee think this is included in the recommendation which talks about "across larger areas".
London Borough of Camden	Guideline	10	21	Re: using long term contracts for providers: it would be useful to have longer terms attached to central funding pots to encourage longer-term contracts for providers. Many funding opportunities are for 12 months funding	Thank you for your comment. The committee agree that this is a problem and is a significant barrier to services and care continuation. The committee made this recommendation with the intention of helping to address the problem through considering the use of long-term contracts. In light of your comment they did however place more emphasis on the point by explicitly stating there are 'likely benefits' of using long-term contracts.

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London Borough of Camden	Guideline	12	2	Re: homeless MDT recommendation: Camden Council & NCL CCG are piloting an MDT approach to homeless healthcare within its adult supported accommodation pathway.	Thank you for your comment that is interesting. NICE will consider your comments where relevant support activity is being planned.
London Borough of Camden	Guideline	12	14	Person-centred case management and continuity of care for as long as it is needed is resource intensive so needs to be backed up with adequate funding	Thank you for raising this. The committee agree with you and although they acknowledge that this element of the recommendation may seem aspirational, they do believe it is possible within current resources, albeit those resources may need to be used differently. However the committee did also strengthen the wording in a recommendation, which supports your point, that the likely benefits of using long-term contracts for providers should be considered. They made this recommendation to reflect that long-term contracts provide stability and can support the improvement and extent of services as long as there is flexibility to adapt to changing local needs.
London Borough of Camden	Guideline	12	25	Better coordination is also required between different mainstream providers to ensure safe, timely & appropriate hospital discharge and care	Thank you for your comment. The committee agree that this is an issue and wrote a section of the guideline dedicated to transitions between settings. They also signposted from there to the NICE guideline on transitions between hospital and the community, which contains important, relevant recommendations.
London Borough of Camden	Guideline	17	5	It would be useful if the current 'Duty to Refer' requirement for front line health and social care staff coming into contact with ppl experiencing risk of homelessness be strengthened to a 'Duty to Collaborate' for more effective partnership working and coordination	Thank you for your comment. NICE guidelines are not able to change legislation which Duty to refer is based on. However, the guideline recommends collaborative, integrated, multidisciplinary working across sectors and agencies.

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London Borough of Camden	Guideline	17	7	Re: ensuring frontline staff are able to identify needs for referral to specialist homeless health & social care; would also be useful to ensuring there are resources available (e.g. move on coordinators/ housing support workers) to support frontline and social care staff to support with and properly assess insecure/ risk of homeless issues on / soon after admission, rather than at discharge	Thank you for your suggestion. Although this has not explicitly been stated in this recommendation, the committee addressed your comment by emphasising the importance of multidisciplinary approaches to addressing the often complex needs of people experiencing homelessness. This includes the establishment of multidisciplinary homelessness teams.
London Borough of Camden	Guideline	17	10	It would also be useful to encourage joint protocols and training between health and housing and social care to help recognise the complex issues around homelessness. in order to prioritise moving up waiting lists	Thank you for your comment. The committee did not make this change to the recommendation, not least because they agreed there was already an emphasis throughout the draft guideline on joint working across health, social care and housing to address complex needs. Examples include reference to the joint strategic needs assessment and also the development of joint protocols for information sharing.
London Borough of Camden	Guideline	18	2	There can also be challenges for outreach staff around engaging with services on behalf of NRPF clients for fear of enforcement action; services need to be transparent and clear around links with Home Office enforcement and NRPF policy	Thank you for your comment. This is not an exhaustive and overall this would be covered by "concerns about eligibility including immigration status".

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London Borough of Camden	Guideline	22	16	BM: Housing First is a model of tenancy sustainment for people with complex needs that has been proven over many years to deliver positive outcomes and should be part of any local authority's response to homelessness and rough sleeping. LB Camden was the first local authority in England to pilot a Housing First service and now has one of the largest services in the country.	Thank you for your comment. The committee considered evidence about Housing First and the results showed a positive impact on housing status and tenancy sustainment, although more mixed results about quality of life and service outcomes. Economic evidence showed promising results that Housing First is cost-effective. The committee also had experience of Housing First and they agreed that well-coordinated collaboration between healthcare, social care and housing services leads to the best outcomes. On the basis of the evidence and supported by their own experience the committee therefore recommended that the health and social care needs of people experiencing homelessness should be met through multidisciplinary teams. They also recommended that wrap around health and social care support that is flexible to the person's changing needs be provided to help them maintain suitable accommodation. These and other recommendations in the same section of the guideline promote the values and important elements of Housing First and the committee felt it would be restricting to specifically recommend the formal Housing First model. The research evidence they considered was conducted largely in France and Canada and although the evidence based for Housing First in the UK is evolving, the delivery of housing first type interventions varies here, with some differences between models described as housing first and some models with many of the same features but not necessarily labelled 'Housing First'. The

					committee therefore agreed the most appropriate, evidence based solution was to recommend those important features without stipulating the model by name.
London Borough of Camden	Guideline	25	5	Training around legal duties and powers / legal entitlements could be on an annual basis to take account of updates in legislation and staff turnover	Thank you for your comment. The committee did not want to specify frequency of the trainings in the recommendations without evidence.
London Borough of Redbridge	Guideline	General	General	In Redbridge we have implemented much of this guidance already and have invested significant additional funding and resources in our local provision through MHCLG & PHE grant funding. Given the time limited nature of this funding and the ongoing pressure on funding and resources in Local Government implementing the full range of recommendations could be challenging for some Boroughs……I wonder how with some many competing priorities how we can ensure that authorities keep this high on their agenda.	Thank you for your comment. It is encouraging to hear that Redbridge is already implementing approaches recommended in this guideline. It is hoped that the publication of this national guideline will help prioritise this topic in the future as well.

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London Borough of Redbridge	Guideline	General	General	Redbridge has had significant levels of homelessness and rough sleeping for several years and we have conducted a lot of work locally to try and address this issue. We whole heartedly support the NICE recommendations and are committed to ensure we deliver best practice in this area. We are keen to support the development of these guidelines and would be happy to share the work we have done locally as well as engaging in any further development or consultation sessions with yourselves to progress this work.	Thank you for your comments in this consultation to support the finalisation of this guideline. Hopefully you can take part in any future consultations as well, for example if the guideline will be updated in the future.
London Borough of Redbridge	Guideline	11 026	19 009 - 012	As part of our COVID 19 response in Redbridge we created a multi-disciplinary service based around the 'Making Every Adult Matter' (MEAM) approach which utilises care navigators to ensure that individuals are engaged with the relevant services to meet their wide-ranging health & social needs. The MEAM approach has proved very effective with this cohort and we would be happy to share our experiences to the NICE shared learning database	Thank you very much for this information. It is good to hear of practice examples like these and they will be passed to NICE colleagues responsible for the shared learning case studies.

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Marie Curie	General			**About Marie Curie** Marie Curie is the UK's leading charity for people affected by terminal illness. We deliver palliative and end of life care directly to people across the UK both in their own homes and in our nine hospices and we run an information and support service which helped over 50,000 people last year. We are also the largest charitable funder of palliative and end of life care research in the UK and we campaign to improve access to and the quality of palliative and end of life care. References • Dying in the Cold; Being Homeless at the End of Life; co-authored by Ellie Wagstaff, Marie Curie and Dr Joy Rafferty, Strathcarron Hospice	Thank you for your comment and for providing feedback on the draft guideline.

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Marie Curie	Guideline	General		**Comment; Guideline; General.** The notable absence of bereavement support in the Guideline must be addressed in order to support PEH and their families, frontline organisations and health and social care professionals. PEH often experience profound loss, such as bereavement and the loss of many aspects of 'normal' life[1]. Bereavement contributes heavily to people becoming homeless[2], and the death of someone experiencing homelessness can have a significant impact on other service users, bringing up old losses. Those experiencing homelessness often have repeated bereavements and may deal with these in self-destructive ways, putting them at increased risk of loneliness, depression, isolation and suicidal ideas[3]. Also, people working in the homeless sector are often exposed to the deaths of those they care for, sometimes in difficult circumstances[4]. As a result, they are at high risk of secondary trauma and burnout[5]. Bereavement support should be a core component of providing a holistic palliative care service for PEH, and must be reflected in the Guideline. [1]Kennedy P, Sarafi C, Greenish W. Homelessness and end of life care. London: St Mungo's and Marie Curie Care, 2013. Available at https://www.mariecurie.org.uk/globalassets/media/documents/commissioning-our-services/currentpartnerships/homeless_report.pd	Thank you for your comment. The committee realise bereavement is an issue that impacts people experiencing homelessness but bereavement support was not something that came up in our evidence reviews, nor was it identified as a particular issue in the review protocols. The references you provide have been checked to see whether any were missed by the searches underpinning the evidence reviews or through our screening processes. Here are the conclusions for each reference: 1) Kennedy P, Sarafi C, Greenish W. Homelessness and end of life care. London: St Mungo's and Marie Curie Care, 2013. Available at https://www.mariecurie.org.uk/globalassets/media/documents/commissioning-our-services/currentpartnerships/homeless_report.pdf. - This is a narative report/tool sharing report for service providers and does not fit the inclusion criteria for our evidence reviews. 2) Kennedy P, Sarafi C, G [INCOMPLETE REF] - We are unable to identify the article with the information provided. 3) Kennedy P. Living with loss – a homeless perspective. Cruse 2013 Conference, Warwick University. 9-10 July 2013. CRUSE. - This is a conference abstract and would thus not be included in our evidence reviews. 4) Lakeman R. How homeless sector workers deal with the death of service users: a grounded theory study. Death Studies, 35(10), pp.925-948, 2011. - This study focuses on how service providers deal with death in a palliative care

				f [2]Kennedy P, Sarafi C, G [INCOMPLETE REF] [3]Kennedy P. Living with loss – a homeless perspective. Cruse 2013 Conference, Warwick University. 9-10 July 2013. CRUSE. Available at: https://www.cruse.org.uk/sites/ default/files/default_images/pdf/Events/ Homelessness [4]Lakeman R. How homeless sector workers deal with the death of service users: a grounded theory study. Death Studies, 35(10), pp.925- 948, 2011. [5] Schiff J, Lane, A. Burnout and PTSD in workers Past, present and future 25 in the homelessness sector in Calgary. Calgary: University of Calgary, 2016	setting and as such has a different phenomenon of interest than the review protocol for our qualitative review and would not be included in our evidence review. 5) Schiff J, Lane, A. Burnout and PTSD in workers Past, present and future 25 in the homelessness sector in Calgary. Calgary: University of Calgary, 2016. This study focuses on the symptoms of burnout, vicarious traumatization and PTSD among workers in the homeless-serving sector and as such has a different phenomenon of interest than our study protocol and would not be included in our evidence review.
Marie Curie	Guideline	4	019 - 021	**Comment; Context; p4 line 19-21. When referencing service teams as part of acute hospital admissions and experiences of emergency care for people experiencing homelessness (PEH), palliative care teams must be specifically mentioned as part of primary care and social care workforces.** Inconsistent identification and engagement with palliative care services of PEH due to complex trauma, active addictions, mistrust of services and fear of needing care and a lack of palliative care training for frontline organisations, mean acute settings (and hospices) are often engaged at crisis point when conditions of PEH are at an	Thank you for your comment. The committee did not consider it necessary to specify this in the context section because other examples are not given here either, However, based on your and other stakeholders' comments they agreed to add more to the recommendations about addressing palliative care needs. .

				advanced stage (29) . As well as being distressing for the patient themselves, it places intense pressure on these services especially when there are typically high rates of self-discharge and readmissions. There is evidence that PEH are five times as likely to have an emergency readmission and A&E visits after being discharged from hospital (30). Including palliative care teams in any context or narrative around emergency and acute services must be reflected in the Guideline.	
Marie Curie	Guideline	7		Comment; Guideline, 1.1.7, p7. We agree that active support to help PEH re-engage with services is important in the Guideline, but solutions must also be proposed. Link Workers across the UK have been invaluable during the pandemic in contacting patients who are vulnerable, making connections and helping meet their needs (32). We believe the Guideline should include Link Workers as part of re-engagement solutions, as the direct relationships they build with patients to support their health and wellbeing can lead to trust and potentially more willingness to access palliative care services.	Thank you for your suggestion. The qualitative review underpinning the guideline located one study about homelessness hospital link workers, the results from which contributed to a review finding about the benefits of service collaboration. The committee used this and related findings to inform recommendations about planning and commissioning services in a more joined up, coordinated way with the aim of increasing efficiency of care provision and awareness of what other services provide as well as reducing duplication and delays in care, and closing gaps in service delivery. The committee did not feel the findings from the review provided them with the basis on which to specifically recommend link workers but they feel the other approaches to improving engagement that they were able to recommend will help to address the issue you highlight.

Marie Curie	Guideline	8		comment; Guideline, p8. We believe the guideline target audience must reference frontline homelessness organisations, including hostels, specifically in recognition of the high level of practical and emotional support they provide to PEH, usually as the first port of call. This should complement the term 'advocate' used in the Guideline. Comment; Guideline, General. Despite PEH having significantly worse health than the general population, high death rates and more complex needs, they have much poorer access to palliative and end of life care (33). We acknowledge that palliative care services are recognised on p46 line 9 in the context of multi-disciplinary teams, but have concerns that the importance and value of palliative care service links with frontline organisations, hostels and in acute settings are not reflected in the crux of the Guideline recommendations as a key integrated aspect of health and social care for PEH.	Thank you for your comment. A definition of social care staff has been added to the Terms used in this guideline and make it clear that this means front line social care practitioners that may work in residential care, hostels and homelessness services. Based on your and other stakeholders' comments, the committee added a recommendation about making provision to palliative care for those for whom death is not unexpected in the next 6 to 12 months. The committee also added palliative care needs to the list of health and social care needs that should be addressed by providing wrap around health and social care support.
Marie Curie	Guideline	8		**Comment; Guideline; 1.1.9 p8.** Some people experiencing homelessness have literacy problems and so it would be important to include "face to face or in person" to the list of communication methods described	Thank you for your comment, the suggested change has been made.

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Marie Curie	Guideline	8		**Comment; Guideline; 1.1.12 p8.** Service information offered to PEH must explicitly mention palliative care services in the Guideline as part of primary care and social care services and voluntary and charity sector services. Many frontline organisations do not have direct links with specialist palliative care services, including the third sector, thus early identification and engagement would strongly benefit patient quality of life, while also reducing the risk of a crisis admission to acute services.	Thank you for your comment. The committee agree with you about the need to improve access to palliative care for people experiencing homelessness. On the basis of yours and other stakeholder comments they made changes to some recommendations to try to address this, for example stating that wrap around health and social care should encompass the person's needs, including palliative care needs and they also made an additional recommendation about palliative care in the section on long-term support. The committee did not make changes to the particular recommendation that you cite because it is intended to be all encompassing in its reference to the provision of information about health and social care services.
Marie Curie	Guideline	9		**Comment; Guideline; 1.2.1 p9**. We recognise the importance of striving to end and prevent homelessness in commissioning in housing service contexts, but for PEH who are living with a terminal condition which will likely result in their death, it is important that palliative care and wider health services remain available to provide wrap-around support (as the Guideline recognises in section 1.9). This approach should be mirrored in commissioning to avoid the potential of having a significantly determinantal impact on PEH physical and mental health, reigniting the vicious circle of complex trauma.	Thank you for your comment. The committee agree with you about the importance of improving access to palliative care services for people experiencing homelessness. Although they did not make a change to the recommendation you mention, they did add to the recommendation that wrap around care and support should encompass people's needs, including palliative care needs. While finalising the guideline they also made a new recommendation about palliative care in the section on long-term support.

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Marie Curie	Guideline	11		**Comment, Guideline, 1.2.8 p11**. We believe this recommendation would benefit from not only supporting PEH to register with GP services and document issues, but also to support PEH to use and (re)engage with services to once again highlighting the value of introductions to Link Workers.	Thank you for your comment. Other sections of the guideline, such as Improving access to and engagement with health and social care, The role of peers, and How services should be delivered cover issues related to supporting people to use and (re)engage with services.
Marie Curie	Guideline	12		**Comment, Guideline, 1.3.2 p12.** We have concerns that palliative care is not fully recognised as part of the approach to multidisciplinary team working (acknowledge the reference on p46). Palliative care should be a specifically referenced aspect of primary and social care services in multi-disciplinary teams to enable PEH to have the opportunity for the best quality of life.	Thank you for your comment. The committee agree with you and have added that wraparound health and social care should encompass people's palliative care needs.
Marie Curie	Guideline	12		**Comment, Guideline, 1.3.2 p12**. Suggest adding an additional bullet point to this list "if the death of the person would not be unexpected in the next 6-12 months, consider referral for support from community palliative care teams."	Thank you for your suggestion. The committee addressed this by adding a new recommendation about palliative care to the section of the guideline on long-term support.

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Marie Curie	Guideline	16		**Comment; Guideline, 1.5.6 p16.** PEH have a much higher likelihood of having a long-term health condition. Early onset of frailty is more common[ii], as are cancer[iii] and early prevalence of cardiovascular disease[iv]. As a result, the average date of death for people experiencing homelessness is 46 for men and just 43 for women[v] - this reduced life expectancy brings further challenges at the end of life. Health and social care packages for PEH must reflect their palliative care needs which have been identified through a comprehensive needs assessment. The prevalence of premature frailty among PEH means that people frequently have advanced ill-health and high support needs and may be experiencing cognitive impairment at a far younger age than the general population. While nursing homes provide excellent care for people with such needs, admissions criteria are often oriented towards those over 65 years old.	Thank you for your comment. The committee did not want to conflate frailty with palliative care needs and did not reference palliative care needs here but the recommendation was revised so that residential care and supported housing is specifically mentioned. The committee added a recommendation to the section on Long-term support about providing palliative care to those for whom death is not unexpected in the next 6 to 12 months.

Marie Curie	Guideline	17		**Comment; Guideline; 1.5.11 p17.** Often, PEH who have a terminal condition are unable to access palliative care until very late in their illness. It can be difficult to recognise a change or deterioration in the health of a person experiencing homelessness who may face barriers to regularly engaging with healthcare services , while substance dependency can mask symptoms and make diagnosis and prognosis more difficult , which can be a barrier to initiating conversations about end of life care . In addition, hostel staff who are not trained in health care can find conversations about wishes towards the end of life daunting, therefore research suggests considering conversations about what matters most to a person as an essential starting point for considering what would be important to someone should their health deteriorate (38). We believe the Guideline should champion palliative care training for all health and social care staff, as well as frontline homelessness organisations, who support PEH to ensure as early identification as possible for PEH who may benefit from a palliative approach. This should include Advanced Care Planning (ACP), as it can be particularly challenging for PEH to have conversations with professionals expressing their wishes and priorities for end of life care. ACP is predicated on choice, but the choices many have are restricted and many of the options available to the general population are unavailable – not least the choice of where they	Thank you for your comment. The committee agree with the issues you have raised and although our literature search did identify one study from the UK [(Shulman 2018), which contributed to several review findings in Review C], they acknowledge that the draft recommendations were not sufficiently specific on palliative care. On the basis of yours and other stakeholder comments they made changes to some recommendations to try to address this. They also added a recommendation about palliative care to the section of the guideline on long term support. The study you reference has been checked (Hudson, B. F., Shulman, C., Low, J., Hewett, N., Daley, J., Davis, S., ... & Stone, P. (2017). Challenges to discussing palliative care with people experiencing homelessness: a qualitative study. BMJ open, 7(11), e017502.). This reference was identified in our literature search but was excluded at full text screening based on 'no qualitative data on phenomena of interest'.

				would like to die. Therefore it is important that conversations focus around that matters most to the individual and what can be done to meet their needs now and should their health continue to deteriorate. A more flexible 'parallel planning' approach – where plans are developed that allow for unpredictability in a patient's condition – has value for homeless people. Under this approach, concerns about a person's deteriorating health are used to trigger conversations about their care needs and preferences – rather than a definitive diagnosis which may be impractical or impossible to obtain . This can help facilitate conversations about a person's health and what may improve their quality of life, which are often easier to have with a person experiencing homelessness than a conversation about dying and death .	
Marie Curie	Guideline	17		**Comment; Guideline; 1.5.12 p17.** We support this recommendation in the Guideline. The option of fast-tracking PEH with rapidly deteriorating needs associated with terminal conditions is crucial for giving them the best quality of life in the remaining time they have left, and a dignified death.	Thank you for your support for this recommendation.

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Marie Curie	Guideline	17		**Comment; Guideline; 1.5.14; p17.** We support the approach to outreach services and believe this must include palliative care as part of primary and social care outreach.	Thank you for your suggestion. The committee agree to make more explicit references to palliative care although not in this particular recommendation. Instead, they specified that wraparound health and social care should address palliative care needs and they also added a new recommendation about palliative care to the section on long-term support.
Marie Curie	Guideline	21		**Comment; Guideline; 1.8 p21.** The support PEH receive while transferring between care settings is crucial. This should embody a whole-system approach to ensure PEH do not slip between the cracks of the multiple services they require which often work in silo. Lack of coordination between services for PEH has been historically poor and, a persons' experience at the end of life can be made much more challenging by poor coordination between homelessness services and the other services they may be engaged with, such as a hospice team or palliative care social worker. This leads to people falling through the gaps between services, with no single service being the lead organisation in a person's care . We strongly recommend that the Guideline champions hospital palliative care in-reach programmes coordinated through Pathway, for example, to support a proactive solution. This service supports improved health outcomes and reduced re-admissions to hospital through facilitating patient engagement in treatment, discharge planning and ongoing community	Thank you for your comment. The committee agree with you about the issues you raise and have endeavoured to address these throughout the guideline and in particular, in the section focussed on models of multidisciplinary team working. They did not review evidence specifically about in reach palliative care programmes so were unable to specifically recommend this. They did however recommend that hospital admissions, be used as an opportunity to assess people's needs in a comprehensive and holistic way, including appropriate referral and this would of cause palliative care needs. They also recommended that multidisciplinary homelessness teams should offer health and social care support that encompasses people's palliative care needs, which would also address the issues you raise and following the guideline consultation they also added a specific recommendation that palliative care needs should be provided for if the death of the person in the next 6 to 12 months would not be unexpected.

				support. The Guideline must also reflect a joined-up approach to PEH health and social care needs, including palliative care, to ensure PEH are able to access all the physical, emotional and spiritual support they need, when they need it.	

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Marie Curie	Guideline	22		Comment; Guideline; 1.9 p22. Where a person has been made homeless by being evicted, local authorities require an eviction to reach its final stage – bailiffs arriving at the home to execute the eviction – before emergency accommodation can be offered. People must present at their local authority's offices on the day of the eviction to be given emergency accommodation – often with all of their possessions with them. This is extremely distressing, and inappropriate for terminally ill people who are dealing with severe symptoms or mobility issues, and whose possessions may include medical equipment . Housing officers and homelessness professionals often have a lack of understanding of the particular needs of terminally ill people, particularly when a person is living with a less well-understood condition such as motor neurone disease or multiple sclerosis.. This can lead to insensitivity to people's needs, for example the perception that terminally ill people will all go to hospital or a hospice and that there is no need for them to apply for accommodation . In addition, may people with palliative care needs may not have received a formal diagnosis, which can act as a barrier to service and support access Emergency measures introduced during the Covid-19 pandemic aimed at getting people off of the streets and into accommodation have improved much of this. Homelessness teams have demonstrated more flexibility regarding the documentation they require to process	Thank you for your comment. The committee discussed that Housing First is an effective intervention to reduce homelessness and agreed with many of the principles highlighted in the model. However, the committee agreed that the evidence did not show its suitability in improving access to, or engagement with health and social care, which was the objective of the review question. The committee discussed that there is huge variation in the fidelity of the housing first model and agreed not to specify it in the recommendations although many of the principles of the model are reflected in the recommendations. The committee also discussed palliative care and acknowledged that the draft recommendations were not sufficiently specific on this topic. On the basis of yours and other stakeholder comments, they made changes to some recommendations to try to address this. They also added a recommendation about palliative care to the section of the guideline on long term support.

				applications and have introduced telephone consultations rather than requiring people to present at local authority housing departments. This shows that improvement is possible – however there is a risk that after the pandemic local authorities return to 'business as usual' and poor practice resumes . We recommend that the Guideline champions a 'housing first' approach to be adopted for PEH at the end of life . This approach should prioritise getting people quickly into suitable homes on a fast-track basis, and then addressing any other support needs they may have through coordinated support.	

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Marie Curie	Guideline	22		**Comment; Guideline; 1.9.3 p22.** We support the recommendation that its important to recognise the need for a range of accommodation types suitable for PEH with specialist support. This is even more crucial for PEH with palliative care needs. There is a distinct lack of options for PEH at the end of their life (41). They may be too young for care homes and community hospitals, and mainstream services may struggle to cope with those who experience complex trauma, problem substance/alcohol use and poor mental health. Research shows that many experiencing homelessness want to remain in their homeless accommodation if their health deteriorates (42). Those working in homelessness services usually have experience of working with people with complex trauma, challenging behaviour, mental health problems and substance misuse, and as a result may be better placed than hospitals to meet peoples' emotional needs (43). However, providing this support in homelessness accommodation is not without its challenges e.g. medicine storage and staff typically having no palliative care training to support end of life needs. We believe the Guideline must ensure that a palliative care response in community homelessness settings e.g. hostels is possible, in the form of specialist support/ palliative care beds is possible, to avoid a hospital admission.	Thank you for your comment. It is hoped that the recommendations in this guideline can improve access to suitable and needs-based care and support for people with palliative care needs. Based on the consultation feedback the committee made two new recommendations addressing people with frailty and the need for tailor the long-term care to meet this and providing palliative care for those for whom death in the next 6-12 months will not be unexpected.

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Marie Curie	Guideline	24		**Comment; Guideline; 1.11 p24.** We support the recognition of long-term support in the Guideline, and need to express resilience, patience and compassion when engaging with PEH, and PEH living with a terminal illness. This approach is even more crucial in a palliative care context, with a need to continually advocate for long-term wrap-around support which is tailored to an individual's needs for the best quality of life possible. Comment; Guideline; 1.11 p24. It is important to acknowledge that a relentless emphasis on "recovery" can place pressure on both patients and staff, when recovery from physical illnesses is unlikely. Suggest adding "not all patients will recover, for patients who you would not be surprised if they were to die from a physical illness in the next 6-12 months, consider changing the focus of conversations to what matters most to the person and what living well means to them",	Thank you for your support for the guideline. The committee were careful to ensure that the recommendations clearly set out how services and support should be delivered to people experiencing homelessness and not just what those services and support should be. Hopefully this is demonstrated including with the general principles, some of which have actually been strengthened since the guideline consultation. For example, one of the general principles recommends specifically promoting engagement with services by being person-centred, empathetic, non-judgmental and services needing to be inclusive, addressing health inequalities and being responsive to diverse needs of people. The committee have also made more explicit reference to addressing palliative care needs through wraparound health and social care support and they added new recommendation about provision for palliative care needs in the section on long-term support.
Marie Curie	Guideline	25		**Comment; Guideline; 1.12 p25.** Ensuring staff feel equipped to support PEH is paramount, even more so for PEH living with a terminal illness. The majority of frontline homelessness organisations and social care staff in particular, have no palliative care training, and PEH palliative care needs are often missed as a result.	Thank you for your comment. Palliative care needs are part of potential health and social care needs of people experiencing homelessness and so the committee think that our recommendation on training and understanding the health and social care needs of people experiencing homelessness should cover this. Also to note that based on your and other stakeholders' comments the committee have revised the guideline to make explicit reference to palliative care in the section on homelessness MDTs as well on long-term support.

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Marie Curie	Guideline	28	14	Comment: Terms used in this guideline; Recovery Oriented Language P28 Line 14: In the context of palliative care, "recovery" is not always a possibility. The emphasis on using recovery focused language, when recovery in a physical sense is unlikely, could create harmful and restrictive implications on the focus of conversations and language which may be detrimental to person centred care (52). The Guideline must better advocate for palliative and end of life care training for all health and social care professionals and frontline homelessness organisations supporting PEH with a terminal illness, to ensure responses are appropriate to individual care needs, and workforces feel empowered to identify and support PEH in these circumstances.	Thank you for your comment. The committee agree with you and have revised the definition based on this and other stakeholder comments to include a recognition that if recovery is unlikely, conversations might focus more on exploring what is important to the person and what living well means to them
Marie Curie	Evidence Review C	General		**Comment; Evidence Review C, General.** While palliative care is cited in the evidence review in the context of international studies which have explored barriers to accessing palliative care for PEH and recommendations, this has not been transferred into the draft Guideline. In many cases it is unknown what, if any, palliative care support PEH have been able to access and receive. Palliative care services can support improved quality of life, and the research cited in Evidence Review C clearly evidences trends of late access and lack of appropriate palliative care services for PEH which can have a negative impact of the time	Thank you for your comment, which we discussed with the committee. Although the literature search did not identify much evidence specifically about palliative care, one study from the UK (Shulman 2018) was included, which contributed to several review findings in Review C. Your comment was discussed with the committee and they agree with you about the need to improve access to palliative care for people experiencing homelessness. On the basis of yours and other stakeholder comments, they made changes to some recommendations to try to address this. The committee also agreed to make a recommendation about palliative care in the section on Long-term support.

				they have left. Difficulty recognising palliative care needs also must be acknowledged within the Guideline, with solutions to support mitigation. This includes championing and providing accessible palliative care training for frontline organisations and hostels to empower workforces to help identify people who could benefit from a palliative care approach This approach to training has been successfully piloted (59). Further evidence has shown the consistent in-reach from palliative care teams into homeless hostels can be powerful in improving access to support for those with palliative or end of life care needs (60) …we believe this must be acknowledged in the Guideline.	Thank you for providing these references. They have been checked for relevance to this review and reasons for exclusion are provided after each reference: Shulman, C., Hudson, B. F., Kennedy, P., Brophy, N., & Stone, P. (2018). Evaluation of training on palliative care for staff working within a homeless hostel. Nurse education today, 71, 135-144. This reference was identified in our search but excluded at the title and abstract screening stage because it does not match the phenomenon of interest in the qualitative review protocol of this guideline. (60) Armstrong, M., Shulman, C., Hudson, B., Brophy, N., Daley, J., Hewett, N., & Stone, P. (2021). The benefits and challenges of embedding specialist palliative care teams within homeless hostels to enhance support and learning: Perspectives from palliative care teams and hostel staff. Palliative Medicine, 02692163211006318. This study was published after the literature search date for this review question and therefore was not included.
National Housing Federation	Guideline	General		Q1 Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. · Continuity of care and long-term support will be challenging for the NHS and housing providers, because of current funding arrangements – but it needs to be done so that people's needs can be met and public funds savings can be made	Thank you for your comment. The committee agree and acknowledged that currently, continued long-term support is quite rare, and funding of services is often not aligned with such an approach. The guideline highlights that investments in such care would represent value for money. However, NICE is not involved in funding decisions, but it is hoped commissioners will take up this guidance, and any additional funding will be made available to implement this

					guidance. Your comment will be passed to the NICE team, which plans implementation support.
National Housing Federation	Guideline	General		Q2 Would implementation of any of the draft recommendations have significant cost implications? • Continuity of care and long-term support would have initial costs for the NHS or national government budget – but needs to be done so that people's needs can be met. Can also reduce costs over the longer term. • Use of supported housing as an alternative to hospital/residential care or for hospital discharge/step down and as a location for health screening (e.g. Hep C)/vaccination can reduce costs and improve take up of preventative health care, so would have significant positive cost implications for the NHS Integration of housing and health will lead to cost savings for the NHS	Thank you for your comment. The committee agree and acknowledge that care continuity and long-term support might result in additional resources to services. For example, the committee discussed that there is variation in current practice and that long-term support can be limited at present. It was also discussed that integrated and multidisciplinary support depending on the individual needs would likely improve long-term outcomes and bring savings in terms of reduced overall costs due to homelessness and unaddressed complex needs. The committee made a number of recommendations that will hopefully encourage commissioners to plan long-term and stable services. They also agree that there may be a need for additional funding. However, NICE does not have a remit to make recommendations on funding decisions.

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National Housing Federation	Guideline	General		Q3 What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) • Training on all forms of homelessness (not just rough sleeping) and information sessions on Homelessness Reduction Act requirements (e.g. partnership working, Duty to Refer (I see this is included in the draft)) • Good practice examples on housing with support. See e.g. https://startsathome.org.uk/stories/ Training on referrals to supported housing	Thank you for sharing examples of good practice. It is encouraging to see that there are already initiatives happening that will support the implementation of some of the recommendations in this guidance. The committee have made a number of recommendations in the areas that you have highlighted.

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National Housing Federation	Guideline	General		Q4 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. • Supported housing is facing a significant increase in demand and increased financial pressure https://www.housing.org.uk/resources/briefing-on-the-financial-impact-of-thecoronavirus-crisis-on-supported-housing-providers/ ; https://www.homeless.org.uk/connect/blogs/2021/sep/15/homelessness-provision-for-future • People have been stuck in temporary accommodation for longer than usual because of temporary bans on moving and a lack of move-on solutions. There has been a government focus on moving rough sleepers into accommodation but not homeless families. Housing associations have helped to rehouse both groups. https://www.housing.org.uk/our-work/coronavirus/communitiestogether/ • Homelessness has many causes (p40) but poverty is a significant driver of homelessness. The coronavirus pandemic has driven up poverty levels and temporary welfare mitigations (e.g. £20/week uplift to Universal Credit) have been discontinued	Thank you for your comment and highlighting the impact of the Covid-19 pandemic on services and people experiencing homelessness. The underlying causes of homelessness, including poverty, are acknowledged in the context section of the guideline. The committee recognise the rise in poverty levels; however, it is beyond the scope of this guidance to say anything further on this. Increased demand for services and limited capacity that resulted due to the Covid-19 pandemic will require additional funding. Where appropriate, the committee highlighted that such investments, e.g. in housing with health and social care support, represent value for money. However, NICE is not involved in funding decisions. Since the issues you raise may impact the implementation of the guidance, your comment will also be passed to the NICE team, which plans implementation support.

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National Housing Federation	Guideline	General	General	As a general rule, we would suggest using the formulation “health, care and support” as opposed to “health and care”, as homeless people may have support needs that are not at the level of personal care but, if met, would have a significant positive effect on their health. It would be useful to clarify the difference between “care” and “support” in the preamble.	Thank you for your comment. The committee think that it is established that the concept of 'social care' already includes support as a core element and therefore have agreed not to add "support".
National Housing Federation	Guideline	7	15	We suggest the addition of “1.1.8 Recognise that convalescence, recovery and storage of medicines can be challenging for someone who does not have a home in which to do these things. Commit to working in partnership to source housing for the individual concerned.”	Thank you for your comment. This guideline does not cover housing provision or allocation as such and no recommendation has been added based on this suggestion but the committee think the issues you raise are otherwise largely covered by the guideline. For example, the guideline makes recommendations in relation to providing intermediate care for those who have healthcare needs that cannot be safely managed in the community but who do not need inpatient hospital care; and about recognising that providing suitable accommodation suitable to the person's assessed health and social care needs can support long-term recovery and stability (in the rationale section the committee stated that this may include practical and logistical considerations such as aids and appropriate storage for medication).

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National Housing Federation	Guideline	9	10	Add, as 1.2.2, “Recognise that supported housing takes pressure off public services and saves public funds. Plans for adult social care should reflect the essential role of supported housing in delivering independence and wellbeing for many people with long-term care and support needs.” See our submission to the HCLG committee inquiry into long-term funding of adult social care for more details: https://committees.parliament.uk/writtenevidence/25815/pdf/	Thank you for your comment. The committee are not able to comment on this statement because they did not review evidence about it. The focus of this guideline is not on housing although recommendations touch upon supported housing in the guideline, including in the section on Housing with health and social care support and in the recommendation about long-term care packages for people experiencing homelessness assessed as frail.
National Housing Federation	Guideline	9	17	We recommend adding “(including supported housing providers)”	Thank you for your suggestion. The committee did not make a change to this recommendation because they agreed that supported housing providers are covered by the reference to assessing the quality and capacity of 'existing mainstream and specialist service provision'.
National Housing Federation	Guideline	10	4	We recommend adding bullet point “assess the availability of supported housing and future need for supported housing”.	Thank you for your comment. Mainstream and specialist service provision would cover supported housing. The recommendation also covers availability, i.e. capacity of existing service provision, and future need, i.e. service development and investment.
National Housing Federation	Guideline	10	6	We recommend ending point with “, such as with supported housing providers and general needs housing associations.”	Thank you for your comment. The committee did not want to specify housing providers or general needs housing associations here as they wanted to keep it generic and inclusive of different services.

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National Housing Federation	Guideline	10	15	We recommend writing, “enable **and fund** long-term support…”	Thank you for your comment, the committee think "enable" contains the element of appropriate funding.
National Housing Federation	Guideline	10	17	We recommend writing, “health and social care **and supported housing** services”	Thank you for your comment. This guideline focuses on health and social care services and not housing provision as such. However, the guideline recommends commissioners of housing services to be involved in the development of these services so wraparound health and social care support in addition to housing provision would be considered.
National Housing Federation	Guideline	10	21	We recommend adding an explanatory note: “long-term contracts enable long-term planning and support service provision, including training and retention of high quality staff”	Thank you for your comment. Yes, there are likely benefits of long-term contracts and the committee have revised the wording of the recommendation to emphasise this but the committee recognises that there needs to be flexibility to adapt to changing local needs and this has been discussed in the rationale section.
National Housing Federation	Guideline	12	4	End line with “, including housing associations (who provide 70% of supported housing).”	Thank you for your suggestion. The committee did not think it was necessary to make this edit because 'housing services' is intended to be a broad umbrella term, which would includehousing associations.
National Housing Federation	Guideline	12	024 /025	We recommend adding bullet point “recognise the role of supported housing in delivering the above”.	Thank you for your comment. They committee did not feel it was necessary to specify the role of supported housing in this recommendation but they do recognise this contribution and made a section of recommendations dedicated to this subject.

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National Housing Federation	Guideline	13	6 - 7	We recommend adding bullet point “supported housing providers”.	Thank you for your comment. The committee made some changes to this recommendation, including adding 'outreach and homelessness practitioners'.
National Housing Federation	Guideline	16	11	We recommend adding “Fund services accordingly (i.e. long-term).”	Thank you for your suggestion. It is beyond the remit of NICE guidelines to make recommendations about funding for care and support so the committee were unable to make this change.
National Housing Federation	Guideline	16	21	We recommend adding “and this is funded adequately”.	Thank you for your suggestion. It is beyond the remit of NICE guidelines to make recommendations about funding for care and support so the committee were unable to make this change.
National Housing Federation	Guideline	17	8 - 9	We recommend writing, “specialist homeless health and social care, **including supported housing**”	Thank you for your suggestion. In making this recommendation, the committee did specifically wish to convey that front line staff can identify specialist health and social care needs. There are other points throughout the guideline where they also refer to housing needs or housing services.
National Housing Federation	Guideline	19	13	We recommend writing, “health and social care **and housing** plan”	Thank you for your comment. The focus of this guideline is to improve access and engagement with health and social care and the recommendations in this section focus on assessing the person's health and social care needs. Housing needs and plan are linked but separate to this. However, the committee have revised the recommendation to specify that this should be done in the context of the person's housing (and benefits) situation.

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National Housing Federation	Guideline	20	13	We suggest adding point 1.7.2 “Create links with / commission housing associations that provide step down / hospital discharge services / supported housing”.	Thank you for your comment. There was no evidence identified about who should deliver intermediate care and the committee did not think this needs to be specified in the recommendations. This is for the consideration of local commissioners.
National Housing Federation	Guideline	22	5	We recommend writing, “health and social care **and support** needs”	Thank you for your comment. The committee think that it is established that the concept of 'social care' already includes support as a core element and they therefore agreed not to add "support".
National Housing Federation	Guideline	22	8	We recommend writing, “Provide wraparound health and social care **and housing-related** support…”	Thank you for your comment. The focus of this guideline is about improving access to and engagement with health and social care and wraparound health and social care support in this recommendation is within the context of responding to their housing needs.
National Housing Federation	Guideline	22	13	We recommend writing, “self-contained accommodation **with access to floating support”**	Thank you for your comment. The relevant support would depend on the assessed needs of the person. The committee have also acknowledged the importance of having access to support services for people experiencing homelessness during transitions in recommendations.
National Housing Federation	Guideline	22	18	We recommend writing, “Provide emotional and practical **and housing-related** support for as long as it is needed.”	Thank you for your comment. Practical support would include housing-related support. The suggested change has therefore not been made.

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National Housing Federation	Guideline	24	18	We recommend ending line with “and fund this accordingly.”	Thank you for your comment. Essentially, appropriate funding underpins most recommendations in this guideline and it was not considered something that should be included in this recommendation. The Planning and commissioning section covers issues around commissioners planning services based on local needs but more specifically than that, the question of funding is beyond the remit of NICE guidance.
National Housing Federation	Guideline	25	4	We suggest adding point 1.11.5. “Ensure that funding arrangements are multiyear so that support can be provided over the long term, including in supported housing settings”.	Thank you for your comment. Commissioners are responsible for enabling care provision for people who need it regardless of contract lengths of individual providers. In the section on Commissioning and planning, the committee did recommend to consider the likely benefits of long-term contracts for providers. However, funding from central government may make this difficult but this is outside the remit of this guideline.

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National Housing Federation	Guideline	29	29	We recommend adding in a definition of "Supported housing", given its role in helping to achieve positive health outcomes. See also below re: Housing First. We suggest: "Supported housing is any housing scheme where housing, support and sometimes care services are provided. It includes retirement communities and extra care housing, homeless hostels, mental health step-down units, domestic abuse refuges and housing for people with learning or physical disabilities and people with autism. We recommend adding in a definition of "Supported housing", given its role in helping to achieve positive health outcomes. See also below re: Housing First. We suggest: "Supported housing is any housing scheme where housing, support and sometimes care services are provided. It includes retirement communities and extra care housing, homeless hostels, mental health step-down units, domestic abuse refuges and housing for people with learning or physical disabilities and people with autism. "Support services help people settle into a new home, maintain their tenancies, ensure their property is safe and secure, learn life skills including cooking or budgeting and work with third parties such as landlords, Jobcentre staff or probation officers. They are designed for people who want to be as independent as possible but need assistance with some aspects of daily living.	Thank you for your comment. The term supported housing is only used once in this guideline and the committee did not think it is necessary to define it and think it is generally relatively well understood.

				"Supported housing exists to make sure everyone in our communities can live their best life, whatever their circumstances, ideally within their own home. It provides vital support for some of the most vulnerable people in society, for working age and older people alike. For many in these groups, the only viable alternatives to supported housing are residential care, hospital or another secure institution. This puts strain on already limited resources and can have a negative impact on people who could live independently with the right support. Supported housing helps save public money, avoiding lengthy and costly hospital stays. It also helps avoid rent arrears and tenancy breakdown."	
National Housing Federation	Guideline	31	3	We'd like to see a clarification of what is meant by "usual care for people experiencing homelessness" – is this "support"?	Thank you for your comment. 'Usual care' in this context means the amount of time that people experiencing homelessness would usually spend in a health or social care 'contact', meaning a meeting, appointment or session with a practitioner. This will be the comparison against which 'longer' contacts will be tested in the proposed research in order to ascertain whether better outcomes can be achieved when people experience longer contacts with practitioners.
National Housing Federation	Guideline	49	7	Housing associations can help make links with peer mentors.	Thank you for your comment. Housing associations has been added to the text.

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National Housing Federation	Guideline	50	21	“Inreach”, where services go to where people live (e.g. supported housing) are also effective in increasing take-up	Thank you for your comment. The committee considered using the term 'inreach' but agreed that it is not a particularly well defined or understood term and more importantly, 'inreach' as it is often understood is included in the definition of outreach, which is defined in the guideline as: "Bringing health and care services to people who might not otherwise have access to or engage with existing services, provided in a mobile way in the locations where people are, for example on the street, in temporary accommodation facilities and in day centres."
National Housing Federation	Guideline	55	General	We recommend including a reference to “inreach” services as well. See previous line and see Coastline example here.	Thank you for your comment. The committee considered using the term 'inreach' but agreed that it is not a particularly well defined or understood term and more importantly, 'inreach' as it is often understood is included in the definition of outreach, which is defined in the guideline as: "Bringing health and care services to people who might not otherwise have access to or engage with existing services, provided in a mobile way in the locations where people are, for example on the street, in temporary accommodation facilities and in day centres."

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National Housing Federation	Guideline	62 - 63	General	It is very positive that the recommendations include a reference to “Housing with health and social care support” and a discussion of how to help people access this and how this can be funded. We recommend including references to other forms of supported housing for people experiencing homelessness as well as Housing First. Housing First is an intervention for people with high, multiple and complex needs and a long history of failed attempts to end their homelessness via the traditional route, but it is not appropriate for everyone experiencing homelessness. Other forms of supported housing, such as medium/low support hostels/shared houses, resettlement support (floating support), brokerage services, dog-friendly accommodation, etc. can be appropriate to meet the support needs of other homeless individuals. Supported housing reduces public spending costs but its funding is in jeopardy: http://s3-eu-west-1.amazonaws.com/pub.housing.org.uk/Sitra_Supported_Housing_Needs_Assessment_Report.pdf https://www.housing.org.uk/resources/report-on-developing-new-supported-housing-for-people-with-long-term-care-and-support-needs/	Thank you for your comment. This was something the committee discussed thoroughly when making this recommendation and again after receiving this comment. The committee deliberately agreed to keep it generic, there are various models and options for housing that could be applicable to different individuals depending on their specific needs but the focus of this guideline is not on housing.

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National Housing Federation	Evidence Review A - B	General	General	The evidence review rightly assesses the usefulness and cost-effectiveness of Housing First in addressing the health and social care needs of people experiencing homelessness. It compares these costs to the costs of hostel accommodation. However, Housing First is a specific supported housing intervention for people with multiple and complex needs; it is not appropriate for all groups experiencing homelessness (and is mainly for single people). (e.g. “Housing First is highly effective in ending homelessness among people with high and complex needs, but it does not constitute a solution to single homelessness, or rough sleeping, in itself.” in https://www.mungos.org/app/uploads/2018/02/ST_Mungos_HousingFirst_Report_2018.pdf”) Housing First England state that Housing First is appropriate for 10%-20% of the homeless population (see also https://researchbriefings.files.parliament.uk/documents/CBP-8368/CBP-8368.pdf). Other groups can and do benefit from other models of supported housing, such as medium/low support hostels. These services provide on-site wellbeing support or link residents in with health services, and provide housing-related support (see above) that improves their wellbeing. Supported housing saves the public purse around £940 per resident per year (see also https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/572454/rr927-supported-accommodation-review.pdf). Studies that compare supported	Thank you for your comment and links to the reports. The committee agree that there is a need for a range of accommodation types suitable for the varied needs of people experiencing homelessness, and a recommendation was made about this. The committee also agree that Housing First studies conducted in the United States will not fully reflect the same intervention within the UK context. This evidence as rated as being partially applicable to the NICE decision making context and all the limitations that you identified have already been acknowledged in the full evidence review. However, it should be noted that even though not directly applicable, such non-UK studies can indicate the potential cost-effectiveness of such models of care in the UK, especially as there was a lack of good quality UK-based studies. The committee also agree that there are various funding arrangements and that these vary between countries. However, the exact funding arrangements do not matter from the public sector perspective cost-effectiveness analysis since the public sector, e.g. government, would generally cover these costs through the housing benefit system. However, there may be implications for implementation, so your comment will be passed to the NICE team, which plans implementation support. It should also be noted that several UK-based

				housing with Housing First in the United States will not give an accurate account of the differences as regards value for money in the UK because the way services are delivered and funded is different. Some of the US studies compare Housing Fist to shelter accommodating, which are not the same as hostels in the UK. In England, supported housing is funded through capital funding to build it (shared housing with communal areas) from various government or charitable grant streams, and revenue funding (for support) from local authorities through commissioning (to pay on-site or visiting support staff) and then in the case of registered providers of social housing controlled rents/service charges (to pay for the building and services related to occupation - e.g the lifts and communal areas). Tenants are able to claim Housing Benefit to cover these costs. Housing First capital and support costs are commissioned separately (often the building is a general needs property and if let on a social housing rent it will be lower than a purpose build supported housing scheme), and the support is floating support (sometimes commissioned by local authorities, sometimes charitable funding) rather than on-site staff. The properties are single units so there may be lower security costs. In the UK, Housing First can be expensive if the support cost and the cost of the property (which could be in the PRS given the severe shortage of social housing or could be an affordable rent property which is 80% of market rent) is calculated.	economic evaluations on the Housing First model were included that report costings applicable to the NICE decision making context. The findings of these studies are in line with those of non-UK studies.

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National Housing Federation	Evidence Review C	340		Appropriate use of supported housing depends on adequate referrals. The evidence relating to supported housing being inappropriate on page 340 appears to be the result of inappropriate referrals based on a poor quality or inexistent needs assessment. It would be useful to include resources on appropriate supported housing referrals, or training on this.	Thank you for your comment, which refers to the evidence table for the study Kesia 2018 and extracted data regarding falling between service thresholds. The authors do not conclude this finding is a result of inappropriate referrals based on a poor quality or inexistent needs assessment so this inference cannot be included in the evidence review.

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NHS England and NHS Improvement - HIIT	Guideline	General		Q1 Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. • How services should be delivered and overarching general principles to drive forward that the inclusion health agenda is 'everyone's business' to ultimately improve access, outcomes and experience for people. This will be challenging to implement as involves whole system approaches, planning and long term funding.at a cross government, national, ICS and place-based level. • Co-designing and co-delivering services with people with lived experience of homelessness to ensure accessible care and support models that apply to what matters to people whereby placed based planning is central to service based interventions.	Thank you for your response. Hopefully this guideline will contribute to the inclusion health agenda and improve access and engagement, outcomes and experiences for people experiencing homelessness. Many of the challenges you mention are acknowledged in the rationale and impact sections of the guideline and the committee discussion of the evidence sections in the evidence reviews. It is also acknowledged that services might need additional funding to implement some of the recommendations. However, NICE is not involved in sectorial funding decisions. The committee also agree and acknowledge that co-designing and co-delivering services with people with lived experiences of homelessness to improve health and social care quality might be challenging, and currently, practice is variable. However, they make recommendations to support this, e.g. by involving peers, and refer to other NICE guidance, e.g. the section on involving people in service design and improvement in NICE's guideline on people's experience in adult social care services and NICE's guideline on community engagement. Your comment will be passed to the NICE team, which supports the implementation of the guidance.

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NHS England and NHS Improvement - HIIT	Guideline	General		Q2 Would implementation of any of the draft recommendations have significant cost implications? · Staff training and longer contact times between staff members and people experiencing homelessness.	Thank you for your comment. The committee agree and acknowledge that staff training and longer contact times might result in additional resource implications to services. However, the committee also explained that this might result in cost savings in the longer term. For example, having appropriately trained and supported staff may improve service engagement and result in more supported discharges and fewer people coming back to services with unmet needs; practitioners who can build a trusting relationship with the client may prevent a crisis and be able to initiate timely and appropriate care. This may also improve staff motivation, wellbeing and increase staff retention. Economic analysis was also undertaken as part of the development of the guideline that indicated that reduced practitioner caseloads (equivalent to longer consultation times) might represent a cost-effective use of public sector resources.

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NHS England and NHS Improvement - HIIT	Guideline	General		Q3 What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) • A stronger emphasis of the NHS Constitution overarching principle of 'all NHS services being 'available to all' especially people experiencing homelessness' who are most vulnerable to many poor health outcomes. Improvements in mainstream are referred to in the report but could be clearer and an emphasis on this being everyone's and NHS core business throughout. Aligning with 'call to action' approaches as shown here for inclusion health groups: Inclusion Health: applying All Our Health - GOV.UK (www.gov.uk) • Reference should be made to the NHSEI Health Inequalities Improvement Team (HIIT) vision 'Exceptional quality healthcare for all through equitable access, excellent experience and optimal outcomes'. • Reference should be made to the NHSEI Health Inequalities Improvement Team approach 'Core20PLUS5'. Core20PLUS5 is an NHSEI approach developed by the Health Inequalities Improvement Team to support NHS Integrated Care Systems (ICSs) to reduce health inequalities by offering ICSs a focused approach to enable prioritisation of energies and resources as they address health inequalities in the period 2021-2024. The Core20PLUS5 approach recognises that it is the NHS contribution to a wider system effort by Local Authorities, communities and the Voluntary, Community and	Thank you for your comment. The committee was aware of the developments in this area. The view was that the homeless population is a subset of Core20PLUS5, and none of the clinical priorities are specific to this population. The committee have highlighted the needs of this inclusion group, the potential impact of intersectionality and its context within the broader inequalities agenda, so they're sure that it will be considered by ICSs inequalities leads when they look at their most disadvantaged population and inclusion groups. Specific programmes have not been reference in the guideline to avoid needing to update the text when programmes change. However, the reference to the NHSEI Health Inequalities Improvement Team 'Health Inequalities Improvement Planning Matrix' and other support tools to implement the Core20PLUS5 approach will be passed to the NICE team, which plans the implementation support. The committee agreed that collaborative system-level planning and commissioning is essential in overcoming many challenges this population experiences in accessing and engaging with services and addressing the inequalities. As a result, they made recommendations on this, encouraging commissioners and providers to work in partnerships to respond to homelessness strategically. They also recommend involving commissioners from other sectors such as criminal justice and domestic abuse as needed

				Social Enterprise (VCSE) sector to tackling health inequalities – and aims to complement and enhance existing work in this area. Core20PLUS5 is a strategic approach which has been identified as it offers the greatest potential for meeting the NHS Long Term Plan (LTP) commitments to reducing health inequalities and addressing the pressing inequities in access to healthcare services which the COVID-19 pandemic has highlighted. It provides ICSs with a framework for identifying population groups most vulnerable to experiencing inequitable care and those groups that may be 'missed' by a purely universal approach to service delivery. It is an approach that enables the delivery of existing NHS LTP commitments to tackling health inequalities within the existing funding envelope. It is intended to be a multi-year delivery approach which ensures that we consistently ensure equitable access, excellent experience and optimal outcomes to 'communities at the margins'. Core20PLUS5 is made up of three key parts which cover the national priorities as well as a population identification framework designed to be used at ICS level to offer direction and focus in improving health inequalities. In summary: • Core20: The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) • PLUS: ICS-determined population groups experiencing poorer than average health access, experience and/or outcomes - such as minority	and have a whole section on safeguarding. The committee agree that this guideline is service driven. This is because it aimed to provide guidance on integrated health and social care services for people experiencing homelessness. They would expect clinical interventions to be the same, e.g. for cancer, irrespective of whether an individual is experiencing homelessness or not. The aim for this guideline is to make recommendations for commissioners, providers and practitioners how to promote access and engagement with, e.g. cancer treatment. A practitioner would need to refer to other related condition specific NICE guidance for treatment interventions.

				ethnic groups • 5: Five focus clinical areas that align with national priorities. • Reference should be made to the NHSEI Health Inequalities Improvement Team 'Health Inequalities Improvement Planning Matrix' that has been created to support NHSEI programmes and workstreams in understanding the key areas for consideration as health services are designed, implemented and evaluated to ensure that the health inequalities gap is not inadvertently widened. It is intended for national programme and workstreams leads, as well as regional, system and provider service leads. The Core20PLUS5 approach should be adopted for people experiencing homelessness/rough sleeping. • From a systems leadership and transformational change perspective it would be beneficial to highlight the responsibilities of ICS and place-based approaches in overcoming challenges. When we bear witness to recent death reviews, it is clear that collaborative system leadership at an integrated care partnership level is critical and collaboration with a range is partnerships is essential ~ Local Safeguarding Partnerships, Safeguarding Adults Boards, Community Safety Partnerships, Violence Reduction Units and Health Watch. • Support to implement the Core20PLUS5 approach e.g. implementing inclusion health improvement tools that enable Integrated Care and other strategic systems to develop plans to improve access, experience, and outcomes for	

				people. • The guidance feels quite service driven, therefore reference to civic level and community centred interventions, alongside service based, would provide a better balance. • There could be more opportunity within the guidance to emphasis trauma informed pathways that have what matters to people at the centre and to reference these principles throughout. • Good practice pathway models should consider wider determinant of outcomes recognising "excellent clinical care is both essential and absolutely not enough for the complex issues people face" (Bentley 2021) • Emergency care pathways should include active support for people to access; primary care/ GP registration; drugs & alcohol services and broader support such as immigration advice. Emergency care staff should be aware of support services in their local area and sign-post people to these • Updating the Inclusion Health Institute's Framework to consistently support clinical professions would be beneficial and support system change. • Education modules being developed should have a particular focus on this population i.e. RCP and Health Education England. Duty to refer (or if widened to duty to collaborate) must be incorporated in our healthcare professional's training curriculums.	

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NHS England and NHS Improvement - HIIT	Guideline	General		Q4 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.	N/A
NHS England and NHS Improvement - HIIT	Guideline	General	General	More detail could be provided with regards to the role or Accident and Emergency including – a) That we must have consistent UEC pathways for supporting people experiencing homelessness in ED/A&E b) Emergency care staff should be aware of support services in their local area and sign-post people to these c) People attending A&E should be assisted to access GP registration, drugs & alcohol services, immigration support services	Thank you for your comment. The committee agreed that there was scope to make more explicit reference to the role of hospital emergency departments, hospital based health, and social care practitioners and they therefore made changes to several of the recommendations when finalising the guideline. For example, they stated that homelessness multidisciplinary teams should coordinate care across a range of services including emergency care. They also specified that people should be helped to access help when needed, including through emergency care and they clarified that hospital admissions should use as an opportunity to assess people's needs in a comprehensive and holistic way, including appropriate referral.
NHS England and NHS Improvement - HIIT	Guideline	General	General	We should update the Inclusion Health Institute's Framework and work across the professions to implement consistently clinically	Thank you for your comment.
NHS England and NHS Improvement - HIIT	Guideline	General	General	The duty to refer must be incorporated in our healthcare professional's training curriculums.	Thank you for your comment. NICE does not make recommendations for what should be included in different professions' training curriculums, however, in the recommendation about training for health and social care staff, legal duties are listed, which would include duty

					to refer from the Homelessness Reduction Act 2017.
NHS England and NHS Improvement - HIIT	Guideline	3	018 - 019	Other causes of homelessness that we feel worth mentioning include – refuges and asylum seekers, those experience domestic violence	Thank you for your comment. The committee recognise that homelessness is more common among people who are refugees or asylum seekers and who have experienced domestic abuse and have acknowledged this in the guideline as a whole. However, the section to which you are referring is not intended to give a comprehensive list of issues that cause homelessness. Structural, societal and economic factors are mentioned, including poverty, deprivation, unaffordable housing, unemployment, exclusion and discrimination as well as severe and multiple disadvantage (which includes domestic abuse) and experiences of trauma so the issues you mention most certainly are implicitly covered.
NHS England and NHS Improvement - HIIT	Guideline	3	021 - 023	The nomadic nature of being homeless also contributed to the barriers as it leads to lack of continuity of care/services and break down of communication between the patient as well as services.	Thank you for your comment. However, the section to which you are referring is not intended to give a comprehensive list of barriers to accessing and engaging with services. The committee agree that continuity of care/service can contribute to it but they think that the issue is covered by the recommendations which emphasise for example the importance of continuity of care, long-term commitment and communication tailored to the needs and preferences of the individual.

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NHS England and NHS Improvement - HIIT	Guideline	3	General	For the definition of 'people experiencing homelessness' it would be worthwhile including those who attend secondary care services, for example Accident and Emergency and report being newly homeless (i.e. it may be part of their presenting complaint and not previously an issue).	Thank you for your comment. The committee believe that people who present as newly homeless are already included within the population criteria for this guideline but to make this extra clear we have added this to the definition of the population.
NHS England and NHS Improvement - HIIT	Guideline	4	19	As mentioned, when admitted to hospital, the length of hospital stay is usually much longer – it is often a more challenging admission due to alcohol and drug dependency.	Thank you for your comment. Yes, the committee agree with you but they aimed to keep the context section concise so such detail has not been elaborated on, however, the wording has been amended to reflect that the longer hospital stay is often due to multiple unmet needs.
NHS England and NHS Improvement - HIIT	Guideline	4 - 5	24 - 32 1 - 8	This paragraph discusses the economic impact of homelessness. There is no mention between the link of homelessness and criminal offence. The Queen's Nursing Institute reported research that found a fifth of homeless people have committed 'imprisonable offences' to spend a night in prison and that a quarter of women rough sleepers took an 'unwanted sexual partner' to escape their plight. They also highlighted that 30% of people released from prison have nowhere to live and homeless prior to custody had one-year reconviction rate much higher than the general population - https://www.qni.org.uk/resources/homelessness-criminal-justice-system-2/z	Thank you for your comment and reference. This paragraph gives an overview of homelessness costs and includes criminal justice sector costs (arrests and detentions, court appearances, and injunctions for antisocial behaviour). This paragraph aims to indicate the magnitude of such costs and not provide a systematic review of economic costs or explore the cost drivers. However, the committee do agree that the drivers of criminal justice costs that you mention are important.

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NHS England and NHS Improvement - HIIT	Guideline	4 - 5	24 - 32 1 - 8	This paragraph discusses the economic impact of homelessness. There is no mention between the link of homelessness and criminal offence. The Queen's Nursing Institute reported research that found a fifth of homeless people have committed 'imprisonable offences' to spend a night in prison and that a quarter of women rough sleepers took an 'unwanted sexual partner' to escape their plight. They also highlighted that 30% of people released from prison have nowhere to live and homeless prior to custody had one-year reconviction rate much higher than the general population - https://www.qni.org.uk/resources/homelessness-criminal-justice-system-2/z	Thank you for your comment and reference. This paragraph gives an overview of homelessness costs and includes criminal justice sector costs (arrests and detentions, court appearances, and injunctions for antisocial behaviour). This paragraph aims to indicate the magnitude of such costs and not provide a systematic review of economic costs or explore the cost drivers. However, the committee do agree that the drivers of criminal justice costs that you mention are important.
NHS England and NHS Improvement - HIIT	Guideline	6	4	The team vision of the Health Inequalities Improvement Team is - Exceptional quality healthcare for all through equitable access, excellent experience and optimal outcomes. A stronger emphasis of the NHS Constitution overarching principle of 'all NHS services being 'available to all' especially people experiencing homelessness' who are most vulnerable to many poor health outcomes. Improvements in mainstream are referred to in the report but could be clearer and an emphasis on this being everyone's and NHS core business throughout.	Thank you for your comment. Based on your comment, a reference to the NHS constitution has been added to the rationale section.

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NHS England and NHS Improvement - HIIT	Guideline	6	8 - 10	This aligns with the Health Inequalities Improvement Planning Matrix that highlights the importance of co-produced delivery models, recommending broadening engagement with people with lived experience to include more diverse voices and perspectives: at national, system and local level, this should inform design and implementation of services.	Thank you for your comment and support for the recommendation.
NHS England and NHS Improvement - HIIT	Guideline	6	14 - 18	This aligns with the Health Inequalities Improvement Planning Matrix that highlights the importance of using culturally competent communication, with awareness of healthcare disparities and the impact of socio-cultural factors on health. Communications planning requires codesign/coproduction and engagement.	Thank you for your comment and support for the recommendation. Based on consultation feedback, the recommendation wording has been revised and split it into two separate recommendations. The committee believe that the revisions align well with the comment you made.
NHS England and NHS Improvement - HIIT	Guideline	8	1 - 8	Communication with people experiencing homelessness needs to be culturally competent, this includes being in the correct language. Engaging with groups that know the target audience and work with them to co-produce communications such as leaflets in multiple languages, easy read version, brail versions. Need to consider the general public average literacy age when providing written documentation and that infographics may be more appropriate for some population groups or those who are illiterate.	Thank you for your comment. A lot of this is covered in other NICE guidelines which have been referenced, particularly the NICE guideline on Patient experience in adult NHS services and references have also been made to different formats and tailoring communication according to the person's needs and preferences in this guideline. Recommendations have been revised elsewhere in the guideline to emphasise the need for services to be inclusive and to be responsive to people's diverse needs and this would apply to communication as well.

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NHS England and NHS Improvement - HIIT	Guideline	8	5 - 6	Offering communication methods such as phone call, text messages and emails may drive health inequalities through digital exclusion.	Thank you for your comment. The committee made an addition to a recommendation in this section about taking into account the person's access to a phone or internet. The committee also added face to face as an option for different communication methods. Digital connectivity and inclusion is also captured in other sections of the guideline.
NHS England and NHS Improvement - HIIT	Guideline	10	9 - 10	Work with health and social care providers to improve recording of homelessness status for care provision and audit – collecting data plays a crucial part in delivering services that are safe, effective, and continuously improving. Data that is collected should be cut with a health inequalities lens so that the disaggregated data can be used to identify and drive change that reduces health inequalities.	Thank you for your comment. The committee agreed and this has been commented upon in the rationale section.
NHS England and NHS Improvement - HIIT	Guideline	10	11 - 12	When commissioners are developing services for people experiencing homelessness, they should refer to the Health Inequalities Improvement Planning Matrix which was created by the Health Inequalities Improvement Team at NHSEI to support programmes and workstreams in understanding key areas for consideration as health services are designed, implemented and evaluated to ensure the health inequalities gap is not inadvertently widened.	Thank you for your comment. It is great to see that there are tools to support commissioners. However, to stand the test of time, the committee thought making links or referencing a specific tool was not helpful. Also, this is more of an implementation issue, so your comment will be passed to the NICE team, which plans the implementation support.
NHS England and NHS Improvement - HIIT	Guideline	12	22	Drugs and alcohol services should be readily accessible to these patients when they attend A&E and we must have consistent UEC pathways for supporting people experiencing homelessness in ED/A&E.	Thank you for your comment. The committee agree with you but they did not feel a change is needed to this recommendation because wrap around health and social (the focus of this recommendation) encompasses health in emergency care settings. However the

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					committee made a change to another recommendation, which now states that homelessness multidisciplinary teams should act as an expert team, providing and coordinating care across outreach, primary, and secondary and emergency care, social care and housing services. The addition of emergency care here was made in response to yours and other stakeholder comments.
NHS England and NHS Improvement - HIIT	Guideline	14	12	Involving peers (experts by experience) in delivering and designing services aligns with the Health Inequalities Improvement Planning Matrix that highlights the importance of community participatory research, specifically co-designing and producing research with people with lived experience from diverse backgrounds.	Thank you for your support for these recommendations.
NHS England and NHS Improvement - HIIT	Guideline	14	18	Data that is collected should be cut with a health inequalities lens so that the disaggregated data can be used to identify and drive change that reduces health inequalities.	Thank you for your comment. The committee feel that taken in the context of the guideline as a whole - and in light of changes made while finalising the recommendations - this issue is already covered. For example one of the recommendations about planning and commissioning emphasises that people experiencing homelessness often need additional resources and a more targeted service delivery to ensure that resources are allocated according to need and disadvantage taking into consideration social determinants of health, improve long-term outcomes and address health inequalities.

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NHS England and NHS Improvement - HIIT	Guideline	15	9	Ensure the barriers of communication and digitalisation of services are considered.	Thank you for your comment. This point is covered in the recommendation where it refers to 'help with digital connectivity'. The committee had also made an earlier recommendation to use communication methods based on the person's preferences, for example, phone call, text message, email, letter and face to face.
NHS England and NHS Improvement - HIIT	Guideline	16	19	Those identified as having frailty, consider referral to community frailty hubs/services.	Thank you for your comment. This is dependent on the local services and the homelessness multidisciplinary team would be responsible for coordinating care and referrals as appropriate.
NHS England and NHS Improvement - HIIT	Guideline	19	016 - 019	In assessments to inform health and social care plan, for the multidisciplinary approach, an Independent Mental Capacity Advocate (IMCA) may be required for those who do not lack capacity as per the Mental Capacity Act 2005.	Thank you for your comment. The committee have not commented on the legal requirement to involve a IMCA specifically in the recommendation but have clarified in the rationale that there are legal requirements in certain situations. The guidance also mentions involving advocates (also non-statutory) in the health and social care needs assessment process, as appropriate, to help people access and engage with the process.
NHS England and NHS Improvement - HIIT	Guideline	30	General	Recommendations for research – Data that is collected should be cut with a health inequalities lens so that the disaggregated data can be used to identify and drive change that reduces health inequalities.	Thank you for your comment. The committee agree with you about the importance of addressing health inequalities through the research recommendations. Details related to this are provided in the evidence review, appendix K and specifically in the table's entitled 'Research recommendation rationale' where there are explanations about the equality considerations for the respective research recommendations.

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NHS England and NHS Improvement - HIIT	Guideline	32	5 - 6	Involving people with lived experience of homelessness in service design aligns with the Health Inequalities Improvement Planning Matrix that highlights the importance of co-produced delivery models and the importance of broadening engagement with people with lived experience to include more diverse voices and perspectives: at national, system and local level, this should inform design and implementation of services.	Thank you for your support for this recommendation.
NHS England and NHS Improvement - HIIT	Guideline	35	11	Communication needs to also be culturally competent and appropriate.	Thank you for your comment. The committee agrees with you that communication needs to be culturally competent this is covered in the General principles section with the statement that engagement with services should be promoted by services needing to be inclusive, addressing health inequalities and being responsive to diverse needs of people, so that the different needs of people are covered. This may include consideration relation to culture, gender, disability, sexual orientation, race or ethnicity or other factors.
NHS England and NHS Improvement - HIIT	Guideline	39	1 - 9	Collecting data plays a crucial part in delivering services that are safe, effective, and continuously improving. Data that is collected should be cut with a health inequalities lens so that the disaggregated data can be used to identify and drive change that reduces health inequalities.	Thank you for your comment. The committee agree with you and have added some text about this to the section you were referring to.

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NHS England and NHS Improvement - HIIT	Guideline	40	10 - 12	Involving people with lived experience of homelessness in service design aligns with the Health Inequalities Improvement Planning Matrix that highlights the importance of co-produced delivery models and the importance of broadening engagement with people with lived experience to include more diverse voices and perspectives: at national, system and local level, this should inform design and implementation of services.	Thank you for your comment and agreement with involving people with lived experience in service design.
NHS England and NHS Improvement - HIIT	Guideline	45	5 - 8	The point that the specialist multidisclinary teams could bring value and expertise in working with other 'inclusion health' groups who may be at risk of homelessness and whose needs often overlap considerable wit people experiencing homelessness would help to deliver a service that is equitable accessible. It also aligns with the Health Inequalities Improvement Team approach of Core20PLUS5 – with the approach defining the target population (Core20PLUS) for reducing the health inequalities gap. 'Core20': The most deprived quintile (20%) of the ICS population identified geographically by the Index of Multiple Deprivation (IMD 1&2). This is inclusive of people experiencing homelessness, rough sleeping and other inclusion health groups. PLUS: Another population group, determined at ICS level, based on population health data. This will typically include ethnic minority communities, and other populations experiencing unwarranted variation in access, experience and/or outcomes	Thank you for your comment. The guideline focuses on people experiencing homelessness, however, the committee discussed that many of the issues for people experiencing homelessness overlap with issues that other 'inclusion health' groups experience and there may be learning points from the work of homelessness MDTs for wider population groups.

				in relation to the Five Key Clinical Areas, e.g. Coastal communities. Disproportionate numbers may also be included as part of the 'Core 20', but these 'PLUS' groups will require particular and culturally sensitive consideration.	
NHS England and NHS Improvement - HIIT	Guideline	52	12 - 24	Comment on longer waiting times being a barrier to accessing and engaging with health and social care, affecting people experiencing homelessness in particular - this needs to be strongly considered in any Elective Recovery Strategy. It also highlights the importance of homelessness status being recorded in NHS organisational systems so that the patient can be flagged as a priority.	Thank you for your comment. The committee agree with you and have made a recommendation about improving the recording of people's homelessness status.
NHS England and NHS Improvement - HIIT	Guideline	57	16 - 22	'Hospital admissions are an opportunity for a comprehensive and holistic assessment of a persons need to enable appropriate personalised care planning that integrates health, social care and housing needs. A hospital stay can be an opportunity to start addressing the often complex and underlying issues…' Whilst we agree with this statement, we must be cautious as to whether using an acute hospital bed is the most appropriate setting for this to happen, particularly with references to the capacity issues witnessed through the pandemic and with the NHS's attempt to recover elective work. This may be better achieved in intermediate care or more ambulatory care services for example Same Day Emergency Care (SDEC) and integrated care services across communities and more inclusive follow up and out-patients pathways.	Thank you for your comment. The recommendation has been rephrased to clarify that if people experiencing homelessness happen to be admitted, it should be seen as an opportunity to assess their needs and make an appropriate referral. Capacity issues should not be a reason not to do this, given the difficulties this population experiences in accessing and engaging with services. The committee also make recommendations on various models of care that promote access and engagement. Hopefully, more problems will be picked and addressed in the community reducing the pressure on the acute sector. Your comment will be passed to the NICE team, which plans implementation support.

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NHS England and NHS Improvement - HIIT	Guideline	69	14 - 23	Education modules being developed should have a particular focus on the Core20PLUS population (as defined above).	Thank you for your comment. It was agreed not to recommend training on specific programmes but on topic areas instead.
Norfolk County Council	Guideline	6	15 - 16	**General Principles** The recommendation implies that either psychologically informed environments or a trauma informed approach should be used. These are not exclusive and can be used at the same time	Thank you for your comment, the recommendation has been revised to say "and" instead of "or".
Norfolk County Council	Guideline	9	5 - 9	The commissioners listed in the expectation that they work together should be broader and include substance misuse and criminal justice. This recommendation should recognise that commissioners should work together to plan and fund housing and suitable accommodation in addition to addition to multi-disciplinary health and social care services to reflect that these are also housing needs.	Thank you for your comment. The suggested addition has been made, stressing the importance of involving commissioners from other sectors, e.g. criminal justice and domestic abuse, as needed. Substance use services would generally come under local authority public health commissioning. Also, housing services are included, and recommendations have been made acknowledging that access to suitable accommodation is a key determinant of health and social care outcomes in the section on housing with health and social care support.
Norfolk County Council	Guideline	9	14	A health and care needs assessment of the kind proposed here is unlikely to be carried out in this area for example with 7 district councils and multiple commissioners without an identified lead to take responsibility. This probably should be Public Health.	Thank you for your comment. Local authorities are responsible for Joint Strategic Needs Assessments and local homelessness health and social care needs assessment relate to this. However, local authorities should be doing this together with relevant service providers, commissioners, and people with lived experience in an integrated way, as required. The committee

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					felt that they could not give further responsibilities and mandate on this issue.
Norfolk County Council	Guideline	10	13 - 14	Include ensuring that policy considerations about the area with which an individual has a local connection does not get in the way of that individual being able to access safe accommodation and any care and support that they need	Thank you for your comment. The committee have not commented on this specifically but the recommendation about commissioners working in an integrated way across larger areas would cover this.
Norfolk County Council	Guideline	10	24 - 27	The statement about encouraging peer support and the involvement of experts by experience in designing services – this recommendation could note that consideration should be made by commissioners about providing the funding and resources to enable the involvement of and support for experts by experience	Thank you for your comment. As suggested, the recommendation was reworded to include the enabling aspects of the involvement of experts by experience in designing services.
Norfolk County Council	Guideline	14	2 - 4	Role of peers – a good point of engagement in respect of homeless rough sleepers is likely to be when they are off the street and in a health (hospital bed) or care/support (hostel / care setting)	Thank you for your comment. The committee agree with this and have added a reference to A&E as an opportunity for engaging with peers.
Norfolk County Council	Guideline	14 - 15		This guidance about the role of peers should note that consideration should be made by commissioners about providing the funding and resources to enable the involvement of and support for experts by experience	Thank you for your suggestion. In terms of the remit of NICE guidance the recommendations have been as clear as possible about the support that should be provided to enable the role of peers, without specifically telling local authorities what funding they need to provide.

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Norfolk County Council	Guideline	16	2 - 7	This is a good point about not penalising people for missing appointments (providing peer supporter to help people keep appointments). It could be built upon by observing that adjustments should be considered where the chaos which accompanies homelessness for many individuals is a real barrier to a required no of engagement appointments (for example before someone who is opiate dependent receives substitute prescribing)	Thank you for your comment. The circumstances you describe underpins some of the challenges that people experiencing homelessness may experience in accessing and engaging with services and this was discussed by the committee, however, the committee would also emphasise the ways in which services themselves make it difficult for people to engage and they have tried to address this in the guideline.
Norfolk County Council	Guideline	36	14 - 18	**Why the committee made the recomendations** In discussing the advocacy requirements of the Care Act thins section implies to me through use of the phrase 'for example' that there is a legal requirement for advocates under the Act beyond social care. Suggest the following addition – 'assist in their involvement in social care processes'	Thank you for your comment, on the basis of which the text has been revised.
Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		The definition given for homelessness includes sofa surfing with family and friends but does not explicitly reference women/others staying in exploitative situations, exchanging sexual services for accommodation or those living in abusive housing situations.	Thank you for raising this important point, the wording has been amended accordingly.

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Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		The guideline focuses on homelessness and talks about complexity, but doesn't go as far as to describe the issues many homeless people face as being Severe and Multiple Disadvantage (SMD). Although there will be some people where homelessness is a single issue, for most they will have other complexities that compound their problems in relation to housing and homelessness and that impact greatly on their ability to access services and support. We would like to see more emphasis on complex and multiple needs rather than a focus on homelessness as a stand-alone issue. This is significant in relation to both the type of response required to provide effective assistance (i.e. to consider needs beyond housing) and also to partners' recognition and ownership of the issue (i.e. where SMD is an issue relevant to health commissioners and providers, whereas homelessness may be perceived foremost as a responsibility and concern to local authorities). Also, where there is a reference to 'complex needs' in the terms section, we feel this should include domestic abuse as part of this definition and refer to this being described more broadly as 'Severe Multiple Disadvantage'.	Thank you for your comment. Based on your and other stakeholders' comments, including people with lived experience of homelessness, the committee revised the wording to refer to 'severe multiple disadvantage' instead of 'complex needs'. They do not think the guideline focuses on homelessness as a single or stand-alone issue, and would agree the opposite is the case. In this guideline, homelessness is very much seen in the context of health and social care inequalities, disadvantage and unmet needs and the guideline is focused on integrated working to address these by improving access to and engagement with health and social care among people experiencing homelessness.

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Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		There is some discussion around understanding need for different communities and protected characteristics, but this should recognise that homelessness and also SMD can be hidden or less understood in some groups. We have found for example, that women and also people from different ethnic communities seem to be under-represented in data and also in research around this issue. A stronger recommendation for the needs of these under-represented groups to be included in any needs assessment would be welcome, as would recommendations for more research in this area.	Thank you for your comment. The committee agree and they have covered some of these issues in the equalities impact assessment form. It is a little unclear whether you are referring to the local homelessness needs assessment or a needs assessment for an individual person. However, it is considered in both. The local homelessness needs assessment recommendation specifies that the assessment should quantify and characterise the population experiencing homelessness and identify trends and specific needs. This would include consideration about women, ethnic minorities or other potentially under-represented groups. The recommendations about assessment of needs for an individual person experiencing homelessness highlights the importance of considering the person's individual circumstances and situation. The committee revised the guideline in other sections to emphasise the need for the services and staff offering services which aim to address health inequalities, are inclusive and pay attention to the diverse experiences of people using the service. This is also highlighted in a recommendation for training for staff. In terms of research recommendations, equalities considerations have been considered when the research recommendations were drafted. This has been documented in the appendix K of the evidence reports where more detail of the research recommendations is provided.

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Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		1.9.3 mentions having a range of accommodation types, but this could be more explicit around gender responsiveness so that for example women and people from the LGBTQ+ community are not excluded and that their gender and/or sexual orientation and identify is a consideration and not an after-thought.	Thank you for your comment. The committee considered this carefully but agreed not to list different types of accommodation in the recommendation. However, they agree with you about the importance of being responsive to people's experiences and needs in relation to for example gender and sexual orientation and have made this more prominent in other parts of the guideline.
Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		We also welcome the recommendation around understanding the needs of people with NRPF. For our partnership this is a very difficult issue that can leave very vulnerable people with limited care and support options. As such we would like to see a strong recommendation around needs assessment for this vulnerable group and other ways in which evidence of what we know to be very significant needs, can be generated to influence national policy. As such we would like to see a strong recommendation around needs assessment for this vulnerable group and other ways in which evidence of what we know to be very significant needs, can be generated to influence national policy. This should be linked to the safeguarding recommendation.	Thank you for your comment. The recommendations on needs assessment as well as safeguarding apply to all people experiencing homelessness, including people with no or limited recourse to public funds, therefore, no separate recommendations have been made for this population in these sections. The recommendation on local homelessness needs assessment has been amended so that it makes specific reference to quantifying and characterising health inequalities and diversity. The recommendation on assessment of the individual's health and social care needs has also been amended to refer to consideration of inequalities and inclusion needs. However, the committee agreed to specifically mention people with no or limited recourse to public funds in a recommendation about information that should be provided to people experiencing homelessness, including their rights to health and social care services.

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Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		We welcome the inclusion of a need for culturally sensitive services but would add that for some, culturally specific services are also needed. This should also be the case for gender – i.e. services should be gender responsive and there should be some choice in terms of gender specific services/support.	Thank you for your comment. The committee rephrased the recommendation so that is states that services should aim to address health inequalities, be are inclusive and pay attention to the diverse experiences of people using the service, which could be in relation to e.g. gender, religion, sexuality.
Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		We very much welcome the recommendation around the use of a MDT model and we have taken that approach in Nottingham. Initially this was focussed on rough sleeping, but it soon became very evident that we needed to be responding to SMD rather than rough sleeping alone as this was too narrow a focus. As such we feel this should be considered by the panel.	Thank you for your comment. The recommendations on multidisciplinary service provision apply to all people experiencing homelessness, not only those who are sleeping rough.
Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		We noted that it would be useful to have consistent language around key elements such as individual support and care. For example the use of the term ‘care navigation’ or ‘care navigators’ to describe that important individual level support.	Thank you for your comment. It is not clear what the suggestion is, however care navigation is referred to in the section on improving access to and engagement with health and social care. The recommendations also emphasise individual support and care, for example, by emphasising the importance of building trusting relationships and having a designated person to lead on multidisciplinary case management.

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Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		We support the introduction of TIC/PIE but would like the statement to be stronger as we think this is a pivotal issue. We would suggest using the term ‘should’ rather than ‘consider’ in this case.	Thank you for your comment. The word 'consider' is used in the context of NICE guidance to denote a weaker recommendation made because the committee lack the robust evidence on which to make it any stronger or more certain. Please note however that the fact the committee did not review convincing evidence about PIE led them to make a recommendation for future research on precisely that topic.
Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		We support the recommendation in 1.12.1 around training but would echo our previous comments around the need for that training to be culturally and gender responsive.	Thank you for your comment. The committee agree that being culturally and gender responsive is important. They have revised the recommendation wording to include reference to homelessness as part of equality and diversity training, including responsiveness to the impact of discrimination and stigma and of intersectional, overlapping identities.
Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		Assertive outreach is an important aspect of support but we would raise that having gender responsive teams to support women that are rough sleeping or surviving through sex work, would also be an important consideration.	Thank you for your comment. The committee agrees that outreach teams should be responsive for different needs, including experiences that women may have and amended the first recommendation in the section on Outreach services to refer to “multidisciplinary outreach”. The rationale section goes into more detail about why this is important, including being responsive to people’s needs in relation to their gender among other factors.

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Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		We would like to see more specific mention of and guidance around safeguarding.	Thank you for your comment. None of the evidence reviews located data about adult safeguarding in the context of homelessness. The committee nevertheless dedicated one section of the guideline to this subject. The recommendations in that section are based on testimony provided by expert witnesses, in particular focussing on the contribution of Safeguarding Adults Boards and also the importance of social workers within multidisciplinary homelessness teams. The committee recognise that this is a complex and often overlooked area both for commissioners and providers and sought to address this by recommending that health and social care staff be supported to understand the legal duties and powers related to safeguarding. They did not feel they had the basis for mentioning any specific examples but felt that the key practice implications of safeguarding legislation and guidance would necessarily be covered by any training or professional development provided to practitioners.

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Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		We would also raise how the system and services will be held to account in relation to the recommendations made in this guideline. We consider NICE guidance to be an important lever in ensuring quality support but also in ensuring that the system invests appropriately to improve outcomes. As such a strong recommendation around system governance and oversight of the implementation of this guidance would be welcome.	Thank you for your comment. NICE guidelines contribute to the standards against which providers are inspected but making specific recommendations about system governance and oversight of the implementation of the guideline is outside the remit of the guideline. NICE does review the uptake and impact of its guidance and NICE implementation support team works with national partners to support implementation of NICE guidelines.
Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		We felt there may be some value in emphasising the points around flexibility of service provision. Describing barriers to accessing services and support differently if we hope to see the right adjustments in the way services are provided. While it is the case that some people experiencing homelessness (and in particular those experiencing SMD) may be less able to access services due to their circumstances (as described in the document), services themselves frequently create barriers through inflexibility (e.g. through exclusionary criteria, lack of service delivery in line with PIE principles, appointment times / systems). This often starts with recognition. In order to respond correctly (to account for an individual's circumstances), staff working within services must first be able to recognise them (whether achieved by training, appropriate and sensitive assessments, or a combination of both).	Thank you for your comment. The barriers created by services, whether due to for example rigid systems, separate and siloed services, exclusionary criteria, lack of understanding or training among staff etc., have been the focus of this guideline since the beginning and a prominent part of the discussions by the committee throughout. These are addressed in various recommendations and sections in the guideline. For example there are recommendations on: •recognising that more effort and targeted approaches and additional resources are often needed to make health and social care available and accessible to people experiencing homelessness •promoting engagement by being person-centred, empathetic, non-judgmental, inclusive and responsive to people's diverse needs •considering using psychologically-informed environments and trauma-informed care •recognising importance of providing longer

					contact times and long-term commitment to care and considering to reduce caseloads •use of strengths-based approaches •actively supporting re-engagement, with an addition that as appropriate people should be allowed to re-engage with service at the same point as they left the service (to avoid having to start from the beginning) •using communication methods that improve and enable better access and engagement •commissioners developing strategies across services to improve access to health and social care •ensuring people can register with a GP •MDTs providing coordinated care •use of peers (experts by experience) to support people and reduce barriers for accessing services •providing outreach •other approaches to reduce barriers, such as low-threshold services, flexible opening and appointment times, self-referral, drop-in services, 'on-stop shops', transport support or digital connectivity, advocates, care navigation •not penalising people if they miss an appointment •ensuring people can access help when needed and avoiding policies that withdraw support and close cases after a standard duration without safe transfer of care or agreement •ensuring restrictive eligibility criteria does not mean that p[people fall between services if they have multiple health or social care needs •ensuring that people who are assessed as frail

					can get appropriate care packages regardless of their age •ensuring forms to access health and social care or to help with NHS costs are available and people are supported to fill them in •ensuring people can access online information and are supported to use online services •ensure frontline health and social care staff are able to fulfil their duties under Homelessness Reduction Act 2017 •ensure frontline health and social care staff are able to identify when a person needs referral to a specialist homelessness health and social care •providing support through transitions between settings and ensuring planned and coordinated handovers •considering 'open-door' services that people can self-refer to and access after initial support ends •staff training and support.
Nottingham & Nottinghamshire CCG Nottingham City Severe and Multiple Disadvantage Partnership	Guideline	General		We greatly value NICE developing guidelines for this important issue and would like to offer our partnership's help and support. As a system in Nottingham City we feel we are already meeting the recommendations in this draft guidance and are working to go beyond what has been suggested. We are very happy to share our work with you if that would be helpful.	Thank you for your comment and for providing feedback on the draft guideline.

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Royal College of Nursing (RCN)	Guideline	General	General	We do not have any comments to add on this consultation. Thank you for the opportunity to contribute.	Thank you.
Royal College of Physicians (RCP)	General	General	General	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our lead fellow for health inequalities and inclusion health and would like to comment as follows.	Thank you for your comment and for providing feedback on the draft guideline.
Royal College of Physicians (RCP)	Guideline	General	General	Our experts believe there is insufficient attention to hospital management of homeless people: 60% more likely to attend ED than housed people 95% attend with health reason 56% attend with mental health/substance misuse problem Therefore, our experts believe there is a need for an expert housing/mental health team at front door of every hospital, minimum 12 hours/day, 7 days per week.	Thank you for your comment. The committee agreed that there was scope to make more explicit reference to the role of hospitals, hospital based health, and social care practitioners and they therefore made changes to several of the recommendations when finalising the guideline. For example, they stated that homelessness multidisciplinary teams should coordinate care across a range of services including emergency care. They also specified that people should be helped to access help when needed, including through emergency care and they clarified that hospital admissions should use as an opportunity to assess people's needs in a comprehensive and holistic way, including appropriate referral.
Royal College of Physicians (RCP)	Guideline	General	General	Our experts believe there is a need for: • An identified primary care team with expertise in homeless health in every town in England. • An improved primary/secondary care collaboration for seamless, joined up care, health promotion, vaccinations, screening, etc	Thank you for your suggestion. The committee agree with you about the important role of primary and secondary care teams and joint working between them and other health, social care and housing services in improving access to and engagement with care and support for the homeless population. They made several recommendations in support of better

					collaboration, for example, that homelessness multidisciplinary teams should provide and coordinate care across outreach, primary, and secondary and emergency care, social care and housing services. They also recommended that health and social care services be offered to people experiencing homelessness by providing outreach care in non-traditional settings, such as on the street, hostels or day centres. They said that outreach services should cover people's primary healthcare needs and be multidisciplinary and responsive to the range of needs of this population. In terms of having a dedicated primary care team, the committee decided that on the basis of available evidence, care should be provided through specialist homelessness multidisciplinary teams across sectors and levels of care, tailored according to local need and they provided a lot of detail about how these teams should operate. However, they also recognised that specialist homelessness multidisciplinary teams would not be feasible in areas where levels of homelessness are low. For example, in some areas services might encounter one person experiencing homelessness per month. In areas where forming a homelessness multidisciplinary team is not justified, the committee agreed that existing practitioners could act as homelessness leads in mainstream services, for example, in general practice, A&E departments, hospitals and other relevant settings. In this sense, the committee believe the recommendations ensure the provision of expert multidisciplinary health care

					and support for people experiencing homelessness while also acknowledging the varying population needs and pragmatic resource considerations.
Royal College of Physicians (RCP)	Guideline	General	General	Our experts believe a step-down care facility to provide early discharge into a supportive environment with medical and housing support should be considered.	Thank you for your comment. This has been recommended in the guideline (see section on intermediate care).
Royal College of Physicians (RCP)	Guideline	General	General	Our experts believe improvement is needed regarding education about homelessness in medical/nursing schools with appropriate placements.	Thank you for your suggestion. The committee intend that on the basis of the recommendations, in particular those about awareness and recognition of the needs and experiences of this population and the importance of tailoring approaches to support them, that improvements will necessarily be made to initial and ongoing training for relevant practitioners. However, it is beyond the remit of NICE guidelines to make recommendations directly to the General Medical Council, Nursing and Midwifery Council and others responsible for the design and regulation of education and qualifications for health professions.

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Royal College of Speech and Language Therapists (RCSLT)	Guideline	General	General	The Royal College of Speech and Language Therapists Homelessness Clinical Excellence Network (RCSLT Homelessness CEN) is a member group of speech and language therapists working across the UK with an interest in the communication and swallowing needs of people experiencing homelessness. We are delighted NICE has produced draft guidance to improve access and engagement with health and social care for people experiencing homelessness. However, we would recommend more of a focus on communication difficulties. Our comments seek to strengthen the guidance so that communication needs are addressed as a risk factor and a barrier to accessing health and care services.	Thank you for your support for the guideline. Your comments have been considered by the committee and responses are provided below.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	General	General	The RCSLT Homelessness CEN welcomes the recognition that people whose first language is not English may also have additional communication needs such as interpretation and translation services. However, our comments are focused on clinical communication issues including attention, listening, social interaction, understanding, expression, speech and voice. Difficulties in these areas may be present in any language and interpretation and or translation services alone will not address these clinical matters though it may help to uncover them.	Thank you for making this point. The committee agree with you and in finalising the guideline, they made changes to one of the overarching principles so that each person's communication and information needs and preference are taken into account with extra support provided for people with speech, language and communication difficulties.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	3	24	The RCSLT Homelessness CEN notes that speech, language and communication needs (SLCN) are not mentioned in the list of experiences, differences and disorders. We recommend that speech, language and	Thank you for your comment. It was not intended to provide an exhaustive list here. The committee agreed that there are many communication needs that are relevant to this population, who require support that is appropriate to their needs.

				communication needs are added as an unmet need and contributing factor for becoming / remaining homeless. The following evidence highlights the link between people who are homeless and speech, language and communication needs: 1. Speech, language and communication needs are more prevalent in UK adults experiencing homelessness than the general UK adult population. https://onlinelibrary.wiley.com/doi/full/10.1111/1460-6984.12572 (Andrews and Botting, 2020) 2. Adults that experienced homelessness had more difficulties with understanding and expression than adults from a similar socio-economic group that had not experienced homelessness. https://onlinelibrary.wiley.com/doi/abs/10.1111/1460-6984.12521 (Pluck et al, 2020) Adults with histories of homelessness may have worse language skills than would be expected based on their educational backgrounds. The presence of an acquired impairment increases the likelihood of communication needs amongst this population. Based on the published evidence and our experience in the field, we recommend that speech, language and communication needs are added as an unmet need and contributing factor for becoming / remaining homeless.	They have tried to reflect this in revisions to the recommendations. Thank you for providing these references. These have been for relevance to this review and reasons for exclusion are provided after each reference: Andrews, L. and Botting, N. (2020), The speech, language and communication needs of rough sleepers in London. International Journal of Language & Communication Disorders, 55: 917-935. https://doi.org/10.1111/1460-6984.12572. This study does not fit the inclusion criteria for this evidence review protocol because it is a secondary quantitative analysis of service data, which was not a relevant study design for our evidence review. Pluck, G., Barajas, B.M., Hernandez-Rodriguez, J.L. and Martínez, M.A. (2020), Language ability and adult homelessness. International Journal of Language & Communication Disorders, 55: 332-344. https://doi.org/10.1111/1460-6984.12521. This study does not fit the inclusion criteria for this evidence review protocol because the objective of the study is not relevant.

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Royal College of Speech and Language Therapists (RCSLT)	Guideline	4	23	The RCSLT Homelessness CEN are pleased to see communication is recognised as a barrier in the guideline but recommend strengthening this by altering this to read: “appropriate communication”. The guideline currently reads as though only lack of communication is an issue.	Thank you for your comment, the suggested change has been made.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	6	15	The RCSLT Homelessness CEN feel the guidance would be strengthened by the addition of “and a communication-accessible approach.”	Thank you for your comment. The committee agreed to specify and strengthen recommendations related to communication needs in some parts of the guideline, such as providing extra support to those with speech, language and communication difficulties and about homelessness MDTs providing wrap around health and social care support to address needs, including communciation needs. However, it was not thought to be needed here.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	6	17	The RCSLT Homelessness CEN feel the guidance would be strengthened by the addition of “and communication barriers.”	Thank you for your comment. Communication barriers are addressed specifically in the section on Communication and information so this has not been added here.

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Royal College of Speech and Language Therapists (RCSLT)	Guideline	7	15	We welcome the section titled "Communication and Information" but feel the section would have been more robust if a speech and language therapist was part of the Committee team and had contributed to the development of the guidance. To strengthen these provisions, we would be happy to support the guidance going forward and any subsequent implementation measures or quality standards that are developed.	Thank you for your comment. The committee composition was decided during the early scoping phase of the project. Because this topic is around integrated work and spans across various sectors and disciplines, recruitment to the committee was necessarily selective. Speech and language therapist was not prioritised. Thank you for showing interest in future involvement.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	8	3	The RCSLT Homelessness CEN feel the guidance would be strengthened by the addition of "avoids jargon, complex terminology and long pieces of information."	Thank you for your comment. Based on feedback from people with lived experience of homelessness, the committee agreed to add to the recommendation that acronyms should be avoided. Otherwise the suggested changes have not been made as the committee did not think they were needed.

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Royal College of Speech and Language Therapists (RCSLT)	Guideline	8	5	The RCSLT Homelessness CEN are concerned that people experiencing homelessness may have been excluded from speech and language therapy services due to, for example, referral criteria that may be difficult for them to meet e.g. medical evidence of a neurological condition. This means they have never had an opportunity to talk about their communication difficulties in order to explore what does work best for them and state a preference. To help address this barrier we suggest an additional recommendation or training: “health and social care staff working with people experiencing homelessness should undertake Communication Access UK training”. Communication Access UK is an initiative developed in partnership by charities and organisations that share a vision to improve the lives of people with communication difficulties. Together, the partners have developed a free training package which individuals (and organisations) can undertake to improve their awareness of communication difficulties and improve their own communication. For more information, see https://communication-access.co.uk/individual-register/.”	Thank you for your comment. The guideline recommends that each person's communication and information needs, preferences and circumstances should be taken into account. The committee also added to the recommendation around provision of extra support to those with speech, language and communication difficulties. Furthermore, the committee agreed to revise the recommendation on homelessness MDTs providing wrap around health and social care support to meet the person's needs to include a specific mention of communication needs. The committee was not able to make a long list of different areas for training for staff and had to prioritise what they considered the most important ones. The committee did not recommend a particular training provider as they were not able to quality assure the content of their training.

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Royal College of Speech and Language Therapists (RCSLT)	Guideline	8	5	The Accessible Information Standard has been a legal requirement for publicly funded health and care organisations since 2016. The RCSLT Homelessness CEN do not see it mentioned in the guidance. We recommend adding: “health and social care staff working with people experiencing homelessness should have knowledge of and implement the Accessible Information Standard in their work”.	Thank you for your comment. Since it is a legal requirement and applicable generally and not specific to homeless, it was not considered necessary to mention this in the guideline.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	8	9	The RCSLT Homelessness CEN is concerned about the ‘drive to digital’ in relation to people experiencing homelessness. There is no evidence that, for this specific group, virtual contact is as effective as usual care. The consultation specifically asks for issues relating to COVID-19 to be considered by stakeholders. The RCSLT Homelessness CEN believes the guidance can be strengthened by adding “Delivering health and care services to people experiencing homelessness by phone or video removes communication support. Carefully consider the method of service delivery for each person and its impact on the accessibility and effectiveness of your service”.	Thank you for your comment. Face to face has been added as an option of communication methods. The recommendations already capture that people's communication and information needs and preferences should be taken into account and the guideline is not pushing for virtual/digital services but trying to make these more accessible for people experiencing homelessness (if this is needed or preferred).
Royal College of Speech and Language Therapists (RCSLT)	Guideline	8	14	The RCSLT Homelessness CEN feel the guidance would be strengthened by the addition of “low literacy levels and speech, language and communication needs.	Thank you for your comment, the recommendation has been revised as suggested.

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Royal College of Speech and Language Therapists (RCSLT)	Guideline	8	15	The RCSLT Homelessness CEN is concerned that the guidance conflates communication confidence and speech, language and communication needs. An advocate may help support somebody to feel more comfortable and confident in accessing health and care services, but it is not necessarily the case that they have appropriate training to help with literacy or reinforcing information in ways that are appropriate for someone with speech, language and communication needs. We recommend adding “suitably trained” to this line.	Thank you for your comment. There are different needs to involve an advocate and both scenarios you describe may be relevant. In some cases a trained independent advocate is relevant, in other cases advocacy may be provided by someone nominated by the person. The committee agreed not to make changes based on this comment.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	8	16	The RCSLT Homelessness CEN suggests the addition of “where a person has speech, language and communication needs an intermediary can explain things in more accessible language, ensure understanding and retention of information and allow the person to make their voice heard to their full potential”.	Thank you for your comment. This is not a guideline on speech, language and communication needs or on advocacy and therefore this level of detail was not considered needed in the recommendations.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	8	22	The RCSLT Homelessness CEN suggests the guidance can be strengthened here by adding “their rights to accessible information in line with the Accessible Information Standard”.	Thank you for your comment. Since Accessible Information Standard is a legal requirement and applicable generally and not specific to homeless, it was not considered necessary to mention this in the guideline.

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Royal College of Speech and Language Therapists (RCSLT)	Guideline	9	General	The RCSLT Homelessness CEN is concerned that planners and commissioners with no knowledge of speech, language and communication needs, swallowing needs and speech and language therapy will not think to involve NHS or third sector speech and language therapy services as part of their health and care needs assessment. Supporting evidence: • Dysphagia (eating, drinking and swallowing issues) and respiratory illness are a significant consideration in people experiencing homelessness (Gurgel et al, 2009) https://journals.sagepub.com/doi/10.1177/00034894091180070 1). • Due to a lack of access to primary healthcare and therefore subsequent specialist services such as speech and language therapy, difficulties such as dysphagia can be missed in this population (Bhattacharyya, 2014) https://journals.sagepub.com/doi/10.1177/0194599814549156). We suggest this part of the guidance could address unconscious incompetence by explicitly stating that planners and commissioners should actively seek the views and experience of multidisciplinary health and social care services that have historically not been accessed by people experiencing homelessness.	Thank you for your comment. The committee agreed not to specify which specific health and social care services should be involved in planning services, however, the guideline makes it clear that planning services should be integrated and collaborative. Based on consultation feedback the committee have otherwise added communication needs to different sections in the guideline as they agree this is an important consideration.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	11	8	The RCSLT Homelessness CEN suggests adding “people with disabilities and long-term conditions including those with hidden speech, language and communication needs”.	Thank you for your comment. The committee agreed to include 'disabled people' in to the list of examples. These are indeed just examples and is not aiming to be an exhaustive list. In terms of

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					extra support for people with speech, language and communication difficulties, the committee added this to the section on Communication and information.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	12	15	The RCSLT Homelessness CEN is concerned that communication needs are not included in the list of services that comprise “wraparound health and social care support” despite the guidance recognising that communication needs can act as a barrier to accessing a range of services listed here. We recommend adding “- communication needs (such as speech and language therapy).”	Thank you for your suggestion. The committee agree with your point and have added communication needs to this list, although they have kept it deliberately general because of course communication needs in this context would be broader than those assessed or supported by speech and language therapy.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	15	9	The RCSLT Homelessness CEN notes a report from the Chief Scientist’s Office (CZG/2/100) “Consultation between General Practitioners and people with a communication disability” from 2014 provides information about environmental factors that present barriers to communication for people with communication disability. These include open and public reception areas, busy waiting rooms, and phone call access only to make appointments. We think the guidance can be strengthened by adding an example here such as “Provision of communication accessible environments and services with staff trained in accessible communication.”	Thank you for your comment. Based on the consultation feedback, the committee agreed to add to a recommendation within the section on Communication and information that providing extra support for people with speech, language and communication difficulties is an example of how to take into account each person's communication and information needs and preferences and their circumstances. The committee do not think more detail of how this is done is needed in the guideline as this will depend on the person's individual needs, preferences and circumstances.

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Royal College of Speech and Language Therapists (RCSLT)	Guideline	16	15	The RCSLT Homelessness CEN suggests the addition of "Ensure that restrictive eligibility criteria includes excluding people who have co-existing communication and learning difficulties from services."	Thank you for your comment. Based on the consultation feedback the committee agreed to revise the recommendation to be more generic and give the coexisting mental health and drug and alcohol treatment needs as an example. Therefore, people with coexisting communication and learning difficulties could also be included within the recommendation if applicable.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	16	24	The RCSLT suggest the addition of "easy read and accessible materials" here.	Thank you for your suggestion. The committee did not make this change because they felt the point had already been made in an earlier recommendation to ensure that written information is available in different formats and languages, including Easy Read.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	17	8	The RCSLT Homelessness CEN suggests the addition of "Ensure that frontline staff are suitably trained in communication-accessibility."	Thank you for your comment. The committee carefully considered the recommendation about training for staff and had to prioritise only the most important ones that would make the biggest difference to the population as a whole. Training on communication accessibility was not considered a priority although the committee recognise it may be useful.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	17	21	The RCSLT Homelessness CEN are concerned that disengagement is sometimes prompted by communication difficulties. Therefore, we suggest the addition of "have speech, language and communication needs or have difficulty engaging with services because of hidden speech, language and communication needs".	Thank you for your comment. These are just examples and the committee did not think addition of this was needed but have specified speech, language and communication difficulties and communication needs in other parts of the guideline.

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Royal College of Speech and Language Therapists (RCSLT)	Guideline	19	10	The RCSLT Homelessness CEN suggest the addition of “communication abilities.”	Thank you for your comment. The committee believed that this could be a very long list and agreed that to be useful it should be kept brief and pragmatic, whilst recognising that communication abilities is one issue to consider.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	25	6	The RCSLT Homelessness CEN suggest the addition of “communication accessibility.”	Thank you for this suggestion. The committee have not made this change because their intention was to ensure this list referred to areas for training in quite broad terms, rather than listing specific areas and risking missing any out of such a list. They believe that training around communication accessibility should be covered by understanding the health and social care needs of people experiencing homelessness.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	26	16	The RCSLT Homelessness CEN suggest the addition of “communication needs.”	Thank you for your comment. Based on consultation feedback, the term 'complex needs' is no longer used in the recommendations and instead ‘severe and multiple disadvantage’ is used instead. The committee acknowledge that communication needs may be present in people experiencing severe and multiple disadvantage but it is not typically included within the definition of severe and multiple disadvantaged.
Royal College of Speech and Language Therapists (RCSLT)	Guideline	30	General	The RCSLT Homelessness CEN are concerned that communication needs are not included in the list of needs that may require “wraparound health and social care support”. This is despite the guidance recognising that communication needs can act as a barrier to accessing a range of services. We recommend adding adding “communication needs.”	Thank you for your comment. The committee agreed to specify communication needs in the recommendation about MDTs providing wraparound health and social care support.

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Royal College of Speech and Language Therapists (RCSLT)	Guideline	50	28	The RCSLT Homelessness CEN notes that good quality evidence highlights a lack of knowledge of free / low-cost dental care services. Poor oral care can result in significant health conditions including where an individual has compromised swallowing skills leading to aspiration pneumonia. Supporting evidence: • Dysphagia (eating, drinking and swallowing issues) and respiratory illness are a significant consideration in people experiencing homelessness (Gurgel et al, 2009) https://journals.sagepub.com/doi/10.1177/00034894091180070 1). • Due to lack of access to primary healthcare and therefore subsequent specialist services such as SLT, difficulties such as dysphagia can be missed in this population (Bhattacharyya, 2014) https://journals.sagepub.com/doi/10.1177/0194599814549156). Without adequate assessment and support for dysphagia (and the pulmonary and complex health consequences), people experiencing homelessness may present with unmet needs. The risk of eating and drinking foods or drinks that are unsafe could be catastrophic. Understanding and access to safe foods (and accessible information around this), and the impact on nutrition and hydration needs may be poorly understood. We recommend the guidance	Thank you for your comment. The guideline does not go into detail about specific conditions so recommendations around dysphagia have not been added. Dental care is part of primary care and the guideline addresses information about and access to primary care in various places. Furthermore, the guideline makes a recommendation about supporting people with appropriate forms to access free or low-cost care, such as dental care.

				is strengthened by highlighting these risks in this section.	

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Shared Health Foundation	Guideline	General	General	Research published in the House of Commons library, states 119,830 children were placed in temporary accommodation in England alone in March 2021. The evidence is clear; homeless children are more likely to be in poor health than non-homeless children. Homeless children experience lower levels of immunisations, higher levels of chronic co-morbidities (both physiological and psychological), higher rates of infection, higher rates of accidents and developmental delay. There are evidenced cases of primary care registration refusal, rejected referrals and significantly a Sudden Infant Death (SID) within temporary accommodation setting due to poor safe sleeping provision and advice and minimal access to appropriate clinical care and input. In your Consultation Comments and Responses document you claim that “children under 16 might be covered tangentially if they accompany someone in the included population”. Clinical guidance is required from NICE to best protect the health, wellbeing and safeguarding of homeless children. Providing quality clinical care for homeless families we will see a reduction in CAMHS referrals, inappropriate use of A+E and less adult rough sleepers in the future. Furthermore, consideration needs to be given to how omittance of Under 16s impacts those covered by this guidance with dependants.	Thank you for your comment. The committee agree with you about the importance of this issue. However, at the time when the scope of the guideline was developed, it was agreed that children and young people under 16 years of age experiencing homelessness would not covered by this guideline because the legal frameworks, their needs, experiences and circumstances are likely to be different to adults experiencing homelessness and in order to manage the size and focus of the guideline. NICE will decide if a guideline focusing on children experiencing homelessness will be developed in the future. That said, the committee revised the recommendation on assessing people's health and social care needs to include reference to considering if the person has children or dependents.

				Therefore, we believe it is inappropriate to not to include under 16's in this Integrated health and social care for people experiencing homelessness NICE guidance without commitment to production of a guidance specifically for children experiencing homelessness to run alongside this.	

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Somerset Safeguarding Adults Board	General	General	General	The guideline appears to not have fully understood the role of Safeguarding Adult Boards or that their remit is limited by the Care Act (2014) to adults with care and support needs. Those people who are homeless and have care and support needs (whether assessed or not) would therefore already fall within the remit of a SABs work (although SABs are strategic partnerships and don't have a role individual cases other than those referred for Safeguarding Adult Reviews) and the current drafting appears to not recognise this. There is also a role for SABs to support housing and homelessness organisations in recognising signs of abuse or neglect, and their duties under the Care Act, so that appropriate referrals are made and less people 'fall through the gaps', but this does not appear to have been recognised in the guideline as it stands.	Thank you for your comment. In the committee's experience, people with care and support needs who are experiencing homelessness are often overlooked by SABs. The committee recognised the role of SABs as defined in the Care Act, 2014 and its Statutory Guidance and were aware of the strategic, oversight and partnership role beyond SARs. NICE guidance is not intended to be a fully comprehensive manual. There was no research evidence or committee experience that SABs were generally failing to deliver on the 5th and 6th bullets of 14.139 of the Statutory Guidance and it was not, therefore, considered necessary to make a recommendation regarding this.
Somerset Safeguarding Adults Board	Guideline	23	10	**1.10.3** Any safeguarding lead on the board would be there anyway because of their safeguarding role, which by definition would encompass people who are homeless, and specifying that someone should attend in addition to this is unnecessary. We therefore suggest that this recommendation is removed.	Thank you for your suggestion. The committee considered it important that there should be a person on the Safeguarding Adults Board who is knowledgeable about homelessness as this is a group of people which, in their experience, can often be overlooked in the work of the Board. The committee did not consider this had to be an additional member, simply a member who took a lead role in relation to safeguarding issues concerning people experiencing homelessness. The recommendation has therefore not been removed but the wording has been amended to enhance its clarity.

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Somerset Safeguarding Adults Board	Guideline	23	12	**1.10.4** The contents of annual plans are for determination by local SABs. Specific SAB objectives are therefore only necessary if there is an identified area for development in relation to people who are homeless with care and support needs. Requiring the insertion of an objective simply to be able to satisfy this guideline risks tokenism, and a similar approach being repeated for people with different housing and/or care needs regardless of the local situation, resulting in a plan that no longer reflects local priorities. It also fails to recognise that people who are homeless may have a range of needs that extend beyond their homelessness which are addressed through work that, while not explicitly for people who are homeless, includes working with this group. We therefore suggest that this recommendation is removed.	Thank you for your suggestion, which the committee considered. In their experience homelessness is rarely specifically referred to in Safeguarding Adults Board strategic plans, and yet this is a group of people in the most vulnerable of situations. The committee therefore agreed that homelessness should be specifically and visibly encompassed in SAB strategic plans in order to evidence Partners' responsiveness to the situation in each area albeit that the committee recognise that SABs have the freedom to decide on the precise content. While they did not delete this recommendation the committee did however combine it with a related recommendation so in the final guideline there is a single recommendation for homelessness issues to be included in SAB strategic plans and annual reports.
Somerset Safeguarding Adults Board	Guideline	23	15	**1.10.5** The contents of annual reports are for determination by local SABs. The annual report will cover relevant issues across the adult safeguarding spectrum, which will inevitably include people who are homeless with care and support needs even if work is not explicitly referenced as being for this group. As with the annual plan, inserting text in the way proposed risks tokenism in order to demonstrate compliance with this guideline, and a similar approach being repeated for people with different housing and/or care needs regardless of relevance to the work that the SAB has done	Thank you for your suggestion, which the committee considered. In their experience homelessness is rarely specifically referred to in Safeguarding Adults Board annual reports and yet this is a group of people in the most vulnerable of situations. The committee therefore agreed that homelessness should be specifically and visibly encompassed in SAB annual reports in order to evidence Partners' responsiveness to the situation in each area albeit that the committee recognise that SABs have the freedom to decide on the precise content. While they did not delete this recommendation the committee did however combine it with a related recommendation so in the final guideline there is

				during the year. We therefore suggest that this recommendation is removed.	a single recommendation for homelessness issues to be included in SAB strategic plans and annual reports.
Somerset Safeguarding Adults Board	Guideline	23	17	**1.10.6** If a Safeguarding Adults Review (SAR) makes recommendations relating to provision of homelessness services these would naturally be shared with relevant sectors or agencies anyway – that is the point of undertaking a SAR to identify and share learning. We therefore suggest that this recommendation is removed.	Thank you for your suggestion. The committee's experience is that this does not happen universally and that the interpretation of "key stakeholders" is sometimes very narrow; often not beyond the people directly involved in the review. This recommendation encourages much wider circulation to maximise learning so the committee have neither edited nor removed it from the final version of the guideline.
Somerset Safeguarding Adults Board	Guideline	24	1	**1.10.7** We feel that this guideline fits with the role of SABs to seek assurance.	Thank you for your support.
St Mungo's	General	General	General	This comment is in response to the question posed by the comments box: 'Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.' By 'practice' we are taking this to mean 'outcomes for people experiencing homelessness'. The model which would result in good practice is a well-coordinated, multidisciplinary inclusion health support service, which has in-reach and outreach to various accommodation settings and the street, and can supplement the existing health systems on offer. This then heightens the threshold at which accommodation providers can continue to support people with more complex health needs, before they would need to move on to more intense support. For those people	Thank you for your comment. In this question, 'practice', referred to the recommendations which will have the most significant change in the way services or health and social care are delivered to people experiencing homelessness. The committee agree that a coordinated, multidisciplinary approach, with in-reach and outreach elements, intermediate care, supported discharge, and housing with integrated wraparound health and social care support would improve outcomes for people experiencing homelessness, and they made recommendations in these areas. But they also acknowledged that there is a variation in practice, and some of these recommendations will mean that services will have to change the way they deliver health and social care to people experiencing

				whose needs will still not be met by this offer, there must then be an intermediate care service which follows a step-up-step-down model and acts as a bridge between the more acute health services, such as hospital and care homes, and traditional accommodation services. This must be supplemented by specific accommodation models for this cohort. To enable this, and to ensure it works efficiently and effectively, all of the areas mentioned in the guidelines are important and will have an impact on practice. These areas are not autonomous and there are problems with disentangling them. For example, staff support and development is necessary to improving access and engagement with health and social care. The following are challenges which could affect implementation of the guidance. - Funding. Particularly for mental health and drug and alcohol services, more funding is needed to enable some of the good practices set out here. Spending on drug and alcohol services has been cut by a quarter on average since 2015-16 (https://www.ippr.org/blog/public-health-cuts); and mental health services continue to be under-resourced and under-funded (https://www.bma.org.uk/media/2750/bma-the-impact-of-covid-19-on-mental-health-in-england.pdf). Further, research by WPI Economics shows that in 2019, councils in England spent nearly £1 billion less on services supporting single homeless people compared to a decade ago. The emergency funding pots and	homelessness. For example, in areas with low rates of homelessness, recommending designated leads on homelessness may be a change in practice. The committee also agree that services are interlinked and recommendations to facilitate integrated health and care were made throughout. The committee agree that staff support and development is essential and made recommendations on this. They also highlighted that a range of accommodation types might be required to support the person's assessed health and social care needs. Recommendations on intermediate care services were also made which recognised that, for example, people move between areas and that commissioners may have to work together to strategically plan and deliver health and social care across larger areas. It is hoped that these recommendations will be taken up by commissioners and providers. However, your comment, highlighting issues that may impact the implementation of these recommendations, will be passed to the NICE team that provides support with guidance implementation. Where possible, local variation in practice has been highlighted as well as areas where services may require additional resources to implement recommendations that support longer-term and joined-up care and highlighted that such

				spending commitments during the pandemic do not cover what has been lost from homelessness services for single people on an annual basis. However, it is not just more funding, but the need for funding to be longer-term and joined up. Short term funding creates significant difficulties for local authorities, hampering their ability to commission effectively and strategically plan or revise existing initiatives. It was highlighted in the Kerslake Commission Interim Report (https://www.commissiononroughsleeping.org/interim-report/) that constant bidding for different funding pots, and the multiple and lengthy monitoring requirements attached them, are resource intensive and a barrier to joined up and strategic service delivery. Rushed bidding rounds and short-term funding may force local authorities to take a light-touch, risk-averse approach to developing services due to concerns the funding will not be continued, and they will not be able to afford to continue the services. - Local variation. This was an issue highlighted in the Kerslake Commission final report (https://www.commissiononroughsleeping.org/) Different local authorities have differing resources available for people experiencing rough sleeping and homelessness. Different local authorities also have different levels of understanding of the issues. For example, if a local authority did not historically have a large cohort of people experiencing rough sleeping, they will have less familiarity with the causes and solutions and therefore often find it more challenging to implement effective support. Local	investments would represent value for money. The committee agree that there is a need for more social housing funding. However, NICE is not involved in funding decisions. The rationale and impact sections, and also committee discussion of the evidence sections in full evidence reviews do acknowledge the issue around short-termism, and that continued long-term support is quite rare, and that current funding of services is often not aligned with such an approach. It is hoped that commissioners and providers of services will take up this guidance, and that appropriate funding will be made available to support the implementation of the recommendations.

				variation in regards to what partnerships are in place is also a challenge. The Kerslake Commission Interim Report highlighted that the degree of success that areas had in mobilising and meeting the needs of their rough sleeping populations was largely determined by pre-existing services and infrastructure. Areas without these pooled resources and connections already present struggled to meet the mark. This difference in provision, as well as funding limitations, can then result in authorities which do offer a service having to ration provision to prevent being overwhelmed. - An understanding of complex needs. This is specific area in the guidelines and training to improve understanding of complex needs has been recommended. However, we are concerned that if it is not implemented effectively, a lack of awareness and understanding of complex needs across services will be a significant barrier to delivering the other areas of the guidance. An understanding of complex needs is crucial to making mainstream health services more accessible to many people experiencing homelessness. St Mungo's has had discussions with practioners at Primary Care Networks (PCNs) who have highlighted that, for example, single day training does not create the fundamental attitude change needed and must be continuously re-visited. This creates further difficulties in resourcing. - Accommodation viability. There is currently a	

				lack of understanding from, for example, integrated care systems, on the build in time needed for accommodation. An education piece would be needed here. - Difficulty in accessing existing housing pathways. There is a current assumption from health systems working with people experiencing homelessness that they will be able to access existing housing pathways. However, the existing housing pathways are locally commissioned services which will require, for example, a local connection, and due to capacity there will be difficulties with health systems using the limited bed spaces in existing housing pathways. - Too few people to commission separate accommodation-based health services. Linked to the above problem, there therefore needs to be separate accommodation based services for people discharged from hospital with ongoing clinical needs, or needs which surpass the ability of the local housing pathway, which health funds and can refer people in to. However, in many areas there will not be enough people to warrant this additional service. St Mungo's therefore supports the recommendation in the Kerslake Commission that local authorities should make greater use of pan-regional commissioning of specialised services to enable this. A lack of appropriate housing. Although St Mungo's welcomes the recognition that "providing suitable accommodation that matches	

				the person's assessed health and social care needs" can "support access to and engagement with health and social care services and long-term recovery and stability" the challenge here lies in the lack of appropriate housing available. There is a need for more social housing (St Mungo's reiterates the call for 90,000 social homes to be built annually), as well as bringing forward the much needed reforms on the private rented sector to improve viability for people who have experienced homelessness and often have mental or physical health difficulties. Increasing integrated multidisciplinary teams will also increase the capacity of existing accommodation as it heightens the threshold at which accommodation providers can continue to support people with complex needs.	
St Mungo's	General	General	General	This comment is in response to the question posed by the comments box 'Would implementation of any of the draft recommendations have significant cost implications?' Many of these recommendations would have significant cost implications. However, they will be far more cost effective in the long-term, thus saving money further down the line. As noted on page 4 lines 28-32, many of these actions focus on preventing problems from getting worse and costing far more. As noted on page 10, line 28, there is a need for more specialist services. In many cases this will need increased funding, although in some cases what will be required is areas pooling funding for	Thank you for your comment. The committee agree with our points and it is acknowledged throughout the rationale and impact sections of the guideline and in the separate evidence reviews that some of the recommendations will have resource implications for services. Where possible the potential cost savings resulting from these recommendations have also been considered, e.g. due to reduced morbidity and mortality, and also the overall cost effectiveness of recommendations. The committee agree that there will be a need for increased funding to implement some of these recommendations. However, NICE is not involved in funding decisions. The committee also agree that a lack of specialist staff will mean that more investment may be required, and it may impact the

				a sub-regional model. Increasing the number of homelessness multidisciplinary teams will require increased funding as there is currently a limited number of specialist staff available who have expertise in both homelessness and expertise in mental health. For example, the high level of understaffing and lower level of resource in mental health teams mean they will find it challenging to increase allocations to homelessness multidisciplinary teams. One of the primary reasons that restrictive gatekeeping criteria are erected is because of a lack of resource. For providers, competing budget constraint caused by having separate and limited funding pots can create incentives to reduce provision and push people onto other service caseloads. Having joint commissioning but also adequate resource would address this.	implementation of some of the recommendations. Your comment will be passed on to the NICE team, which plans implementation support. Also, hopefully, the recommendations on planning and commissioning will encourage joint commissioning and will address some of the issues you raise.
St Mungo's	General	General	General	This comment is in response to the question posed by the comments box: 'What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)' A good practice example of health and homelessness partnership working is in Lewisham. This is on page 27 of the final report for the Kerslake Commission: https://www.commissiononroughsleeping.org/ One specific challenge which this partnership working has helped is uptake of the Covid-19 vaccine amongst people experiencing rough sleeping and homelessness. This model of good	Thank you for your comment and for providing us with some examples. There are many recommendations across the guidance that support the type of practices adopted in Lewisham and other models that you highlighted, e.g. outreach/assertive outreach, low-threshold services, advocates, a key practitioner coordinating care. The committee agree that there is the need for joint commissioning and integrated working across agencies and professions and the importance of using strengths-based approaches to care, and made recommendations on this. To reinforce the idea that homelessness should not be seen as just a

				partnership working between health and homelessness has meant health colleagues going in to services to understand people's concerns about the vaccine and what else could be done. As of July 2021, there was a 57% vaccination take up amongst vulnerable adults – far higher than elsewhere in the country. This model of partnership working would similarly help people experiencing homelessness overcome other challenges in accessing health related support, for example it would be beneficial in uptake of the flu vaccine, and uptake of preventative initiatives such as screening. This model of partnership working in Lewisham has also helped in the immediate challenge of tackling outbreaks and ill health amongst people experiencing homelessness who are living in hostels or other shared living, as health experts were able to use their expertise to review risk assessment, put health strategies in place, and help isolation pathways. All too often people experiencing homelessness and rough sleeping are pushed between pillar and post to access the support they need, and they fall through the gaps between services. Health, homelessness, and drugs and alcohol services are all designed and funded as if people fit into one box, rather than the reality that people's problems are complex and interwoven. They cannot be addressed one-by-one but need	housing issue, the committee made recommendations on housing and wraparound health and social care support, i.e. a multidisciplinary team-based collaborative approach to support the person experiencing homelessness holistically, taking into consideration their individual needs, including physical and mental health needs, drug and alcohol recovery needs, care and social needs, and practical needs, in addition to their housing needs. The challenges of registering for GP services are acknowledged and recommendations that reinforce NHS guidance on this have been made in the guideline. The committee also emphasised a multidisciplinary approach to care throughout and suggested what these teams could include, for example, social workers and allied social care professionals, housing options officers or homelessness prevention officers, voluntary and charity sector professionals, and staff with practical expertise in accessing benefits and entitlements for people experiencing homelessness. The committee also recommended homelessness leads that would support organisations to provide appropriate care for people experiencing homelessness. Hopefully, this will encourage more collaborative and joint working. Also, variation in practice has been acknowledged, where possible, and hopefully, this guidance will reduce variation in practice that you refer to, e.g. eligibility to a Care Act assessment. Thank you for the resources to help with implementation. These will be passed

				to be approached holistically. To best support people we need integrated support and housing pathways, with a treatment package arranged for them in a way which works for them in that particular point in their recovery journey. One of the best ways to do this is through increasing joint commissioning. A good practice example of joint commissioning is in Bristol. After a successful bid to Government, Bristol secured a £3.3 million grant to help adults in the city facing disadvantages such as homelessness, mental health problems, substance issues, domestic abuse and being in the criminal justice system. It was envisaged that the grant would support development of the partnership's 'My Team Around Me' multi-agency team concept, to provide long-term wraparound support to a person with multiple needs to ensure consistent relationships and better, sustainable outcomes. This is on page 32 of the final report for the Kerslake Commission: https://www.commissiononroughsleeping.org/ On page 7, lines 3-5, the guidelines set out a commitment to a strengths-based approach, which we fully support as a way to best help people experiencing homelessness and rough sleeping achieve their potential and flourish. This is reflected in St Mungo's Recovery Approach. The Recovery Approach sets out what St Mungo's sees as the best ways to work with clients to support their recovery through four 'building blocks': § Building initial relationships and trust	on to the NICE team which plans implementation support.

				§ Securing resources and opportunities § Developing client skills § Providing support that enables and empowers In 2020, St Mungo's commissioned Revolving Doors Agency to undertake a critical and independent Rapid Evidence Review of the St Mungo's Recovery Approach. The review confirmed that there is a positive evidence base to support the components of our approach and showed that we are drawing on well researched good practice. For example, person-centred approaches result in "more appropriate and better received" support and "has been effective in supporting people who were entrenched in rough sleeping into accommodation." It also supports the Recovery Approach in trauma-informed care which it says has "demonstrated cost-effectiveness and a range of positive individual and service outcomes". The review also makes recommendations for further research where more evidence would help. The full review can be found here: https://www.mungos.org/st-mungos-recovery-approach-a-review-of-the-evidence/ We would be willing to submit our experiences of this approach to the NICE shared learning database. A challenge which people experiencing homelessness and rough sleeping face is registering with a GP. This is very important as primary care is a gateway to other health	

				services, as well as a preventative measure to avert increased A&E visits. A persisting problem with GP registration is that people are refused on the grounds of lacking ID, having no fixed address or not being able to prove their immigration status. This is despite NHS guidelines. The Groundswell 'My Right to Healthcare' cards are a practical resource for helping people to register with a GP. (https://groundswell.org.uk/what-we-do/resources/healthcare-cards/) Good integration between health and homelessness is vital for helping people overcome the challenge of (1) accessing healthcare services and (2) improving health outcomes, particularly from an earlier preventative stage. Better integration reflects the need for homelessness to be seen not just as a housing issue but as a health issue. One of St Mungo's Housing First services in Camden is an example of good practice integration of health and homelessness as it has an Occupational Therapist (OT). The OT is supported by Homeless Link's Housing First Fund to work with clients who have the most difficulty engaging. Using her specialist healthcare knowledge, the OT works alongside Housing First staff to ensure that clients can access services, especially where those rigid structures and methods have proved insurmountable in keeping clients within treatment and care programmes. She is able to assess, establish and evidence their clinical	

				requirements and needs. This includes ensuring that capacity is assessed accurately, that adequate care is provided and stepping in when this is not the case. The OT provides a bridge with health and social care. The OT also works with clients to make sure they have everything they need to meet their support needs within their homes and to access the community through digital inclusion. This has been particularly beneficial during the Covid-19 pandemic, affording access to virtual medical appointments and learning opportunities. However, to build on this, we would like to see (1) more health and social care workers embedded in homeless settings who are part of the Local Authority's Adult Social Care (ASC) team and therefore able to carry out Care Act assessments and secure ASC funded care packages for people experiencing homelessness and rough sleeping and (2) an increased number of health and social care workers who provide services in non-traditional settings and assess people face-to-face on the street. There are examples of ASC departments stating that an individual must be in accommodation prior to carrying out a Care Act assessment, but this is not supported in the Care Act. We would be willing to submit our experiences of this approach to the NICE shared learning database.	

				Another example of good practice, in terms of health integration with homelessness, is the Homeless Pathway Team in Wandsworth. This is a multidisciplinary team which will include rough sleeping engagement workers, a nurse, a psychologist a recovery worker and a client engagement worker. The purpose of the team is to support and link people in to substance use services, working with those who were engaged as part of the Everyone In initiative. This is funded through money from Public Health England (PHE). This team was only recently commissioned and there is therefore limited data on the service, but it provides an example of a good innovation to reach out to a marginalised group with complex needs through a multidisciplinary team. This works towards overcoming one of the specific challenges which people experiencing homelessness and rough sleeping face in accessing and making use of substance use support. With a reduction in outreach services, and fewer specialist workers able to engage people where they are, people who want help with drug and alcohol problems often have to attend drop-ins followed by structured appointments. Many people will likely be expected to attend appointments with other services, such as for their mental health or to claim benefits. Pushed between pillar and post, these expectations can be too much for some, who drop out of treatment. These challenges are explored further in St Mungo's report: Knocked	

				Back (https://www.mungos.org/publication/knocked-back-full-research/) · The challenge of engaging people who, due to a multitude of reasons including a lack of trust in healthcare, find it difficult to engage in traditional settings, can be helped through in-reach and outreach of health services, and dedicated teams bridging the gaps. For example, St Mungo's recognises that hostels are likely to have a population who have a higher diagnosis of Hepatitis C and has therefore recruited a Hepatitis C Coordinator role to work in partnership with the Find & Treat team (the NHS-funded specialist outreach service) to improve access to testing and treatment for people experiencing homelessness and rough sleeping in London who are possibly more marginalised and less likely to access current treatment models. This is a model is effective at improving access and eradication as it uses an individual who is 'within' the homelessness system to help coordinate between services that already exist (such as Find & Treat, and the Hepatitis C Trust) and to help promote access to testing and treatment. This is funded through an Organisational Distribution Network payment model within NHS.	

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St Mungo's	General	General	General	This comment is in response to the question posed by the comments box: '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.' Covid-19 has exposed, and in some cases exacerbated, existing health inequalities in the UK. New evidence collected during the Covid-19 pandemic reveals this group to be more vulnerable than the general population to a public health crisis, while they are also less likely to be able to protect themselves from it (https://www.mungos.org/publication/housing-and-health-working-together-to-respond-to-rough-sleeping-during-covid-19/). St Mungo's would want to reiterate the urgent need to recognise rough sleeping and homelessness as not simply a housing issue, but a health issue. One particular area which was exacerbated has been mental ill health, which people experiencing homelessness and rough sleeping are disproportionately affected by. As the Mental Health Foundation noted "we are all in the same storm, but we are not all in the same boat" – there has been a divergence of experiences during the pandemic and "in certain disadvantaged groups there are even higher proportions of people with suicidal thoughts and feelings."	Thank you for sharing with us the reports, which have identified the impact of the Covid-19 pandemic on people experiencing homelessness. The committee agrees that homelessness is a public health issue and providing housing is only part of the solution and that other wraparound multidisciplinary support and care will need to be in place to address their health and social care needs and multiple disadvantage. The guideline focuses on health and social care and the committee have made recommendations on housing and wraparound health and social care support which should address your concern that homelessness should not be seen as simply a housing issue. The committee also recognised mental health problems in this population, irrespective of Covid-19, and made recommendations on wraparound care, which considers their individual needs, including mental health needs. The guideline aims to encourage integrated health and care for people experiencing homelessness. The committee made many recommendations to that effect which should address some of your comments on key partnership working. The committee was aware of barriers to access and engagement this population faces. They made many recommendations to promote access and engagement, e.g. outreach services, low-threshold services, self-referral, drop-in services, 'one-stop shops' for multiple services, involvement of peers and provision of trauma-informed care. It is hoped that overall the

				The response during the pandemic also highlighted just how key partnership working is. It needs a fully collaborative response between every part of the supporting framework, from housing to health to welfare to the criminal justice system. The benefits of partnership working can be found in the Kerslake Commission's interim and final report: https://www.commissiononroughsleeping.org/ The issue of lower rates of Covid-19 vaccination, due to low vaccine confidence and barriers in access to healthcare, has also drawn attention to a problem which was already present prior to the pandemic but is of even greater urgency now. The need to increase vaccine uptake is crucial not just for Covid-19 but other health issues, such as flu, which have a disproportionately large effect on this vulnerable population.	recommendations in the guideline will help improve care for people experiencing homelessness, whether at a time of global pandemic or not.
St Mungo's	Guideline	General	General	St Mungo's welcomes these guidelines and feels they contain many positive steps towards better health and social care for people experiencing homelessness and rough sleeping. However, a concern that they concentrate more on the end goal, and therefore in some cases it would be helpful to have corresponding implementation guidance or a roadmap. They are also extensive and we therefore feel that they need more clarity on priorities.	Thank you for your support for the guideline. Your comments will be passed to the NICE team responsible for implementation and please note the tools and resources published alongside the guideline on the NICE website.

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St Mungo's	Guideline	General	General	There is no explicit discussion on end of life palliative care for this population. This is important as homeless people experience high symptom burden at the end of life, yet palliative care service use is limited. The best outcome would be a person centred approach which supports people in their preferences, for example making it possible for people to stay in their accommodation, if that is what they would prefer. St Mungo's runs a palliative care service which is the only one of its kind in the UK. It helps to equip teams with the skill sand the knowledge to work in a palliative care informed way, and it also brokers support from the local health systems. (https://www.mungos.org/service_model/palliative-care/) We would be willing to submit our experiences of this approach to the NICE shared learning database. There is also an exemplary palliative care service in Canada called PEACH. This has an integrated, multidisciplinary care team and provides direct clinical support in a roving model. (http://www.icha-toronto.ca/programs/peach-palliative-education-and-care-for-the-homeless)	Thank you for your comment and for your offer of further information, which will be passed to NICE colleagues working on guideline implementation. The committee agree with the issues you have raised and although they considered evidence about a lack of palliative care services tailored to the needs of people experiencing homelessness, they acknowledge that the draft recommendations were not sufficiently specific on this issue. They therefore revised several recommendations on the basis of yours and similar stakeholder comments, for example explicitly stating that wrap around health and social care support should encompass the person's needs, including palliative care needs and that homelessness multidisciplinary teams should include healthcare professionals with relevant expertise, including in palliative care. They also added a recommendation about palliative care to the section of the guideline on Long-term support.

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St Mungo's	Guideline	General	General	There is a lack of focus in these guidelines on the unmet need for people who are 'stuck' in supported accommodation pathways, who meet the threshold for care interventions yet there are limited services available for their need. The challenge is both due to the limited availability of appropriate accommodation, as well as the more hidden needs of individuals in a supported accommodation pathways as it is often assumed that their needs are being met and they do not require an assessment. In regards to appropriate accommodation, there is a distinct lack of care homes for this population and many mainstream services can struggle to cope due to the often more complex needs. In regards to ensuring that appropriate assessments are carried out, this requires (1) a greater understanding from social care staff on the needs of people experiencing homelessness and rough sleeping and (2) increased in-reach from social workers to homelessness settings to make care act assessments.	Thank you for your comment. The guideline recommendations touches on the issues you raise, including recognising that providing accommodation suitable the individual's needs can support access to and engagement with health and social care services and long-term recovery and stability. The guideline also makes recommendations about the wraparound health and social care support people should receive based on their assessed need. However, it is not within the remit of this guideline to make recommendations about increasing availability of accommodation and allocations of housing. The guideline also makes a specific recommendation about providing long-term care packages, which could include residential care or supported housing, to people assesses as frail. In terms of ensuring that appropriate assessments are carried out, the guideline already includes a recommendation about health and social care staff receiving training on the health and social care needs of people experiencing homelessness and their rights to access services, and the recommendation on MDTs includes suggestion to include social workers in the MDT as well as recommendations on outreach services on street, hostels and day centres, involving a multidisciplinary team.

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St Mungo's	Guideline	General	General	One area which only has one mention in these guidelines is frailty. Currently, spaces are not designed with frailty in mind because people experiencing homelessness and rough sleeping are often younger (the majority of people experiencing homelessness and rough sleeping in 2019/20 was between 36 - 45 years old). However, as highlighted in the 'Rationale and impact' section, premature aging and frailty are common among people experiencing homelessness with multiple and complex needs. More spaces need to be designed with this in mind.	Thank you for your comment. The committee took your comment on board and agreed to make another recommendation addressing frailty in the section on Long-term support recommending that it should be recognised that some people experiencing homelessness experience frailty at an earlier age (both physical and cognitive) than the general population and their long-term care should be tailored to meet this.
St Mungo's	Guideline	General	General	The title of the guidance is 'people experiencing homelessness' yet the scope also includes those who have formerly experienced homelessness and are at risk again. We think that the title should be broadened to 'people experiencing and at risk of homelessness' to (1) better reflect the scope as it stands (2) reflect the fact that those at risk of homelessness often have worse health and difficulties in accessing health and social care, and equally require integrated care in order to prevent them from becoming homeless. For example St Mungo's thinks those who have had eviction notices served should be included in the scope. This is a cohort that are also at high risk of sleeping rough, as shown by CHAIN data on rough sleeping in London which showed an increase in the number of people sleeping rough whose last settled base was the private rented sector, up from 34% in 2018/19 to 38% in 2019/20.	Thank you for your comment. The committee recognise that people at risk of homelessness often have health and social care needs and may have barriers to accessing support. However, the scope of the guideline, including the population the guideline covers, was signed off and published in December 2020 after stakeholder consultation and cannot be changed at this stage. The population of the guideline was agreed after careful consideration to manage the scope of the guideline.

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St Mungo's	Guideline	General	General	In the guidelines, there is a general lack of recognition of the different experiences of homelessness that people face. People who are homeless are not one homogenous group. Individuals' experiences of homelessness are shaped by the impact of a range of overlapping factors, including race, ethnicity, religion, socioeconomic status, class, sexuality, gender identity, age, disability and immigration status. Social and economic circumstances affect a person's exposure to harmful situations and their access to, and experiences of, resources and support, as well as compounding ill health. It is important that people who are homeless are not treated as one homogenous group, as the distinct needs and experiences of individuals mean a tailored, informed and inclusive offer of support is needed to alleviate homelessness.	Thank you for your comment. The committee agrees and have carefully considered the individual needs and experiences throughout the development of this guideline and again after receiving consultation feedback. The guideline in general stresses the importance of individualised, person-centred approach, based on the person's needs, including inclusion and diversity related needs but the committee have tried to make this even clearer in the revised guideline if this was not clear enough. The committee very much thinks that the individual's past and present experiences, access and engagement to services and recovery journey is based on the often overlapping and intersecting experiences and characteristics and it is important for the services and individual practitioners to be responsive to these and this has been reflected in the revisions made to the guideline.
St Mungo's	Guideline	General	General	In the guidelines, there needs to be more overall emphasis on a 'no wrong door' approach and the idea that every contact matters. Although two separate ideas, they both tie into the fundamental thread, which must run throughout the guidelines, that the health and social care system is one route into recovery for people experiencing homelessness, whether or not health needs are their primary presenting needs. Every part of the system has the responsibility and the ability to help someone experiencing homelessness recover, and centring the principles of no wrong door, and that every contact matters, is key to this.	Thank you for your comment. The committee decided not to introduce another concept such as 'No Wrong Door' to the guideline. However, they think that overall the principles of this approach are covered by the recommendations in this guideline. The guideline aims to promote access and engagement, integration of care, and provide staff with appropriate training and development to respond to the needs of people experiencing homelessness. If implemented effectively, this guidance will ensure that services can provide people experiencing homelessness with an appropriate intervention/referral regardless of where they enter the care system.

					In the access section, it is explicitly recommended that frontline health and social care staff are supported to identify and act on needs. Also, recommendations throughout were developed, keeping in mind that every contact should be seen as an opportunity to engage and build trust with people who might otherwise find it difficult to engage. All of the above should align with the principles of a 'No Wrong Door' approach, and the comittee hope that it addresses your concerns.
St Mungo's	Guideline	General	General	In the guidelines, there is too little discussion of the specific changes needed in substance use, which is a significant problem that faces people experiencing homelessness. In the 'Knocked Back' report by St Mungo's in 2020, it was highlighted that drug and alcohol related causes are the biggest killer of people sleeping rough or in emergency accommodation. The number of deaths caused by drug poisoning increased 135% between 2013 and 2018, with a 55% rise in just one year between 2017 and 2018. The two key issues that need increased focus are (1) rapid access to substitute prescribing to increase the ability to engage with the support on offer. As substance use resources have decreased dramatically, it has been increasingly difficult to offer fast scripts, and they can sometimes take days or even weeks. This means that a moment of opportunity to engage the individual has been lost. (2) rapid access to detox. The number of detox and rehab centres in the UK registered with the Care Quality Commission has fallen and spending by local authorities has reduced by	Thank you for your comment. Assessing and responding to the drug and alcohol treatment needs that people experiencing homelessness may have has been addressed throughout the guideline. Rapid access to substitute prescribing and rapid access to detox were not specifically featured in the evidence that was identified in the evidence reviews and therefore no specific recommendations on these have been made. However, the committee think if these are assessed as being specific needs of the local homeless population based on the local homelessness health and social care needs assessment, they may need to be addressed by the commissioners.

				£135 million. Partially as a result of reduced funding, there is also more of a requirement from substance use services for the individual to show requisite interest over a period of time. Having the ability to access emergency detox services is crucial for engaging people in the small window of opportunity where they demonstrate willingness.	
St Mungo's	Guideline	3	10	St Mungo's would question why only 'unsupported' temporary accommodation is included in the guidance. St Mungo's would argue that everyone in temporary accommodation, be it supported or unsupported, should be included.	Thank you for your comment. People in supported temporary accommodation is also included and it's been covered in the previous bullet point.
St Mungo's	Guideline	3	17	Currently the population scope excludes people in long term institutions. However, homelessness often starts at transition points such as leaving care or prison, or hospital. For example, the individual may lose their tenancy during the stay. Or, if someone has been in hospital, their living situation may no longer be tenable because the treatment they have had has rendered them immobile. We would therefore recommend that they are included in the scope.	Thank you for your comment. The committee recognise the risk of homelessness for people in prisons or hospitals. However, the guideline's scope (published in December 2020) defines the population of this guideline and indeed does not include people at risk of homelessness, with the exception of those with a history of homelessness with a high risk of returning to homelessness due to ongoing complex health and social care needs. The scope specifically states that the does not cover people staying in institutions in the long-term. The population of the guideline was agreed after careful consideration to manage the scope of the guideline.
St Mungo's	Guideline	5	18	St Mungo's would suggest the addition of and recognition of 'rough sleeping and homelessness as a public health issue' as this was one of the	Thank you for your comment, the suggested change has been made.

				foundations of the Covid-19 response which we hope will be continued.	
St Mungo's	Guideline	6	15	St Mungo's would change the wording from 'consider using' to 'should always be using'. Psychologically informed environments and trauma-informed care should not be viewed as an optional extra, as they have a significant impact on a person's recovery, and if not used, can seriously hinder progress.	Thank you for your comment. The committee agree about the importance of psychologically informed environments and trauma informed care, however, they also agreed that there is some uncertainty around it and more research is needed on the topic to hopefully inform future updated of the guidance and made a research recommendation about it. Therefore, the committee was not able to make a stronger recommendation about it.
St Mungo's	Guideline	6	16	St Mungo's would recommend that 'or' is changed to 'and'. Psychologically informed environments and trauma informed care are not interchangeable and are also not mutually exclusive. Both should be in place.	Thank you for your comment, the recommendation has been revised to say "and" instead of "or".
St Mungo's	Guideline	6	18	St Mungo's thinks that there is a need to add a further point on different experiences of homelessness here. People who are homeless are not one homogenous group. Individuals' experiences of homelessness are shaped by the impact of a range of overlapping factors, including race, ethnicity, religion, socioeconomic status, class, sexuality, gender identity, age, disability and immigration status. Social and economic circumstances affect a person's exposure to harmful situations and their access to, and experiences of, resources and support, as well as compounding ill health. The general principles of service delivery must recognise that the distinct needs and experiences of individuals	Thank you for your suggestion. On the basis of yours and other, similar, stakeholder comments the committee made some changes, adding the consideration of social determinants of health to a recommendation in general principles and also the section on 'planning and commissioning'. Social determinants of health are now also referenced in the context section and referred to throughout the rationale sections.

				mean a tailored, informed and inclusive offer of support is needed to alleviate homelessness.	
St Mungo's	Guideline	7	12	St Mungo's thinks that these guidelines would be more helpful for practioners if they set out clearly a non-exhaustive list of the circumstances leading to an increased difficulty in engaging. These would include: • Fear of side effects • Needle phobia • Only wanting one of the vaccines which is not on offer • Distrust of government and/or healthcare Not wanting to share personal data; or not thinking they are at risk.	Thank you for your comment. The wording in this recommendation has been revised and the committee decided to not have a list of potential circumstances but state more generally about people finding services difficult to engage with as there could be multitude of reasons for this, including the ones you list but also others.
St Mungo's	Guideline	8	1	There is nothing in this section reiterating that an individual does not need to have an address to register with a GP. We feel that it is important to continually reiterate this message to a wide audience as it is not currently followed in practice.	Thank you for your comment. As suggested, the recommendation has been reworded to reiterate GP registration without a permanent address.
St Mungo's	Guideline	8	5	St Mungo's would suggest that it is not simply the communication method which should be based on the individual's preferences, but also where that communication is sent, for example, letters being sent to their keyworker. That is not made explicit here.	Thank you for your comment. This would be captured by using communication methods based on the person's preferences and this was not specifically mentioned.
St Mungo's	Guideline	8	14	This should include information being accessible in verbal formats, for example the short films made by Groundswell on the Covid-19 vaccine.	Thank you for your comment, it was agreed not to give examples of what the extra support might be as it may vary.

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St Mungo's	Guideline	8	14	Another way that these guidelines should consider reflecting the individual's needs in their communications is through ensuring that all communication is, for example, gender-informed, or LGBTQ+-informed.	Thank you for your comment. In the section on General principles the committee revised a recommendation to be explicit about services needing to be inclusive, addressing health inequalities and being responsive to diverse needs of people. This would include responsiveness to experiences related to gender, LGBTQ+ and other issues. This applies to communication as well.
St Mungo's	Guideline	8	23	We think that this section should include the sentence 'including their right to access a GP if they do not have an address as set out in NHS guidelines: https://www.nhs.uk/nhs-services/gps/how-to-register-with-a-gp-surgery/' , This is very important as a GP is a gateway to accessing other health services, as well as prevents A&E visits. Difficulties in seeing a GP also mean that homeless people are often not participants in NHS vaccination and screening programmes, such as influenza vaccinations. That rationale is why we think that it should be singled out here.	Thank you for your comment, this to the recommendation has been added as suggested.
St Mungo's	Guideline	8	23	We would recommend that underneath this bullet point there should be a sub-category saying 'This should include the rights of those who have No Recourse to Public Funds or have limited access to public funds, and what services they can access.' This is a group who represent a significant proportion of the people who sleep rough in England and who are particularly vulnerable as they are unable to access essential services. They are therefore in need of targeted information and support on what they are able to access.	Thank you for your comment; the recommendation has been revised based on your suggestion.

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St Mungo's	Guideline	9	14	St Mungo's would add in the word 'integrated' between 'local' and 'homelessness'. This is to stress the message of partnership and integrated working running throughout the guidelines, which is fundamental in the needs assessment.	Thank you for your comment. The committee considered this but agreed that it is already clear from the recommendation that it is a joint effort with involvement from different providers and people and adding the word 'integrated' would not enhance the recommendation.
St Mungo's	Guideline	9	17	St Mungo's would query the addition of 'service users' as well as 'experts by experience', as it suggests that service users are not experts by experience. We would suggest deleting 'service users'.	Thank you for your comment; "service users" has been removed as suggested.
St Mungo's	Guideline	9	20	St Mungo's would recommend the addition of 'and specific needs' at the end of this sentence. To best meet the specific needs that people might have, it is necessary to quantify and characterise them.	Thank you for your comment; the suggested change has been made.
St Mungo's	Guideline	10	13	The Guidelines have recommended planning and delivering services across larger areas. St Mungo's welcomes this but would recommend that the guidelines add in the recommendation made in the final report of the Kerslake Commission: "To ensure that an appropriate offer of support is always available, local authorities should make greater use of pan-regional commissioning of specialised services."	Thank you for your comment. The committee think this is included in the recommendation which talks about "across larger areas".
St Mungo's	Guideline	10	18	We would recommend adding 'and type' between 'level' and 'of local need'. This is because people experiencing homelessness are not one homogenous group and have different needs to help them recover from homelessness, which may require different interventions. Services must be designed to reflect this. For example, one area may have a high proportion of non-UK nationals experiencing homelessness, or	Thank you for your comment, the suggested change has been made.

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				a more significant number of women experiencing homelessness, or of people with disabilities experiencing homelessness. These groups may need a different service offer.	
St Mungo's	Guideline	10	21	We would recommend adding the line 'whilst maintain the ability to test and pilot initiatives to respond to changing Circumstances'. St Mungo's would wholeheartedly agree with the need to have longer term contracts to provide certainty for providers and commissioners, and to develop culture change. However, we would argue it is also important to maintain a level of flexibility alongside this. This is reflected in the evidence section which states 'as long as there is flexibility to adapt to changing local needs' (39, 30)	Thank you for your comment. The committee have not added the suggestion to the recommendation but the wording has otherwise been revised slightly to emphasise that there are likely benefits of long-term contracts. As you say, the importance of maintaining flexibility is reflected in the rationale section.
St Mungo's	Guideline	10	28	St Mungo's would recommend that 'Consider' is replaced by 'Assess the need for…' to strengthen the wording. Tailoring services and support should not be a side consideration but must be provided if there is a need for them.	Thank you for your comment. The local homelessness health and social care needs assessment should quantify and characterise the local homeless population, including any specific needs so the committee think this is already covered and consideration should then be given to services and support depending on need.
St Mungo's	Guideline	11	5	St Mungo's would recommend changing 'without recourse to public funds' to 'with no, or limited, access to public funds'. It is important to include the cohort of people who have limited access to public funds as this similarly can push them into destitution and too often 'No Recourse to Public Funds' is used as a catch-all term which is inaccurate for some people who are still waiting on their immigration status.	Thank you for your comment, the suggested change has been made.

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St Mungo's	Guideline	11	8	St Mungo's would recommend adding 'disabled' as a further group of people experiencing homelessness who may face particular needs.	Thank you for your comment, 'disabled people' has been added to the list based on your and other stakeholders' comments.
St Mungo's	Guideline	11	11	The strategies in the 'access' section should be explicitly based on a 'no wrong door' approach, which could be highlighted here.	Thank you for your comment. The committee decided not to introduce another concept such as 'No Wrong Door' to the guideline. However, the committee think that overall the principles of this approach are covered by the recommendations in this guideline. The guideline aims to promote access and engagement, integration of care, and provide staff with appropriate training and development to respond to the needs of people experiencing homelessness. If implemented effectively, this guidance will ensure that services can provide people experiencing homelessness with an appropriate intervention/referral regardless of where they enter the care system. In the access section, it is explicitly recommended that frontline health and social care staff are supported to identify and act on needs. Also, recommendations throughout were developed, keeping in mind that every contact should be seen as an opportunity to engage and build trust with people who might otherwise find it difficult to engage. All of the above should align with the principles of a 'No Wrong Door' approach, and it is hoped that it addresses your concerns.
St Mungo's	Guideline	12	13	We are unclear of the addition of 'case management' here as all services and care should be person-centred, not solely the case management.	Thank you for your comment. The committee agree with you about the importance of all care and support being person centred and for this reason one of the recommendations in the opening section (general principles) states that engagement with (all relevant) services should

					be promoted by being person-centred, empathetic, non-judgmental and services needing to be inclusive, addressing health inequalities and being responsive to diverse needs of people.
St Mungo's	Guideline	12	29	St Mungo's would recommend making the addition 'and develop and share examples of good practice'. This further extends the collaborative approach put forward in the guidelines, and emphasises the needs for places to work together across areas especially where they have smaller populations of people experiencing homelessness.	Thank you for your comment, the suggested change has been made.
St Mungo's	Guideline	15	2	These guidelines recommend "tailored support for professional development, including access to 2 further training and employment opportunities." An example of good practice in this area is St Mungo's Recovery College which offers a variety of free courses aimed at people who have experienced homelessness. St Mungo's Recovery Colleges provide safe and inclusive learning opportunities, supporting recovery through involvement in learning. The colleges teach a wide range of topics such as wellbeing, health and personal development, digital skills and IT, arts, creativity or music. It is currently running digitally. https://www.mungos.org/our-services/recovery-college/ We would be willing to submit our experiences of this approach to the NICE shared learning database.	Thank you for this information, it is good to know that there are examples of good practice in this context and the link you provide for further details has been noted.

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St Mungo's	Guideline	15	9	We would recommend that it is made clear that these services should all be delivered in a person-centred, trauma-informed way. It is not just about *what* services are being delivered, but *how* they are delivered.	Thank you for your comment. As suggested, this was reiterated in the recommendation by adding psychologically informed environments and trauma informed care to the bulleted list. The committee also agree that there is a clear emphasis throughout the recommendations on the way in which services should be delivered, not least in the general principles at the start of the guideline.
St Mungo's	Guideline	15	18	We would recommend that examples of what digital connectivity is in practice should be outlined here.	Thank you for your comment. The committee felt that this terminology is widely understood so they did not add further detail to this recommendation. However they do feel the term is well explained in the rationale section, which refers to digital exclusion being a major barrier to access and goes on to describe evidence that people without access to the internet and those without a phone experienced difficulties in accessing healthcare.
St Mungo's	Guideline	16	10	We would recommend that 'and worked through with the individual' is added after 'transfer of care to another service has been arranged'. This is to reiterate the guidelines' emphasis on a person-centred approach which is based on shared decision making.	Thank you for your comment. Safe transfer of care would imply engagement with an individual. However, some changes in wording have been made to make this more explicit.

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St Mungo's	Guideline	17	2	We would recommend 'can' is replaced by 'are supported to'. This is because services may say that people experiencing homelessness and rough sleeping *can* register with a GP, but this is very different from it being easy to do. Supporting people to register reflects the recognition made by the committee that this cohort may need more effort and targeted approaches to level up outcomes.	Thank you for your suggestion. The committee did not make this change because they had originally intended for this recommendation to convey the message that policies should be in place so that it is possible for people experiencing to register, as they are aware this is not always the case. The issue you raise, about enabling or supporting people to register is addressed elsewhere in the guideline.
St Mungo's	Guideline	18	6	We feel that the wording should be changed from 'Consider' to 'All outreach teams should be made multidisciplinary, where possible', which strengthens the sentiment. As discussed in the evidence in these guidelines: "Improving integrated service provision should lead to improved outcomes, more appropriate use of services, and a lower need for emergency care and hospital admissions, reducing associated costs". As demonstrated here, integrated service provision is crucial, and therefore it should be stressed that where possible it should be done. As part of making outreach multidisciplinary, we think it is important to increase the number of social workers who go on outreach shifts so that more care act assessments can be done on the streets, rather than creating a barrier by asking people to come to services. There are examples of Adult Social Care (ASC) departments stating that an individual must be in accommodation prior to carrying out a Care Act assessment, but this is not supported in the Care Act. Examples have been raised by St Mungo's outreach	Thank you for your comment. The recommendations in this section have been revised and the multidisciplinary nature of outreach has been strengthened by referring to "multidisciplinary outreach" in the first recommendation of this section. The committee have not specified that outreach teams should include social workers but this may well be the case in order to meet people's needs. Elsewhere in the guideline, the committee recommend that social workers could be part of the homelessness MDT.

				workers where people experiencing rough sleeping had not been able to access a care act assessment because of logistical barriers in place. For example, one outreach worker told us about a client who was asked to go to the council building during office hours, which they needed to be driven to, and the office only opened at 9am which was two hours after the night shelter closed, meaning that they had nowhere to go aside from sitting in the city centre. The difficulties created by their situation, as well as intimidation of the institutional setting, meant they were unable to access the care act assessment. This would have been hugely helped by a social worker being embedded in the outreach team, and therefore is able to carry out the assessment where the client is.	
St Mungo's	Guideline	18	21	We recommend that the wording should be changed from 'who are disengaging' to 'find it difficult to engage with'. This removes the language of blame (as highlighted on page 35 where the need for language to be non-judgemental is stressed) and reflects that there are multiple barriers to engagement for the individual – they should be supported to engage not blamed for not engaging.	Thank you for your comment on the basis of which the wording has been revised.

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St Mungo's	Guideline	19		We recommend emphasising the need to use a common terminology that can be shared across all disciplines and teams that are involved in someone's support and care. This is crucial in enabling a continuity of care and ensuring the individual is not re-traumatised by having to retell their story multiple times and information is effectively passed on to enable ongoing support and treatment. This would be further improved if the client is supported to have ownership of this. St Mungo's is currently building an assessment toolkit for services' use. This will look at the language used, and also advice for staff to advocate appropriately in care act assessments.	Thank you for your comment. The committee have not made a specific recommendation about using common terminology as such, however, the guideline does recommend avoiding the use of jargon and acronyms and tailoring the communication to the individual's needs and preferences. The committee have also revised the recommendation on assessing a person's health and social care needs to specifically say that unnecessary and potentially distressing repetition of history that is already on record should be avoided. This is also discussed in the "rationale and impact" section. And the committee revised the recommendation on homelessness multidisciplinary teams to include that there should be protocols and systems in place for sharing information. The guideline also includes a recommendation about involving peers and advocates the assessment process, as appropriate.
St Mungo's	Guideline	21	9	We would question the addition of 'building a relationship of trust' in this section as this should be the basis for the majority of the service provision and support throughout the guidelines. Singling it out here suggests that is not the case and it is more pertinent here than elsewhere. We would therefore suggest stressing this more earlier on in the guidelines.	Thank you for your comment. The committee agree that the importance of creating and sustaining trusting relationships to try to improve engagement with services is a theme throughout the guideline but in certain instances - like the one you highlight - the committee wished to make explicit reference to it. The first time it is referenced is in the general principles, which indicates it is something the committee see as having relevance to all aspects that the guideline addresses.

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St Mungo's	Guideline	22	10	We would recommend adding 'and progress along their recovery journey'. This is because it is not solely down to staying in accommodation, but about all facets of their recovery.	Thank you for your comment which the committee carefully considered. They agreed not to add this to the recommendation as this particular recommendation is specifically about maintaining suitable accommodation. Recovery journey is implied but the focus is on maintaining accommodation.
St Mungo's	Guideline	22	15	We recommend reflecting some of the other differences in accommodation type outside of support level, for example whether a hostel is wet or dry. This helps to show the variety of factors which can affect the appropriateness of the accommodation.	Thank you for your comment. This was something the committee discussed thoroughly when making this recommendation and again after receiving this comment. The committee deliberately agreed to keep it generic, there are various models and options for housing that could be applicable to different individuals depending on their specific needs but the focus of this guideline is not on housing.
St Mungo's	Guideline	23	3	St Mungo's suggests adding the need for statutory agencies to listen to and value the input of agencies who work closely with the homeless person, i.e. outreach teams, hostel staff, in assessing the safeguarding needs of homeless people.	Thank you for your suggestion. The committee agreed that this should be emphasised and have reflected this in an edit to a recommendation about multi-disciplinary approaches to enable holistic assessment of need. They have now added that this should involve input from professionals such as those working in homelessness and housing services.
St Mungo's	Guideline	23	10	St Mungo's recommends that 'Local authorities should consider having a safeguarding lead' is changed to 'It is recommended that local authorities have a safeguarding lead'. Having a safeguarding lead for people experiencing homelessness is crucial for the safety and welfare of very vulnerable people, which is often not fully recognised in this area of work. It must therefore be a stronger recommendation.	Thank you for your suggestion. In the absence of robust research findings in this area, the use of "Consider" is as strong a recommendation as can be made. However please note that this recommendation has been slightly amended and now refers to having a lead on the Safeguarding Adults Board for people experiencing homelessness.

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St Mungo's	Guideline	24		**1.11.2** St Mungo's agrees with the premise of building a relationship of trust and many of the examples given. However, we would argue that having this as a separate section under long-term support undermines the need for 'building a relationship of trust' to be at the centre of most of the interactions with people experiencing homelessness. These examples should sit higher up under a more general category such as 'General principles for how services should be delivered'.	Thank you for your comment. The committee did not make the suggested changes because the importance of establishing trusting relationships is already covered by section on general principles.
St Mungo's	Guideline	24	20	We recommend adding 'expectations management and not overpromising to an individual what they may not be able to deliver on'. St Mungo's frontline staff stressed that it is essential to building a relationship of trust.	Thank you for your comment. The committee understand the issue and have revised wording slightly to reflect that there should be an aim to meet immediate expressed needs.
St Mungo's	Guideline	24	21	This is a crucial lesson for how specialist homelessness multidisciplinary teams conduct their long term work. It is important for all disciplines to make this central to their working and not to close the case if the individual disengages, but to continue to strive to build a relationship of trust.	Thank you for your comment.
St Mungo's	Guideline	26	7	We recommend adding 'or unable' in the sentence: 'repeated contact with people who are initially unwilling *or unable* to engage'. This is about ensuring that language reflects the individual's situation. Often mental ill health or other needs may create a barrier which means that they are unable to engage.	Thank you for your comment; the suggested change has now been made.
St Mungo's	Guideline	26	17	We recommend changing 'may' to 'often' to better reflect the frequency of ACEs amongst this cohort.	Thank you for your comment. Based on consultation feedback, the committee have agreed to refer to severe and multiple

					disadvantage instead of complex needs and thus have taken this definition out. But used the word 'often' instead of 'may', as suggested, in a similar context in the definition of severe and multiple disadvantage.
St Mungo's	Guideline	30	13	We would suggest an additional recommendation for research on groups experiencing homelessness with further lenses of disadvantage, for example women, LGBTQ+ people, people who are BAME and those experiencing youth homelessness. This can be used to develop better designed data collection methodologies for these groups, who have different experiences of homelessness and are more likely to be hidden homeless. It is clear that the disproportionate impact of poor health and poor housing falls on many communities and groups within the protected characteristics. However, there is insufficient research or analysis on the causes and solutions for these groups. This was a recommendation in the Kerslake Commission final report (https://www.commissiononroughsleeping.org/) which St Mungo's echoes.	Thank you for your comment. The committee agree with you about the importance of addressing inequalities through the research recommendations. Details related to this are provided in the evidence reviews, appendix K and specifically in the table's entitled 'Research recommendation rationale' where there are explanations about the equality considerations for the respective research recommendations. As one example, the research recommendation about the effectiveness and cost-effectiveness of longer contacts explains that the research should address that certain groups would benefit from longer contact times to ensure complex health and social care needs are identified and addressed. Groups highlighted include LGBTQI people, people from minority ethnic groups, people who are migrants or who have had their asylum application refused, people with autism, women, young people, and people with additional communication needs experiencing homelessness have specific care needs. Since all the research recommendations are seen through an equalities lens the committee did not feel a dedicated research recommendation was needed to address a particular research gap.

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Stepping Stone Projects	Guideline	General	General	Stepping Stone Projects are a homeless prevention charity that aim to prevent homelessness by providing high quality affordable homes and independent living support to those vulnerable people most at risk of homelessness. Established in 1984 we are currently working across 25 local authorities in the north-west providing over 600 homes with wraparound support to a wide range of people at risk of homelessness including: - Care leavers - Young People with complex needs who are estranged from family and support networks - Rough sleepers - Homeless single people with support needs - Singles and families with complex needs - Women and male only - Ex-offenders - Those with lower level mental health issues - Those with NRPF - Unaccompanied asylum-seeking children - New Refugees We utilise a range of accommodation models including intensely supported grouped schemes, lower level supported HMO's and grouped schemes and dispersed accommodation in the community with floating support. Some of our accommodation is owned by SSP, other leased from housing associations and the private rented sector.	Thank you for your comments and for the information you provided about your organisation. It is encouraging to hear that many of the approaches recommended in this guideline are already used in your services. Regarding your concern around long-term support. This has been an important issue highlighted by committee and the guideline aims to address this in different places in the guideline. For example, there is a recommendation in the section on general principles about recognising that people experiencing homelessness need services that provide long-term commitment to care, there is also a recommendation for commissioners, which includes consideration for providing long-term contracts for providers, and there is a separate section that focuses specifically on long-term support. It is hoped these will help highlight this issue and improve long-term support for people experiencing homelessness.

				We found the report to be very well-researched, comprehensive and enlightening. It largely recommends the approaches and practices that we have been advocating and using for many years. As such we agree with all aspects of the report and its recommendations. Our only major comment would be to particularly highlight a couple of areas of the report more. 1. Currently many of the targeted services and accommodation that are currently provided by local authorities and health services are short term and time limited. This means often the service is provided for 3 months or less. This is simply not long enough for many homeless people, particularly those with the most complex needs and entrenched behaviours, to engage and address the issues they have and to make that journey from homelessness and high dependency on public services to a much more independent ways of living. For some they may simply have too many issues to be able to effectively address them all and deal with them all of the time. They will require very long term on-going support to sustain their own home and minimise their dependency on public services. There are models which enable this to be provided that can be commissioned, supported and regulated effectively by commissioners that can be delivered at minimal or no cost to the commissioner. Similarly, many of the services we provide are	

				only offered on very short -term contracts – many are only for 3 months over winter and others are only for a year at a time. We currently provide 30 services across the North-West for homeless people and of these 22 are on contracts of 1 year or less. This is because commissioners funding is only confirmed annually and so many Government homeless programmes are short term. This means as a service provider we are constantly having to bid for contracts and services, setting up new properties, homes and services whilst closing other services, switching service provision, recruiting and training short term temporary staff etc. As a business we cannot plan long term, easily recruit and train high quality staff, provide the continuity of homes, services and support workers to customers as we would like or build the relationships we would want with permanent accommodation providers such as housing associations.	

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The University of Manchester	Guideline	General	General	There is evidence that pharmacists, particularly during COVID-19 have been more accessible for people experiencing homelessness. For example in Scotland, some pharmacists actively prescribe on the streets and provide outreach services (Johnsen, Sarah, Fiona Cuthill, and Janice Blenkinsopp. "Outreach-based clinical pharmacist prescribing input into the healthcare of people experiencing homelessness: a qualitative investigation." *BMC health services research* 21.1 (2021): 1-10) (Lowrie, Frances, et al. "A descriptive study of a novel pharmacist led health outreach service for those experiencing homelessness." *International Journal of Pharmacy Practice* 27.4 (2019): 355-361.) There is evidence that pharmacists, particularly during COVID-19 have been more accessible for people experiencing homelessness. For example in Scotland, some pharmacists actively prescribe on the streets and provide outreach services (Johnsen, Sarah, Fiona Cuthill, and Janice Blenkinsopp. "Outreach-based clinical pharmacist prescribing input into the healthcare of people experiencing homelessness: a qualitative investigation." BMC health services research 21.1 (2021): 1-10) (Lowrie, Frances, et al. "A descriptive study of a novel pharmacist led health outreach service for those experiencing homelessness." International Journal of Pharmacy Practice 27.4 (2019): 355-361.) Pharmacists are also more accessible out of hours (such as in the evenings and weekends)	Thank you for your comment, which was discussed with the guideline committee. Some committee members were aware of evidence on this topic, which is in the process of publication and therefore unavailable to include in this guideline. One study was identified which was conducted in the UK and on the topic of public involvement sessions with persons experiencing homelessness with a view to inform the design of patient-centred clinical pharmacy healthcare services. The study contributed to several review findings: 'A1.10.2 Availability of allied health services', 'A1.17.1 Managing medication', 'A2.2.4 Trust in service providers', 'B3.2 Role and availability of outreach', 'B3.3.1 Service collaboration' in review C. The committee agreed that pharmacy services should feature more in the discussion section of MDT outreach teams. Thank you for providing these references. The references have been checked for relevance to this review and reasons for exclusion are provided after each reference. Johnsen, S., Cuthill, F. & Blenkinsopp, J. Outreach-based clinical pharmacist prescribing input into the healthcare of people experiencing homelessness: a qualitative investigation. BMC Health Serv Res 21, 7 (2021). https://doi.org/10.1186/s12913-020-06013-8. This study was published after the literature search date for this review question and therefore could not be included. Frances Lowrie, Lauren Gibson, Ian Towle,

				and are available nationally. Pharmacists not only provide healthcare and advice but they are gateway into accessing other services but there are barriers as Pharmacists are often not always included in the inclusion health training and are not always aware of the rights to access care for people experiencing homelessness. Paudyal, Vibhu, et al. "Perceived roles and barriers in caring for the people who are homeless: a survey of UK community pharmacists." International journal of clinical pharmacy 41.1 (2019): 215-227. On this basis we advise that pharmacists are specifically referred to in the recommendations	Richard Lowrie, A descriptive study of a novel pharmacist led health outreach service for those experiencing homelessness, International Journal of Pharmacy Practice, Volume 27, Issue 4, August 2019, Pages 355–361, https://doi.org/10.1111/ijpp.12520. This is a descriptive study and this study design was not included in the evidence review. Paudyal, V, Gibson Smith, K, MacLure, K, Forbes-McKay, K, Radley, A & Stewart, D 2019, 'Perceived roles and barriers in caring for the people who are homeless: a survey of UK community pharmacists', International Journal of Clinical Pharmacy, vol. 41, no. 1, pp. 215-227. https://doi.org/10.1007/s11096-019-00789-4. This reference was identified in our search but excluded because the phenomenon of interest and study design didn't align with that of this guideline review.
The University of Manchester	Guideline	General	General	We agree that people experiencing homelessness (and other vulnerable groups) should be given an option as to whether to have a face to face or remote appointment, however unfortunately some practices do not give this option. For example, some practices expect all patients to make an appointment via an online system. Specific recommendation on when to offer a remote consultation would be useful.	Thank you for your comment. It is beyond the scope of a NICE guideline to dictate when to offer a remote appointment but the guideline recommends flexibility in appointment systems and ways in which people experiencing homelessness can better reach and access services as well as a person-centred and needs-based approaches so it is hope this is covered.
The University of Manchester	Guideline	24		**1.11.2** Recommendation of meeting people in a 'park' will not be practical or safe for all health and social care professionals. Perhaps	Thank you for your comment. The committee have not changed this recommendation because they only intended a park to be one example of a way in which a practitioner could demonstrate flexibility in terms of their interaction with people

				recommending meeting in a local day centre or community space would be preferable here.	experiencing homelessness; they were certainly not stipulating that practitioners should always or routinely meet people in parks. The recommendation also mentions appropriate lone worker policies.
University of Hertfordshire	Guideline	General	General	The guidance does not fully recognise the needs of homeless pregnant women, who can become disempowered during pregnancy through reduced agency, lack of opportunity and the inadequate meeting of their basic needs (Came, Matheson, & Kidd, 2021). For pregnant women who experience homelessness pre-existing disadvantages exacerbated their risks by increasing barriers to care and causing further chronic stress needs (Came, Matheson, & Kidd, 2021). Early findings from my own doctoral research highlight that pregnant women experiencing homelessness and living in temporary accommodation experience extreme stress, perceived stigma from staff within housing services and other services (maternity services, etc), and therefore this group of women should have their needs specifically addressed within this guidance. References Matheson, A.; Kidd, J.; Came, H. Women (2021). Patriarchy and Health Inequalities: The Urgent Need to Reorient Our Systems. Int. J. Environ. Res. Public Health, 18, 4472. https://doi.org/10.3390/ ijerph18094472	Thank you for your comment. The committee considered some evidence about pregnant women experiencing homelessness, in particular, accounts of stigma and a lack of information. On this basis, they recommended that services and support be tailored to their needs. Aware of more specific suggestions in another NICE guideline for the provision of services to support pregnant women with complex social factors (including homelessness), the committee agreed to signpost to that guideline. The reason for this was because vital issues around service provision are addressed and recommendations made in far more detail than the committee felt they had the basis to make in this guideline. Finally, the reference you cite was not located by our literature searches, which were conducted in December 2020. Having followed up the reference it is clear it does not meet the inclusion criteria for our evidence reviews because the paper does not report the results of an empirical study, nor is it a systematic review.

University of Hertfordshire	Guideline	General	General	The guidance does not currently acknowledge the multi-layered social exclusion of mothers experiencing homelessness. Benbow (2019) explored the multidimensional nature of social exclusion in the lives of mothers experiencing homelessness. The authors highlight the need for services to employ health-equity approaches to care that ensures compassion, respect, and shared power are achieved. Findings which are backed up by early findings of my own doctoral research into mothers' experiences of living in temporary accommodation. References Benbow et al., (2019) "Until You Hit Rock Bottom There's No Support": Contradictory Sources and Systems of Support for Mothers Experiencing Homelessness in Southwestern Ontario. Canadian Journal of Nursing Research, 51(3) 179–190.	Thank you for your comment. In terms of the specific paper you reference, this was not located by the systematic search designed for the qualitative evidence review underpinning this guideline. One of the commonest reasons that articles are not picked up is to do with the title/abstract/keyword wording of the original article that then affects how it has subsequently indexed on databases. This is likely to explain why the Benbow et al. article was not picked up. The title/abstract/keywords in Benbow et al do not clearly explain what the article is about or the methods they used. It does not mention some of the common terms used to find qualitative studies, such as qualitative or interview. It does however mention 'experiencing' and 'experiences'. The term 'experiencing' is not often used in qualitative filters, as it does not always relate to qualitative studies, for example 'experiencing homelessness' was used to describe the population in a lot of the articles located for the quantitative reviews. The term 'experiences' is one that could be used in qualitative filters but the specific qualitative filter used the singular term 'experience'. This was a conscious decision by the original designers of the qualitative filter to get the best overall results, taking into consideration sensitivity, specificity, precision and accuracy. The qualitative filter used was developed by a team at McMasters University and the write up of the testing they did of the search filter is published here: Wong SS, Wilczynski NL, Haynes RB. Developing optimal search strategies for detecting clinically relevant

					qualitative studies in MEDLINE. Medinfo. 2004;2004:311-6. Having considered your comments based on the Benbow article, the committee acknowledge their importance and they agree that they chime with the small amount of evidence about mothers experiencing homelessness and their perceptions of service providers, which was included in the qualitative review. These data contributed to broader review findings about the way in which, for the general homeless population, fear, apprehension and trust issues can undermine engagement with health and care services. Other findings highlighted that stigma and discrimination characterise people's experience of services and that the quality of the relationship between service providers and people experiencing homelessness is fundamental to people's experience of using services. On the basis of these findings and supported by their own expertise, the committee made recommendations which emphasised person centred, non-judgemental and empathetic engagement, services which address health inequalities, are inclusive and responsive to people's diverse needs and demonstrates an understanding of social determinants of health. They also emphasised the importance of longer contact times in developing and sustaining trusting relationships between frontline health and social care staff and people experiencing homelessness and empowerment through the co-design and co-delivery of services as well as resilience through strengths based approaches.

					While finalising the guideline the committee also edited one particular recommendation to state that multidisciplinary assessments should (among other issues) consider whether the person has children or other dependents and then meet needs accordingly. The committee were therefore reassured that although the specific paper was not included in the evidence review, the issues it raises have been addressed throughout the guideline.

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University of Hertfordshire	Guideline	General	General	**Comment – guidelines should further detail and acknowledge how guidance will support professionals to tailor services to the needs of families, and mothers in particular, experiencing homelessness who need support to establish relationships and who may have limited social support.** Holding et al., (2020) found that perceptions of housing quality, service responsiveness, community safety and benefit changes and low income all have a detrimental effect on tenants' mental health. Bimpson, Reeve & Parr (2020) explored the experiences of mothers who became homeless, and the ways that English housing and social policy interventions respond within existing legal and policy frameworks. They interviewed 26 homeless mothers in 2020, in the North of England. The authors highlight the importance of the quality of the relationship with residential environments and community contexts in enhancing several health and well-being outcomes. This was mirrored in the research into staff experiences by Watson et al (2019) who found that staff identified many barriers to building such supportive, trusting and non-judgemental relationships, but saw such relationships as fundamental to success in their work, and wanted to time and managerial support to build such supportive relationships with those experiencing homelessness. Research has shown that complex trauma can affect people's behaviour in several ways, including forming trusting relationships and emotional management (Keats et al., 2012;	Thank you for your suggestion. The evidence reviews did not locate any evidence specifically about the needs of family groups, with the exception of some evidence about pregnant women experiencing homelessness, including accounts of stigma and discrimination. On this basis, they recommended that services and support be tailored to the needs of pregnant women. They then also signposted from this guideline to another NICE guideline for the provision of services to support pregnant women with complex social factors (including homelessness). The reason for this was because vital issues around service provision are addressed and recommendations made in far more detail than the committee felt they had the basis to make in this guideline. With reference to the needs of families more broadly, as mentioned, the systematic reviews did not locate relevant evidence. The references that you have highlighted are listed below with the reasons they were not included in the evidence base for this guideline: Holding (2020). This was located by our search but excluded because the population is 'social housing tenants', which do not fit our definition of 'people experiencing homelessness'. Bimpson et al (2020) This was located by search but excluded because it is about women's experiences in general terms, not strictly related to accessing health and social care services. The aim of the paper was reportedly 'to understand the circumstances that led to women's homelessness, their experience of parenting while homeless and of living apart from their

				Westaway et al., 2017). However, studies have shown that, if addressed, people can recover (Cockersell, 2011). Early findings from my doctoral thesis (Beadle, ongoing) highlight that mothers experiencing homelessness wished for and would have benefitted from and valued opportunities to connect with other families and mothers within temporary accommodation. However, mothers expressed concerns regarding lack of trust and kept their distance from other women and tenants who were also experiencing homelessness, as a means of protecting themselves and their children. The guidelines do not appear to address the importance of relational safety and perception of community safety within services. Separate homeless services that provide services for families and mothers (particularly lone mothers) could be developed to foster a sense of safety and trust and family-orientated housing environments, which would benefit both mothers' and children's wellbeing and also foster an environment where mothers experiencing homelessness could connect and build peer relationships. References Holding, E., Blank, L., Crowder, M., Ferrari, E., & Goyder, E. (2020). Exploring the relationship between housing concerns, mental health and wellbeing: a qualitative study of social housing tenants. Journal of Public Health,18;42(3), 231-238.	children'. On this basis, it was therefore judged not to fit the phenomenon of interest in our qualitative review protocol although some of the themes that emerged could be said to link with issues around homelessness and access to care and support. Watson et al (2019) This was located by the search but excluded on title and abstract because the study was designed to investigate project workers' experiences of building relationships with people experiencing homelessness living in supported housing projects. It did not therefore obviously meet the phenomenon of interest in protocol for review C. Keats et al (2012) This is a good practice guide and therefore does not fit the study design criteria for either the quantitative or qualitative review protocols. Westaway et al (2017) This was located by our search for qualitative evidence but excluded on the basis of the information in the title and abstract. The focus appeared to be on issues facing men experiencing frequent moves between hostels, in terms of creating relationships, identity and stigma and hope or moving forward. On that basis it therefore did not appear to fit the phenomenon of interest set out in the protocol for review C. Cockersell (2011) This was located by our search for qualitative evidence but excluded on title and abstract because it is a discussion paper rather than a description of the findings from empirical research. It therefore does not fit the study design criteria for review C.

				Bimpson, E., Reeve, K., & Parr, S. (2020). Homeless mothers: Key research findings. UK Collaborative Centre for Housing Advice. Keats, Cockersell, P., Johnson, R., & Maguire, N. (2012). Psychologically Informed Services for Homeless People. (Good Practice Guide) available at: www.rjaconsultancy.org.uk/PIEconcept.htm Keats, H., Maguire, N.J., Johnson, R. & Cockersell, P. (2012) 'Psychologically informed services for homeless people', Good Practice Guide, Department of Communities and Local Government, available at: www.southampton.ac.uk/assets/imported/transforms/peripheral-block/UsefulDownloads Watson, C.L., Nolte, L. & Brown, R. (2019) Building connections against the odds: Project workers reflect on/consider their relationships with people experiencing homelessness, Housing, Care and Support, 22(2): 129-140, https://doi.org/10.1108/HCS-10-2018-0030 Westaway, C., Nolte, L., & Brown, R. (2017). "Developing best practice in psychologically informed environments", Housing, Care and Support, 20(1), pp.19-28, https://doi.org/10.1108/HCS-11-2016-0016	

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University of Hertfordshire	Guideline	General	General	**Comment: Mothers who experience homelessness experience worse mental health when parenting their children living in temporary accommodation.** Dr Nina Carey's (Clinical Psychologist) completed doctoral thesis that explored single mothers' experiences of living in temporary accommodation in London aimed to fill literature gaps by addressing the experiences of these mothers through a psychological lens. There was a particular focus on mental distress and mothers' relationships with their children. This research highlights the importance of advocating for and drawing from alternative, critical approaches within social work which take a less individualistic approach and consider the impact of poverty and insecure housing on one's capability to parent when engaging in multi-agency working who support mothers when homeless. These clinical implications could be referenced within the guidance. Four themes were constructed; 1. Experiencing neglect and abuse within a powerful, unjust system, 2. Feeling trapped in cycles of suffering 3. Mothering against the odds: nurturing through harsh conditions' 4. Surviving and resisting in the face of adversity. The theme 'Mothering against the odds: nurturing through harsh conditions' demonstrated how wider systemic issues influenced mothers' experiences of parenting and mental health. It illustrated the interaction between the influence of housing and wider systems and the influence of mothers' love for their children, on the mother-	Thank you for this information. The evidence reviews underpinning the guideline did not locate studies specifically focussed on women experiencing homelessness and mental health problems. The committee did however consider some evidence about pregnant women experiencing homelessness, including accounts of stigma and a lack of information. They then also signposted from this guideline to another NICE guideline for the provision of services to support pregnant women with complex social factors. The reason for this was because vital issues around service provision are addressed and recommendations made in far more detail than the committee felt they had the basis to make in this guideline. In considering your comment, the committee also wanted to highlight that the mental health needs of people experiencing homelessness are comprehensively addressed, albeit not exclusively in connection with mothers. While they were finalising the guideline and in response to a number of other stakeholder comments, the committee also agreed to expand on a recommendation about the conduct of comprehensive assessments of physical and mental health by stating that this should involve assessment and consideration of whether the person experiencing homelessness has children or other dependents, which would ensure that services are arranged and needs are met accordingly. The committee also wanted to highlight that one study included in the qualitative review aimed to get a better understanding of

				child relationship. Mothers described experiencing great distress due to their experiences of insecure housing and living in temporary housing, and the uncertainty around how long they would have to stay. Mothers' housing situations were associated with trauma; including exacerbation of past experiences which may have been traumatic. Some mothers described the experience causing them to feel they had no choice but to take their own lives. Benefit caps and financial uncertainty meant participants felt trapped in poverty by the system despite how hard they strive to change their situation. This impacted mothers' mood and sense of self and led to fear and anxiety about the future. The condition of the housing was described to cause some children to become sick. Children experienced distress resulting from their housing which manifested through crying and behavioural changes. The guidelines should specify the importance of parenting support for mothers experiencing homelessness, not only in the interest of the women, but also as a preventative and protective strategy for their children. Reference: Carey, N. (2019). Single Mothers' Experiences of Temporary Accommodation and Mental Health: A London- based Study. Unpublished Doctoral Thesis, University of Hertfordshire.	homeless mother's perceptions of service providers, so although not specifically focussed on mothers with mental health problems, this paper contributed to review findings about fear, apprehension and a lack of trust leading to difficulties engaging with services and the importance of the quality of the relationship between the person and the provider. These findings supported a number of recommendations throughout the guideline, which were designed to tackle discrimination, stigma and lack of empowerment experienced by the homeless population more generally.

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University of Hertfordshire	Guideline	General	General	Watson, Nolte & Brown (2019) explored workers' relationships with people experiencing homelessness and found that trusting and empathic relationships between project workers and people experiencing homelessness form the cornerstone for their needs to be met. However, under the UK austerity agenda (and continuing now due to current budget pressures), project workers reported practicing in a context of increasing pressure and limited resources; with relationships often characterised by conditionality and disconnection. Three main themes were identified in this research: "Working hard to build connection", "Supporting each other within an unsupportive context" and "Draining but sustaining". Project workers acted out of strong value systems in building relationships with residents against a backdrop of systemic disconnection. The authors put forward clear clinical implications in a Psychologically Informed Environment (PIE) framework . Services supporting people experiencing homelessness need to be psychologically-informed and organisations need to embed reflection within their policies and every day practice. It was recommended that, in developing services for people experiencing homelessness, interdependence not in/dependence needs to be the aim. The guidelines should refer to the importance of interdependence, not dependence. Reference: Watson, C., Nolte, L., & Brown, R. (2019). "Building connection against the odds: project	Thank you for highlighting this reference and the important themes identified by the research. This particular paper (Watson et al 2019) was located by the search for our qualitative evidence review but excluded based on its title and abstract which described it as an investigation of project workers' experiences of building relationships with people experiencing homelessness and living in supported housing projects. It did not therefore obviously meet the phenomenon of interest in the protocol for review C. However on the basis of their own experience, the committee recognise the problems you highlight and they do believe that the guideline recommendations will help to address these through the emphasis on person centred, non-judgemental and empathetic engagement and consideration of trauma informed care and psychologically informed environments. They also believe the recommendations will promote empowerment through the co-design and co-delivery of services, resilience through strengths based approaches and with respect to relationships with practitioners, they have recommended that longer contact times be recognised as a means of supporting the development of trusting relationships.

				workers relationships with people experiencing homelessness", Housing, Care and Support, 22(2), 129-140, https://doi.org/10.1108/ HCS-10-2018-0030	
University of Hertfordshire	Guideline	General	General	Ali et al (under review) report on a grounded theory study investigating the bonds people have with their social housing and communities, and how this shape their identities and relationships with society. This study contributes to understanding about the bonds people have with their social housing, and the processes that underpin it. This points to the significant potential impact of being unhoused or insecurely housed on a sense of belonging, community and identity. Ali et al highlight how home is associated with a sense of security, safety, and belonging and therefore as pivotal for psychological wellbeing. Therefore, the absence of a home can have a current and ongoing impact on psychological wellbeing. In summary, this research highlights the psychological impact of ongoing changes in social housing policies on its inhabitants' psychological wellbeing and identities. These findings are important for psychologists, social housing communities, and policymakers, particularly in on-going changes to the housing system. Reference Ali, S., Nolte, L., & Harris, C. (Under review). "My home is my past, present and future": A Grounded Theory exploration of the bonds between people and their social housing in London.	Thank you for your comment and for highlighting this research. Although it is difficult to tell without seeing the title and abstract of the paper you are describing, it does not appear to fit the protocols for any of the systematic reviews underpinning this guideline, which are specifically about access to and engagement with health and social care services. However, the committee feel that the recommendations they have made do address many of the issues you raise, in particular the impact of trauma on the lives and wellbeing of people experiencing homelessness. For example the committee recommended that comprehensive assessments of people's social care and physical and mental health needs should avoid unnecessary and potentially distressing repetition of a history which is already on record and that it should include and understanding of the historical context of the person's situation, including past psychological trauma and experience of services. The committee also made several recommendations about the general principles of delivering health and social to people experiencing homelessness, for example being friendly, person-centred, empathetic, non-judgmental and services needing to be inclusive, addressing health inequalities and being responsive to diverse needs of people, and they also recommended

					that consideration be given to using psychologically informed environments and trauma informed care.
University of Hertfordshire	Guideline	General	General	Westaway et al's (2017) research extended understanding of the issues facing those who experience multiple moves around homelessness projects. It considered these issues and how they relate to best practice, informing the delivery of psychologically informed environments (PIEs). A qualitative design was employed, with interviews undertaken with men currently residing in hostels for those with additional needs. These men had already experienced multiple moves within the hostel system. Interpretative phenomenological analysis was used to analyse the data. Main themes consider issues and challenges associated with hope and moving forward; help and the conditional or temporal nature of this; identity and stigma; and intimacy and relationships. Clinical implications of these findings include: best practice for future planning with service users, the relational nature of hope, how best to manage endings and practical guidance for service developments in these settings. The findings of this study point towards the importance of creating secure and containing environments; of facilitating trusting relationships where beginnings and endings are thoughtfully managed and communication is clear and inclusive; where spaces are created to share life	Thank you for your comment and for highlighting this research, which was not included in any of the reviews underpinning the guideline. It was located by our search for qualitative evidence but excluded on the basis of the information in the title and abstract. The focus appeared to be on issues facing men experiencing frequent moves between hostels, in terms of creating relationships, identity and stigma and hope or moving forward. It therefore did not appear to fit the phenomenon of interest set out in the protocol for review C. However, the committee feel that the recommendations they have made do address many of the issues you raise, in particular the importance of creating secure environments and establishing trusting relationships. For example the committee made several recommendations about the general principles of delivering health and social care to people experiencing homelessness, for example being friendly, person-centred, empathetic, non-judgmental and services needing to be inclusive, addressing health inequalities and being responsive to diverse needs of people, and they also recommended that consideration be given to using psychologically informed environments and trauma informed care. The committee also recommended that longer contact times be recognised as a means of supporting the

				stories and experiences, including histories of trauma, allowing for the co-creation of preferred identity; and where moving on is broken down into small and attainable steps. All of these endeavours demonstrate practical approaches to building and developing a PIE. These are challenging areas for staff to work in. Therefore, it is also important to consider how best to support teams in creating and sustaining such environments for service users. Reflective practice and complex case discussion can be seen to support teams in many of these areas (see e.g., Watson et al., 2019). A philosophy of reflective practice underpins PIEs and this study strongly supports this as a practice and a philosophy to support processing emotional aspects of the work, whilst also advocating for the value of complex case discussions and formulations to support staff and inform client work. Clinical psychologists have been identified as "potential leaders in this work" (Heneghan et al., 2014, p. 324). Guidance could refer to clinical psychologists' role in supporting staff teams with interventions such as reflective practice, case consultations etc. While Westaway et al.'s (2017) research reports on a small IPA study, gaining first person accounts from people experiencing chronic and ongoing homelessness is hard to obtain, and therefore, this rare and small but impactful study is of great value. Reference Watson, C., Nolte, L., & Brown, R. (2019). "Building connection against the odds: project	development and sustainment of trusting relationships between frontline health and social care staff and people experiencing homelessness.

				workers relationships with people experiencing homelessness", Housing, Care and Support, 22(2), 129-140, https://doi.org/10.1108/ HCS-10-2018-0030 Westaway, C., Nolte, L., & Brown, R. (2017). "Developing best practice in psychologically informed environments", Housing, Care and Support, 20(1), pp.19-28, https://doi.org/10.1108/HCS-11-2016-0016	
University of Hertfordshire	Guideline	General	General	Creating rules and policies provided professionals and services with control and comfort and a sense of providing structure and support for homeless women, however when homelessness services enforce rigid rules and guidelines often the power and control many women have experienced in violent relationships (including but not limited to domestic abuse) is mirrored within homelessness services, sometimes re-traumatising them and can make it extremely difficult for homeless women to trust professionals (Samsa, 2016). Preliminary findings from my own doctoral thesis show how enforcement of isolation related to Covid-19 policies and procedures were interpreted as oppressive, fear-inducing and creating an additional layer of isolation (both emotional and physical). Opportunities for co-production and participation should be a core part of service delivery so that people experiencing homelessness have an opportunity to inform service design and restructures.	Thank you for sharing this with us. The committee agree about the importance of the issues you raise and they believe that some of the recommendations they made will work to address them, in particular issues around past trauma and isolation. For example, the committee recommended that comprehensive assessments of people's social care and physical and mental health needs should avoid unnecessary and potentially distressing repetition of a history which is already on record and that assessments should include an understanding of the historical context of the person's situation, including past psychological trauma and experience of services. The committee also made several recommendations about the general principles of delivering health and social to people experiencing homelessness, for example being friendly, person-centred, empathetic, non-judgmental and services needing to be inclusive, addressing health inequalities and being responsive to diverse needs of people, and they also recommended that consideration be given to using

					psychologically informed environments and trauma informed care. Specifically on the issue of isolation, the committee recommended that commissioners and service providers be aware that moving to independent accommodation in the community with tenancy responsibilities can be an extremely challenging, stressful and isolating experience for some people and that emotional and practical support should therefore be provided for as long as it is needed.
University of Hertfordshire	Guideline	General	General	Although research included within this feedback (UH doctoral theses) are all relatively small studies, we hope that the importance of first-person accounts of people actually experiencing insecure housing and homelessness informing the guidance speaks for itself on the basis of feedback and findings shared via these comments.	Thank you. The committee share your views about the importance of ensuring the guideline is informed by the expertise of people with lived experience. They would like to reassure you on this issue because the committee included members with lived experience of homelessness and the qualitative evidence review was designed to include data reporting the views and experiences of people with experience of homelessness as well as practitioners in the field. As a result, the recommendations were based on the expertise of committee members with lived experience as well as a wealth of data reporting their views, experiences and insight. Finally, the consultation on the draft guideline involved dedicated work to ensure that the opinions of people with lived experience were gathered and these have been carefully considered during committee discussions and finalising the guideline.

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University of Hertfordshire	Guideline	General	General	Evidence highlights the value of a Clinical Psychologists integrated within homelessness services and across services (Fell & Hewstone, 2015). **References** Fell, B., & Hewstone, M. (2015). Helping people without homes. The Role of Psychologists and Recommendations to Advance Research, Training, Practice and Policy. The Joseph Rowntree Foundation. Accessed on 01.10.19 at: https://www.jrf.org.uk/report/psychologicalperspectives-poverty	Thank you for your comment. The committee agree with you about the valued contribution of clinical psychologists across services to support people experiencing homelessness. They made a specific recommendation that psychologically informed environments and trauma informed care should be considered, particular in the context that people's behaviours and engagement with services can be influenced by traumatic experiences. Furthermore, with recognition of the important role of clinical psychologists in the delivery of Psychologically Informed Environments (PIE) the committee made a research recommendation which specifically states 'clinical psychologist led Psychologically Informed Environments' as the experimental intervention.

University of Hertfordshire	Guideline	6	15	We are concerned that this recommendation may imply that the wording 'psychologically informed approaches should be considered' does not convey the importance of adopting such an approach within homelessness services, specifically in relation to families – and mothers in particular - who find themselves homeless. In addition to experiences of complex trauma, people who experience homelessness may also be affected by substance misuse and other experiences of deep social exclusion, which could already by themselves be seen as traumatic experiences (Fitzpatrick et al., 2011; Bramley et al., 2015). In 2016, the Mental Health Foundation released a report on the importance of psychologically informed environments to care for the mental health of people who have experienced homelessness (Breedvelt, 2016). Staff in shelters, hostels and health services should be aware of individuals' emotional and psychological needs (Breedvelt, 2016; Westaway et al., 2017) and receive support to develop the skills to respond appropriately to these needs (Weston, et al., 2019). Pandemic related social exclusion, existing vulnerabilities and risk factors for safeguarding within families experiencing homelessness have been exacerbated by additional factors introduced by the pandemic (Rosenthel at al., 2020). References Bramley, G., Fitzpatrick, S., Edwards, J., Ford, D., Johnsen, S., Sosenko, F. & Watkins, D. (2015) Hard Edges: mapping severe and multiple	Thank you for this comment. Whilst the committee are in favour of trauma-informed practice or psychologically informed environments, no evidence on the effectiveness of was located. Therefore, there is some uncertainty around this and the committee agreed to make a research recommendation about it so that future research could inform and possibly strengthen future updates of this guideline. The reference you provide for a literature review on psychologically informed environments has been checked (Breedvelt 2016) and none of the studies included in the review meet the inclusion criteria in our evidence reviews.

				disadvantage in England. London: Lankelly Chase Foundation. Breedvelt, J. (February 2016) Psychologically Informed Environments: a literature review. London: Mental Health Foundation and St Mungo's, Broadway Fitzpatrick, Suzanne, Johnsen, Sarah et al. (2 more authors) (2008. Statutory homelessness in England : the experience of families and 16-17 year olds. Research Report. Department for Communities and Local Government. London. Rosenthal, D.M., Ucci, M., Heys, M., Hayward, A., Lakhanpaul, M. (2020). Impacts of COVID-19 on vulnerable children in TA in the UK. The Lancet, 5(5), 241-242. Watson, C.L., Nolte, L. & Brown, R. (2019) Building connections against the odds: Project workers reflect on/consider their relationships with people experiencing homelessness, Housing, Care and Support, 22(2): 129-140, https://doi.org/10.1108/HCS-10-2018-0030 Westaway, C., Nolte, L., & Brown, R. (2017). "Developing best practice in psychologically informed environments", Housing, Care and Support, 20(1), pp.19-28, https://doi.org/10.1108/HCS-11-2016-0016	

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University of Hertfordshire	Guideline	11	3	We are unclear on the term 'disengage' when research shows that services are not currently tailored to support engagement for people experiencing homelessness and staff in services do not always feel supported to facilitate and sustain engagement (see e.g., Watson et al., 2019). Women who are homeless are among the most marginalised groups in our society and their numbers, especially among young women, are increasing (Fabian, 2016). Women experiencing homelessness may 'disengage', but very often the fear of being judged and not living up to the expectations society places on women is a reason why women do not want to seek help and remain 'hidden', yet experience homelessness (and the many adversities that come with it) (Fabian, 2016). Additionally, homeless people are usually stigmatised and blamed for their situation, but women who are homeless carry multiple stigmas and labels such as 'bad mother', which make it difficult to ask for help and can be a very significant barrier for recovery from homelessness (Fabian, 2016). Reference Fabian, D. (2016). Homeless in Europe: Perspectives on female homelessness. FEANTSA. The European Federation of National Organisations Working with the Homeless. Watson, C.L., Nolte, L. & Brown, R. (2019) Building connections against the odds: Project workers reflect on/consider their relationships with people experiencing homelessness,	Thank you for your comment. The wording in this recommendation has been revised to emphasise that services can be difficult to engage with, so not to put any blame on the individual. This recommendation was particularly based on the expert witness testimony that the committee heard around safeguarding issues related to homelessness and the prominence of 'self-neglect' in Safeguarding Adults Reviews. Whilst the committee have avoided using the term self-neglect in the recommendation as it may be perceived as judgmental, this can present as disengagement from services for a variety of reasons but mainly because people find services difficult to engage with because of, as you say, previous experiences, stigma, fear of being judged and so on.

				Housing, Care and Support, 22(2): 129-140, https://doi.org/10.1108/HCS-10-2018-0030	
University of Hertfordshire	Guideline	11	3	Young people - There is evidence that beyond the effect of homeless on societal resources, the experiences of adolescent individuals, and again, mothers in particular, are often silenced (Meadows-Oliver, 2013). Meadows-Oliver (2013) described homeless adolescent mothers' experiences of caring for their children while living in a shelter and highlighted these young women's experiences of homelessness as distressing and isolating. The authors found a role for health professionals to encourage women to remain connected to existing supports and to foster new connections that will help them during their experience. Support provided during the homeless experience can help homeless adolescent mothers gain confidence and enable them to effectively plan for their future (Meadows-Oliver, 2013). Services should be tailored to support lone mothers who are categorised as 'young mothers' as they are likely to be vulnerable to more disadvantage, including economic disadvantage (Pleace et al., 2008), and again, this is important both in relation to their own wellbeing and the wellbeing of their children. References Meadows-Oliver, M. (2009). Adolescent Mothers' Experiences of Caring for Their Children While Homeless Journal of Pediatric Nursing, 24(6).	Thank you for your comment. The committee agrees that there may be various overlapping and intersecting experiences, such as being young, woman and a mother, which will have an impact on the experience they have and their access and engagement with services. The list of examples provided in this recommendation is not aiming to be exhaustive but gives an idea of different groups that may need specific consideration for services and support. Elsewhere in the guideline the recommendations refer to tailoring support according to individual needs and being responsive to people's diversity and inclusion needs.

				Pleace et al (2008). Statutory Homelessness in England: The experience of families and 16-17 year olds. Communities and Local Government	
University of Hertfordshire	Guideline	17	6	We are concerned that the wording within the recommendation gives the impression that traumatic experiences are only historical, whereas the experiences of homelessness itself (and the accompanying social exclusion) can be traumatising. Early findings from my preliminary doctoral thesis (Beadle, ongoing) suggest homeless single mothers experience being homeless as a trauma in itself and responses from services and staff pose a visceral threat to their credibility as a mother and member of society, with potential to negatively impact their mental health and how they seem themselves, which in turn has the potential to negatively impact their own relationship with their child. Additionally, research shows that women who are homeless and who have experienced trauma can be re-traumatised by the power imbalances that exists between women experiencing homelessness and staff within homelessness services. Power differentials within shelters and service agencies between providers and clients must be acknowledged and minimised to create equitable opportunities to overcome housing instability (Benbow, 2019). The guidance could refer to the importance of all services for homeless people, including women and mothers, to be designed and delivered in a way where	Thank you for your comment. The committee do not think the wording in the recommendation you are referring to implies that traumatic experiences are only historical; equally, they can relate to their current situation and experiences of being homeless. The guideline addresses the experience of trauma that many people experiencing homelessness have in several sections of the guideline, including by making recommendations on trauma-informed care and psychologically informed environments, including as part of the assessment of the person's health and social care needs the understanding of the historical context of the person's situation, including past psychological trauma and experience of services and considering involving an advocate to support the person to overcome stigma and previous negative and traumatic experiences. In terms of specific experiences that women may have. The committee has made a recommendation in the Planning and commissioning section about considering services and support specifically addressing the needs of, for example, women. The committee also revised the recommendations elsewhere in the guideline to make it clearer that services and practices should be responsive to people's inclusion and diversity needs, which would

				power differentials in shelters are considered and minimised at all levels of interaction and service delivery. References Benbow et al., (2019) “Until You Hit Rock Bottom There’s No Support”: Contradictory Sources and Systems of Support for Mothers Experiencing Homelessness in Southwestern Ontario. Canadian Journal of Nursing Research, 51(3) 179–190. Beadle, S. (ongoing). Single Mothers’ Experiences of Temporary Accommodation: A Suffolk based study. Current doctoral research, University of Hertfordshire.	include specific needs that women may have. The committee also revised the recommendation in the Outreach services section about providing outreach to include support for people who feel uncomfortable using male-dominated services.

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University of Hertfordshire	Guideline	41	3	**Comment – guidelines could further detail and acknowledge the differing needs for those experiencing homelessness in rural areas.** The guidance does not appear to refer to rural homelessness. The scope of the guidance could be expanded and language amended to specifically address and acknowledge the disparity between people experiencing homelessness in rural areas in comparison to experiences of urban homelessness. Housing provision and the way that homelessness is defined, detected, provided for, experienced and responded to differ between rural and urban areas. There are important differences in funding for housing and provision of housing services in rural and urban areas. It can be particularly difficult to prevent and relieve homelessness in rural areas (Suffolk County Council, 2018). With four-fifths of homelessness cases found in urban areas, rural homelessness often remains neglected and misunderstood (IPPR, 2017). Causes of rural homelessness are often similar to urban areas such as the ending of an assured shorthold tenancy or family breakdown. However, rural areas can experience extra challenges in their housing markets which exacerbate these struggles (IPPR, 2017). Due to this lack of services for people experiencing homelessness in rural areas, many people who are homeless in rural communities rely more on informal networks such as couch surfing with family and friends or look to neighbours for help	Thank you for your comment. The committee recognises that homelessness in rural areas may present differently or may be more 'hidden' or may be less common than in big urban areas. The guideline covers this by recommending a local homelessness health and social care needs assessment which should quantify and characterise the population experiencing homelessness or at risk of homelessness, and identify trends and specific needs. The planning and designing of services would then be informed by this. The differing levels of homelessness is also covered by either recommending a homelessness MDT or a designated homelessness lead in mainstream services depending on scale of the issue in the local area. This guideline's focus is on improving access and engagement with health and social care and is not focusing on housing provision or allocation as such. The preliminary research findings you mention sound interesting and may inform the update of this guideline in the future if published.

				(Schiff & Turner, 2014), Therefore homelessness may 'look' different in rural areas. Families are more likely to have encountered 'hidden homelessness' before entering services in rural areas; this could be acknowledged within the guidance. Early findings from my own preliminary doctoral thesis (Beadle, ongoing) show that single mothers experiencing homelessness in a rural county in the UK (Suffolk) perceived intense stigma from members of the community within their rural local villages, which created feelings of shame and unworthiness, and which impacted their mental health. Additionally, single mothers expressed frustration at being housed in rural areas where they did not have access to their own car and public transport was limited, particularly during the pandemic and lockdowns.	
University of Hertfordshire	Guideline	53	20	'Mental Health services amending their eligibility criteria': Can this be worded more specifically so that the expectation of services is clearer? The evidence shows that people experiencing homelessness, including mothers, experience many barriers to accessing services, including physical health and mental health services. The guidance should explicitly highlight the harms that people experiencing homelessness can encounter when being told that they are not eligible for psychological therapy and/or support from mental health services because their housing is seen as 'unstable' or 'in crisis'.	Thank you for your comment. The committee have revised wording of the recommendation which the text you're commenting on is referring to. The committee have highlighted the consequences that not accessing appropriate health and social care can have in the various parts of the rationale and impact sections and furthermore in the committee's discussion of the evidence sections in the evidence reports.

University of Hertfordshire	Guideline	69	4	**Comment – guidelines should further detail and acknowledge the needs for mothers and single mothers experiencing homelessness** The evidence base supports a need for gender informed homelessness services. Women globally are being disproportionately affected through the health, social and economic consequences of the pandemic (Matheson, Kidd & Came, 2021). A recent report, where forty single parents were interviewed, found that working single parents faced unique challenges created by the COVID-19 crisis that the government needs to address (Gingerbread, 2020). Family homelessness has increased substantially over the last 18 months as a result of redundancies and the pressures of childcare during lockdowns for single mothers and parents who were already facing financial disadvantages. Many families accepted as homeless are young, headed by lone women parents, and either out of work or in part-time work (Pleace et al., 2008). Single mothers who are experiencing homelessness can experience marginalisation by healthcare providers, which can affect their emotional wellbeing. Women who experience homelessness face isolation and the stigma associated with homelessness negativities affect them on a day-to-day basis (Joomun, 2019). Bretherton's (2020) longitudinal study added to the recognition that gender is associated with differentiated trajectories through homelessness. The associations between housing precarity, linked to income precarity, and homelessness are being increasingly recognised and in the	Thank you for your suggestions. The committee did not feel that the evidence reviews underpinning the guideline provided the basis on which to make such detailed recommendations about the experience of women and mothers experiencing homelessness. They did review some related data about pregnant women experiencing homelessness, including accounts of stigma and a lack of information. They then also signposted from this guideline to another NICE guideline for the provision of services to support pregnant women with complex social factors (including homelessness). The reason for this was because vital issues around service provision are addressed and recommendations made in far more detail than the committee felt they had the basis to make in this guideline. In considering your comment the committee also wanted to highlight that the mental health needs of people experiencing homelessness are comprehensively addressed, albeit not exclusively in connection with mothers. While they were finalising the guideline and in response to a number of other stakeholder comments, the committee also agreed to expand on a recommendation about the conduct of comprehensive assessments of physical and mental health by stating that this should involve assessment and consideration of whether the person experiencing homelessness has children or other dependents, which would ensure that services are arranged and needs are met accordingly. The committee also wanted to highlight that one study included in the qualitative

				context of evidence that housing exclusion, alongside poverty, follows a gendered pattern in much of Europe, with women being more likely to be in situations of disadvantage (Bretherton, 2020). Homeless mothers often experience negative attitudes and marginalisation by healthcare providers and it has been shown to affect their emotional wellbeing (Joomun, 2019). The authors found that these mothers experienced barriers to accessing healthcare services, including appointment notification, when frequently mobile, and also difficulty in accessing repeat prescriptions (Joomun, 2019). Single mothers experiencing homelessness identified the loss of home and their possessions and their identity, which was a new finding within that study. The authors found that this contributed to their feelings of loss and the grief experienced by this sense of loss as supported by the theory of grief and grieving (Joomun, 2019). Mothers experiencing homelessness tend to be a relatively disadvantaged group with respect to their health and access to social support, and many have experienced domestic violence (Pleace et al., 2008). These authors' findings reinforced the 'gendered' nature of statutory homelessness, in that it is experienced mainly by lone mothers and their children. Narratives demonstrate that mothers experiencing homelessness often have no sense of security and constantly worry about what is going to happen next. Many feel pessimistic about their prospects of securing stable housing	review aimed to get a better understanding of homeless mother's perceptions of service providers, which contributed to review findings about fear, apprehension and a lack of trust leading to difficulties engaging with services and the importance of the quality of the relationship between the person and the provider. These findings supported a number of recommendations throughout the guideline, which were designed to tackle discrimination, stigma and lack of empowerment experienced by the homeless population more generally.

				and many express feelings of abandonment by the homeless service system (Mayock & Sheridan, 2016). Homelessness services should incorporate gender informed approaches that acknowledge the importance of intersectionality and the interaction of multiple identities and experiences of exclusion (Davis, 2008, cited in Bretherton, 2017). The authors' findings are important for psychologists, social housing communities, and policymakers, particularly in on-going changes to the housing system (Matheson, Kidd & Came, 2021). Ecker, Aubry, & Sylvestre's (2017) review demonstrate that homeless LGBTQ adults have unique physical and mental health challenges, largely concerning HIV and substance use. Transgender and gender non-conforming adults who experience homelessness encounter several challenges in the homelessness system, particularly in regard to safety and gender-affirming supports. The authors provide recommendations for practical implications for support. This guidance should consider and refer to how services will be structured to children and/or parents who are part of family systems where the child and/or parent identifies as LGBTQ, due to the evidence of further harm to their mental health as a result of multi-layered marginalisation. The guidance should also acknowledge and refer to how services may support families that identify as LGBTQ due to	

				higher rates of exclusion from society and support networks, both within housing services (from staff and other tenants within housing) and external services and within their own personal networks, which can further exacerbate mental health difficulties. Early findings from my doctoral thesis (Beadle, ongoing) that explores single mothers' experiences of living in temporary accommodation in Suffolk highlight single mothers' sense of vulnerability and lack of safety as well as sense of being othered when housed in temporary accommodation that provides accommodation for lone mothers and their children alongside single adults and males (without children). Single mothers requested accommodation services that were tailored for and specific to lone mothers and their children and/or for families and parents only, sharing that they would have felt less anxious, less depressed, safer and less worried about the safety and welfare of their own children. References Bretherton, J. (2017). Reconsidering gender in homelessness. European Journal of Homelessness, 11(1). Bretherton, J. (2020). Women's Experiences of Homelessness : A Longitudinal Study. Social Policy and Society Ecker, J., Aubry, T., & Sylvestre, J. (2017). A Review of the Literature on LGBTQ Adults Who Experience Homelessness. Journal of	

				Homosexuality, 66(1). DOI:10.1080/00918369.2017.1413277 Gingerbread (2020). Sharing without caring. Single parents' journey through the Covid-19 crisis. Joomun (2019). Women with Dependent Children who are Homeless and living in Temporary Accommodation: An Interpretative Phenomenological Analysis of their Experiences of Loss and the Barriers to Accessing Healthcare Services. Accessed at: http://orca.cf.ac.uk/130082/1/Lorraine%20Joomun_Final%20Thesis.pdf Matheson,A.;Kidd,J.; Came, H. Women (2021). Patriarchy and Health Inequalities: The Urgent Need to Reorient Our Systems. Int. J. Environ. Res. Public Health, 18, 4472. https://doi.org/10.3390/ ijerph18094472 Mayock, P. and Bretherton, J. (Eds.) (2016) Women's Homelessness in Europe. London: Palgrave Macmillan. Meadows-Oliver, M. (2009). Adolescent Mothers' Experiences of Caring for Their Children While Homeless Journal of Pediatric Nursing, 24(6). Pleace et al (2008). Statutory Homelessness in England: The experience of families and 16-17 year olds. Communities and Local Government	

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University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	General		Q1 **Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why**. Peer support must be recognised for its beneficial impact in its own right, in addition to those workers being seen to assist existing services. In a systematic 'state of the art' review of the literature on peer support for people experiencing homelessness and problem substance use we found these benefits clearly reflected. However, there are common pitfalls in service structures that leave peer support workers vulnerable that must be addressed, specifically, peer support workers must be respected, valued and compensated for their work at a level commensurate with what they contribute (Miler et al., 2020). This requires systemic and organisational culture to be inclusive, aware of and committed to peer for a support in its true sense. These findings were reflected in a feasibility and acceptability study involving embedding peer support in services for people experiencing homelessness and problem substance use (in press). Peer support workers demonstrated considerable benefit but were exposed to challenges from the service providers in which they were embedded, stemming from an unfamiliarity with the true ethos of peer support. We have applied for funding for a full randomised controlled trial (RCT) of this work. The protocol for the feasibility study is available (Parkes et al., 2019).	Thank you for sharing the protocol for the feasibility study on peer support and other references. The committee agrees that involving peers in delivering care or support and co-designing services is efficient and beneficial, not only for the services and the people experiencing homelessness but also for the peers themselves. Committee members with lived experience of homelessness highlighted the value of involving people with lived experience in developing policies, procedures and protocols. As a result, there is a whole section of recommendations on the 'role of peers', and also specifically recommendations on supporting peers to deliver services effectively and maintain their wellbeing and development by providing, e.g. training, supervision and governance structures, psychosocial support, professional development, including access to further training and employment opportunities. The committee refers to drug and alcohol issues throughout the guideline and integrated care models that should consider drug and alcohol recovery needs. A recommendation on outreach services also states that outreach should also provide preventive health opportunities such as harm minimisation. The guideline also cross-referred to existing NICE guidance on coexisting severe mental illness and substance misuse. There are also recommendations on person-centred case management and acknowledge that there is a need for a range of accommodation types suitable for the varied

				Commissioning of harm reduction services to tackle problem substance use among people experiencing homelessness requires recognition that harm reduction is an important option that has benefits in its own right as well as a step towards abstinence. There can be unhelpful media discourse that fuels scepticism and opposition towards the approach, that must be robustly challenged and resisted. 'Buy in' is needed form internal and external stakeholders (Parkes et al., 2021). This is particularly important for alcohol harm reduction, which is severely lacking for people experiencing homelessness and alcohol use disorders. Our research on managed alcohol programmes (MAPs) has highlighted the need for alcohol harm reduction due to the high potential for harm (Carver et al., 2021). Our research also highlighted the key considerations to inform the implementation of MAPs: the importance of individualized care; provision of alcohol; holistic care and a focus on well-being; types of settings and service models; staffing; and autonomy and rules (Parkes et al., 2021). In another systematic review of reviews, we concluded that evidence of interventions for people experiencing homelessness and problem drug use is limited but harm reduction, case management and housing interventions may be effective (Miler et al., 2021). We note that there is no specific reference to the needs of children and young people. Children who are looked after by the state (children in	needs of people experiencing homelessness. Your comment will be passed to the NICE team, which plans implementation support. The population covered were people aged 16 years or older who are experiencing homelessness, so children were outside the scope, and young people aged over 16 years are covered by this guidance. The committee highlighted young people as a specific group that may need specific services and support in a recommendation within the section Planning and commissioning. There is also existing NICE guidance on looked-after children and young people.

				care) are more vulnerable to homelessness, with care experienced people making up 25% of the homeless population (Reeve and Batty 2011). Children in state care are four times more likely to suffer poor health 30 years later than those who grew up with their parents and are particularly vulnerable to premature death, with high rates of death by suicide, and drug and alcohol related causes (Murray et al 2020). Carver, H., Parkes, T., Browne, T., Matheson, C., & Pauly, B. (2020) Investigating the need for alcohol harm reduction and Managed Alcohol Programmes for people experiencing homelessness and alcohol use disorders in Scotland. Drug and Alcohol Review, 40 (2) 220-230. https://doi.org/10.1111/dar.13178 Miler, J., Carver, H., Masterton, W., Parkes, T., Maden, M., Jones, L., & Sumnall, H. (2021) What treatment and services are effective for people who are homeless and use drugs? A systematic 'review of reviews'. PLOS ONE, 16 (7) e0254729. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0254729 Miler J, Carver H, Foster R & Parkes T (2020) Provision of peer support at the intersection of homelessness and problem substance use services: a systematic 'state of the art' review. BMC Public Health, 20, Art. No.: 641. https://doi.org/10.1186/s12889-020-8407-4 Parkes T, Matheson C, Carver H, Budd J, Liddell	

				D, Wallace J, Pauly B, Fotopoulou M, Burley A, Anderson I, MacLennan G & Foster R (2019) Supporting Harm Reduction through Peer Support (SHARPS): testing the feasibility and acceptability of a peer-delivered, relational intervention for people with problem substance use who are homeless, to improve health outcomes, quality of life and social functioning and reduce harms: study protocol. Pilot and Feasibility Studies, 5 (1), Art. No.: 64. https://doi.org/10.1186/s40814-019-0447-0 Parkes T, Carver H, Matheson C, Pauly B, McCulloch P, Browne T, Masterton W & Booth H (2021) Managed alcohol programmes: Scoping the potential of a novel intervention to help prevent infection (COVID-19) for people experiencing alcohol dependency and homelessness - Staff [COVID-19 MAPs Study Briefing - Staff]. Chief Scientist Office. University of Stirling. Parkes, T., Carver, H., Matheson, C., Browne, T., & Pauly, B. (2021) 'It's like a safety haven': Considerations for the implementation of managed alcohol programs in Scotland. Drugs: Education, Prevention and Policy. https://www.tandfonline.com/doi/full/10.1080/09687637.2021.1945536 Reeve, K & Batty, E. The hidden truth about homelessness: Experiences of single homeless in England. Crisis. Available online the_hidden_truth_about_homelessness_es.pdf	

				(crisis.org.uk) accessed 31st October 2021. Murray, E., et al. Non-parental care in childhood and health up to 30 years later: ONS Longitudinal Study 1971–2011, European Journal of Public Health, Volume 30, Issue 6, December 2020, Pages 1121–1127, https://doi.org/10.1093/eurpub/ckaa113	
University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	General		**Q2 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.** Our in-depth qualitative work with one service provider (in Scotland) demonstrated that existing homelessness services had to make significant adaptations in response to the COVID-19 pandemic to balance changing needs resulting from isolation, including to mental health and substance use, with delivering support within the restrictions in face-to-face contact. However, the emergency policy and practice changes also acted to remove barriers to partnership working and offering harm reduction approaches (Parkes et al 2021a, b). Q2 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	Thank you for your comments and references. The guideline aims to encourage integrated health and care for people experiencing homelessness. There are many recommendations on integrated care which should address your comment on partnership working. Even though there are not specific recommendations about managed alcohol programmes, a recommendation on outreach states that provision of preventative health opportunities such as harm minimisation and drug and alcohol treatment services should be provided through outreach. The committee also refers to drug and alcohol issues through the guideline and integrated care models that should consider drug and alcohol recovery needs. The guideline also cross-refers to existing NICE guidance on coexisting severe mental illness and substance misuse.

				guideline for publication. Our in-depth qualitative work with one service provider (in Scotland) demonstrated that existing homelessness services had to make significant adaptations in response to the COVID-19 pandemic to balance changing needs resulting from isolation, including to mental health and substance use, with delivering support within the restrictions in face-to-face contact. However, the emergency policy and practice changes also acted to remove barriers to partnership working and offering harm reduction approaches (Parkes et al 2021a, b). One such approach is Managed Alcohol Programmes (MAPs) (Parkes et al 2021c) which were considered an acceptable and feasible way to protect people experiencing homelessness from harm during the COVID-19 pandemic, by both people with lived/living experience and service providers, although no MAPs were formally established at this time. MAPs have potential to address unmet needs and reach people who are traditionally unable to access or actively excluded from support, and this receptiveness prompted by necessity of COVID-19 can be capitalised on in future. Parkes T, Carver H, Masterton W, Falzon D, Dumbrell J, Grant S & Wilson I (2021a) 'They already operated like it was a crisis, because it always has been a crisis': a qualitative exploration of the response of one homeless	

				service in Scotland to the COVID-19 pandemic. Harm Reduction Journal, 18, Art. No.: 26. https://doi.org/10.1186/s12954-021-00472-w Parkes T, Carver H, Masterton W, Falzon D, Dumbrell J, Grant S & Wilson I (2021b) "You know, we can change the services to suit the circumstances of what is happening in the world": a rapid case study of the COVID-19 response across city centre homelessness and health services in Edinburgh, Scotland. Harm Reduction Journal, 18, Art. No.: 64. https://doi.org/10.1186/s12954-021-00508-1 Parkes T, Carver H, Matheson C, Pauly B, McCulloch P, Browne T, Masterton W & Booth H (2021c) Managed alcohol programmes: Scoping the potential of a novel intervention to help prevent infection (COVID-19) for people experiencing alcohol dependency and homelessness - Staff [COVID-19 MAPs Study Briefing - Staff]. Chief Scientist Office. University of Stirling.	
University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	1		**Text box** This refers to health professionals and social care practitioners. For parity – it should either apply to practitioners in both health and social care, or professionals in both. We suggest practitioners as there are several people who work in health and social care who do not hold a professional qualification.	Thank you for your comment, the suggested change has been made.

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University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	9	5	In planning and commissioning services, it would be beneficial to include local prison and probation services, as there are high rates of justice system involvement among people experiencing homelessness. Similarly, given the specific issues relevant to children and young people, youth and education services are important to include. It is important to consider harm reduction approaches when considering integration with drug/alcohol services, which are considered important by people using services. Participants considered treatment (harm reduction and abstinence based) effective when it provided a facilitative service environment; compassionate and non-judgemental support; time; choices; and opportunities to (re)learn how to live. Interventions that were of longer duration and offered stability to service users were valued, especially by women. In this review we developed a new model, highlighting critical components of effective substance use treatment from the service user's perspective, including a service context of good relationships, with person-centred care and an understanding of the complexity of people's lives (Carver et al. 2020).	Thank you for your comment. The suggested addition has been made, stressing the importance to involve commissioners from other sectors, e.g. criminal justice and domestic abuse, as needed. Also, various health and social care and housing services identified and recommended by this guideline include services relevant to young people. The committee also highlighted young people in a recommendation about considering services and support for groups with specific needs. However, children are outside the scope of this guideline. Even though specific recommendations have not been made on harm reduction interventions as such, the committee recommends outreach services to provide preventative health opportunities such as harm minimisation and drug and alcohol treatments. References to assessing and responding to drug and alcohol treatment needs and integrated models of care in relation to drug or alcohol use have been made in various parts of the guideline. The committee also make many recommendations that cover the principles you identify as important, e.g. compassionate and non-judgmental support, person-centred care, and longer contact times.

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University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	10	21	Long term contracts are invaluable in ensuring service providers have a sense of security and can focus on appropriate relational care that is similarly long term in nature.	Thank you for your comment. Yes, there are likely benefits of long-term contracts and the committee have revised the wording of the recommendation to emphasise this but the committee recognises that there needs to be flexibility to adapt to changing local needs and this has been discussed in the rationale section.
University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	12	18	It is positive to see recognition of a range of professions required to deliver holistic wrap-around support. Examples are given for mental health and psychological needs, and physical rehabilitation needs. It is positive to see Allied Health Professions noted in physical rehabilitation. A potential risk is that people think that this is the only aspect a particular profession can address. For example occupational therapists address mental wellbeing and the needs of people experiencing gender based violence (Thomas (2011). Thomas, Y., Gray, M., & McGinty, S. (2011) A Systematic Review of Occupational Therapy Interventions With Homeless People, Occupational Therapy In Health Care, 25:1, 38- 53, DOI: 10.3109/07380577.2010.528554	Thank you for your support for this recommendation. The committee understand that different health and social care professionals contribute to addressing a range of needs and the ones cited in this recommendation are simply intended as illustrative examples. They therefore agreed not to change this recommendation in the way you suggest.
University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	13	2	Who are allied social care professionals? Allied Health Professional is a recognised title including 14 professions. However, allied social care professionals is not a recognisable title. It is unclear if you mean allied health professionals working in social care.	Thank you for your comment. This term has been removed as it is not widely recognised and the list has also otherwise been revised for clarity.

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University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	13	4	Who are charity sector professionals –unclear if you mean Allied Health Professionals working in the charity sector?	Thank you for your comment. This bullet point simply refers to practitioners supporting the health, care and housing needs of people experiencing homelessness. Specifically, these are people employed in the voluntary or charity sector.

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University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	14	4	The first bullet point of peer work immediately turns to engaging people with practitioners, and most points refer to a peer assisting health and social care service objectives. Whilst this is a benefit of the work, peer support is important in its own right for enabling someone to establish a sense of trust, self-identity and wellbeing, independent of linking someone to professional care. We suggest the benefit of peer support in its own right is highlighted first. We are strong advocates for the involvement of peers (those with lived experience of a particular problem/condition/issue) as a way of facilitating better engagement with those who are homeless in services. Our research (Miler et al. 2020) has shown that peer support interventions were associated with positive outcomes in terms of substance use (alcohol, tobacco and/or drugs), housing status, employment, physical health and quality of life. The qualitative studies included in the review highlighted the positive impacts on service users and peers, for example in terms of a sense of community and better access to treatment. Several challenges were identified in terms of vulnerability; authenticity; boundaries; stigma; and peers having their involvement valued. In another review, the involvement of peers in substance use treatment was valued by people experiencing homelessness and problem substance use (Carver et al., 2020). Peers should continue to be involved/supported to become involved in services accessed by people experiencing homelessness, and their	Thank you for your comment. The committee agree with you about the benefits offered by peer support and this was backed up by the evidence they reviewed and demonstrated in the recommendations they made both about the contribution of peers and the support that should be provided to enable their active role in this context. Although the draft recommendation did not say anything specifically about compensating peers, the committee have since agreed that organisations may need to review their recruitment policies and they revised the recommendations to include reference to "inclusive employment opportunities" as a means of supporting peers to deliver services. You are right to highlight that the recommendations focus on the role of peers in supporting access to health and social care but since this is the crux of the scope the committee believe this is the right approach. However finally, just to highlight that they made a recommendation for future research into the effectiveness and cost-effectiveness of longer contact times with health and social care practitioners and on the basis of other stakeholder comments they added that peers ought to be included as a potential intervention such that the effectiveness of longer contact times with peers could also be the subject of this research.

				contributions should be valued, well supported and compensated. While more research is required regarding peer-delivered interventions, it is likely that the involvement of peers in integrated healthcare services would be beneficial. Carver, Miler, Ring & Parkes (2020) What constitutes effective problematic substance use treatment from the perspective of people who are homeless? A systematic review and meta-ethnography. Harm Reduction Journal, 17, Art.no. 10. Miler, Carver, Foster & Parkes (2020) Provision of peer support at the intersection of homelessness and problem substance use services: A systematic 'state of the art' review. BMC Public Health, 20, Art.no. 641. Parkes et al. (2019) Supporting harm reduction through peer support (SHARPS): Testing the feasibility and acceptability of a peer-delivered, relational intervention for people with problem substance use who are homeless, to improve health outcomes, quality of life and social functioning and reduce harms: Study protocol. Pilot and Feasibility Studies, 5, Art.no. 64.	

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University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	14	18	Peers should not only be involved in data collection, but also analysis, interpretation, and dissemination. They must be employed on stable contracts and appropriately paid at a minimum of £25 per hour as per NIHR involvement guidelines. Payment guidance for researchers and professionals (nihr.ac.uk)	Thank you for your comment. The committee agree with your point and have amended this recommendation so it now refers to involvement in 'participatory research' as well as data collection, although they did not feel it was necessary to spell out every stage in the research process. They also agree that organisations may need to review their recruitment policies so they revised the recommendations to include reference to "inclusive employment opportunities" to stress the importance of this.
University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	15	16	In considering one stop shops, it would be beneficial to consider health and social care inputting into services that already exist rather than setting up and leading new services.	Thank you for your comment. The recommendation does not imply new services would have to be set up, although in some cases this might be needed. This would largely be based on the local homelessness health and social care needs assessment which should "assess the quality and capacity of existing mainstream and specialist service provision to inform the need for service development and investment", as recommended in the Planning and commissioning section.
University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	16	22	Difficult sentence	Thank you for your comment, the wording has been revised slightly and hopefully it is now clearer.

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University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	18	6	This statement asks for *consideration* of making an outreach team multidisciplinary. This appears to contradict earlier statements advocating multidisciplinary.	Thank you for your comment. The recommendations have been revised in this section and the multidisciplinary nature of outreach has now been strengthened by referring to “multidisciplinary outreach” in the first recommendation of this section.
University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	19	3	In assessment of people’s needs, leading with identifying risk of harm seems stigmatising. It would be more person centred to start with assessment of their health and social needs.	Thank you for your comment. The order of the recommendations was carefully considered. The first recommendation of this section is emphasising the duty of recognising immediate risk of harm to self or others which in the committee's experience is a relevant consideration for any health or social care practitioner encountering people experiencing homelessness who can be in particularly vulnerable and at-risk situations. This obviously does not apply to everyone but in the committee's experience, immediate risk of harm is not always recognised to the same degree as in the general population. There are then recommendations on a comprehensive assessment of their health and social care needs.
University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	19	12	It would be helpful to define psychological trauma. This term is often used without clarity about what it is and what it isn’t.	Thank you for your comment. The committee believe the term to be generally widely understood and did not want to apply limits by imposing a definition.

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University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	21	4	When considering discharge from hospital Cornes et al (2021) concluded that "Specialist homeless hospital discharge schemes employing multidisciplinary discharge co-ordination and 'step-down' intermediate care were more effective and cost-effective than standard care. Specialist care was shown to reduce delayed transfers of care. Accident and emergency visits were also 18% lower among homeless patients discharged at a site with a step-down service than at those without. However, there was an impact on the effectiveness of the schemes when they were underfunded or when there was a shortage of permanent supportive housing and longer-term care and support. In these contexts, it remained (tacitly) accepted practice (across both standard and specialist care sites) to discharge homeless patients to the streets, rather than delay their transfer." Cornes, M et al. (2021). Improving care transfers for homeless patients after hospital discharge: a realist evaluation (nihr.ac.uk)	Thank you for highlighting this, which the committee think is addressed by the recommendations to support people experiencing homelessness through transitions between settings (including leaving hospital). They also made a specific recommendation about using intermediate care in this context.

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University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	23	7	This refers to the social worker leading if there is one on the multidisciplinary team. It would seem that if there are to be integrated health and social care, a social worker should be on every team.	Thank you for raising this. The committee considered your point and agreed that whilst having a social worker on a multidisciplinary team is common, it is not universal. Unfortunately, the evidence reviews for this guideline did not locate specific research to demonstrate the value of social work involvement in such teams, and since there could be significant resource implications of recommending this routinely happens, NICE cannot make a recommendation to this effect. Please note however that the recommendation to which you refer has been slightly amended and now starts 'Where a social worker is embedded...' which the committee felt made it sound a little more like an expectation than an exception to the rule.
University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	25	12	Trauma informed care is a much used term that can often be used without engaging with the structural and organisational changes required to enable staff to work safely in this way. It has also been critiqued by some for being disempowering in its focus on negative experiences. It could be coupled with approaches that capitalise on peoples' strengths, such as asset based approaches Evidence for strengths and asset-based outcomes | Quick guides to social care topics | Social care | NICE Communities | About | NICE	Thank you for your suggestion. The committee included a definition of trauma informed care in the 'terms used in this guideline', so it should be clear how it is being used in this context. Also, the term has only been used in the context of 'consider' recommendations, which denote a lack of strong enough evidence for the committee to make firmer recommendations.
University of Stirling, Salvation Army Centre for Addictions Services and Research	Guideline	30	13	There are significant gaps in evidence on a range of elements, and we welcome the committee recommendations. We comment on each question followed by comment on what is not included as a recommendation.	Thank you for your comment and the key points that have been answered here, following the same structure as your response. Q1. The rationale for specifying that the experimental intervention in the research

				Q1 We question why, given the focus on multidisciplinary practices, the first recommendation focuses on a specific profession. This has potential to heighten professional siloes rather than integration. As psychologically informed environments can be and are 'led' by a range of people including peers (and indeed other psychologists -forensic, educational), the first question could be more helpfully constructed in a profession neutral way. For example, how effective are PIEs for people experiencing homelessness (for specific valued outcomes)? Secondary questions could include are PIEs cost-effective, and does leadership by different professions and non-professionals make a difference to acceptability and effectiveness? Q2 We would like to see this include an investigation of the structural barriers to long term commissioning, and the addition of research to understand how these can be removed. The COVID-19 pandemic demonstrated that significant achievements could be made when legislative and policy restrictions were suspended. Q3 It is unclear if this is focused on consultations being longer (e.g. longer with a GP) or considering longer-term support (months and years). Both are important to investigate Given the repeated emphasis on peer	recommendation on PIE should specifically be 'clinical psychology led' is largely to do with the importance that the committee place on the fidelity of the intervention under investigation. They are aware that other similar models purporting to be "PIE" do exist but do not necessarily involve clinical psychologists and when this is the case, the model cannot be legitimately labelled "PIE" because of the intrinsic contribution of clinical psychology, which covers all aspects of the psychologically informed environment. The committee felt that since they are recommending future research on PIE, they should ensure this is clinical psychology led because otherwise it will not legitimately be PIE and it is this high fidelity PIE for which the committee wish to generate evidence of effectiveness in order to provide the basis for firmer practice recommendations in future updates of this guideline. Q2. The committee confirm that structural issues relating to commissioning would be within the scope of the research recommendation as it was originally drafted. This may be clearer in the full explanation of the research recommendation, underpinning rationale and PICO, which can be found in appendix K of the quantitative evidence review A&B. Q3. The focus of this research recommendation is longer term contact times. On the basis of their own expertise and some qualitative evidence, the committee recognise the potential for longer contact times to develop and sustain trusting relationships between health and social care

				involvement, which we support, it would also be beneficial to consider prioritising research into the effectiveness of peer support for people who are homeless (on achieving specific valued outcomes). This is a very valuable approach that we support, although evidence that it improves outcomes is sparse. We have recently conducted a NIHR-funded feasibility and acceptability study for a Randomised Controlled Trial (RCT) of peer navigators in services for people experiencing homelessness and problem substance use, which we are developing into a full RCT. The protocol for the feasibility study is available (Parkes et al 2019). It is also key to consider the effectiveness of peer involvement in service design if this is to be advocated, and how the true ethos of peer support is sustained given the challenges experienced by peer workers in services for people experiencing homelessness or other marginalised identities. Parkes et al. (2019) Supporting harm reduction through peer support (SHARPS): Testing the feasibility and acceptability of a peer-delivered, relational intervention for people with problem substance use who are homeless, to improve health outcomes, quality of life and social functioning and reduce harms: Study protocol. Pilot and Feasibility Studies, 5, Art.no. 64.	practitioners and people experiencing homelessness. However on this basis they were only able to make a relatively weak recommendation on this issue so they prioritised future research on the effectiveness and cost effectiveness of longer health and social care contacts for people experiencing homelessness. Their intention is that positive findings will provide the basis for strong future recommendations for this to be a routine part of health and social care support for people experiencing homelessness. Finally, in relation to your point about peer support, the committee agree with your suggestion and have added 'peer support' to the list of professionals to be included in the research recommendation about longer contact times.