Public Document Pack

Health and Wellbeing Board

Date: **FRIDAY, 11 JULY 2025**

Time: **11.00 am**

Venue: **COMMITTEE ROOMS - 2ND FLOOR WEST WING, GUILDHALL**

Members:

Deputy Helen Fentimen OBE JP, Court of Common Council (Chair)
Sarah Gillinson, Court of Common Council (Deputy Chair)
Gail Beer, Healthwatch
Matthew Bell, Policy and Resources Committee
Dr. Stephanie Coughlin, Homerton Healthcare NHS Foundation Trust (External Member)
Simon Cribbens, Safer City Partnership
David Curran, St Bartholomew's Hospital (External Member)
Deputy Marianne Fredericks, Port Health and Environmental Services Committee
Judith Finlay, Executive Director, Community and Children's Services
Jed Francique, Borough Director for City & Hackney, ELFT (External Member)
Dr. Sandra Husbands, Director of Public Health
Gavin Stedman, Port Health and Public Protection Director
Tony de Wilde, City of London Police
Deputy Ceri Wilkins, Court of Common Council
Amy Wilkinson, City and Hackney Place Based Partnership and North East London Integrated Care Board

Enquiries: **Emmanuel.Ross@cityoflondon.gov.uk - Agenda Planning**
rhys.campbell@cityoflondon.gov.uk - Governance Officer/Clerk to the Board

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Ian Thomas CBE
Town Clerk and Chief Executive

AGENDA

NB: Certain items presented for information have been marked * and will be taken without discussion, unless the Committee Clerk has been informed that a Member has questions or comments prior to the start of the meeting. These for information items have been collated into a supplementary agenda pack and circulated separately.

Part 1 - Public Reports

1. **APOLOGIES FOR ABSENCE**

2. **DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

3. **MINUTES**

   To agree the public minutes and non-public summary of the previous meeting held on 9 May 2025.

   For Decision
   (Pages 5 - 12)

4. **ADULT ADHD SERVICE UPDATE**

   Report of the City and Hackney ADHD Service and Autism Service.

   For Information
   (Pages 13 - 26)

5. **WATER STRESS AND HEALTH - OPPORTUNITIES TO COLLABORATE BETWEEN PARTNERS**

   Joint report of the Director of Public Health and The Executive Director, Environment.

   For Decision
   (Pages 27 - 36)

6. **MATCH PROJECT ON EMBEDDING HEALTH EQUITY**

   Report of the City and Hackney Director of Public Health.

   For Information
   (Pages 37 - 78)

7. **MEETING HEALTH NEEDS FOR PEOPLE ROUGH SLEEPING IN THE CITY OF LONDON**

Report of The Director of Community & Children's Services

For Information
(Pages 79 - 150)

8. **HEALTHWATCH CITY OF LONDON PROGRESS REPORT**

Report of Healthwatch City of London

For Information
(Pages 151 - 158)

9. **SAVING LIVES WITH FIRST AID INTERVENTIONS**

Joint report of the Director of Public Health and Director of Community and Children's Services

For Information
(Pages 159 - 164)

10. *** ADULT SOCIAL CARE STRATEGY 2025-29**

Report of The Director of Community and Children's Services.

For Information

11. ***ADULT SOCIAL CARE SELF-EVALUATION FRAMEWORK 2024-5**

Report of The Director of Community and Children's Services.

For Information

12. ***COMMERCIAL ENVIRONMENTAL HEALTH SERVICE PLAN 2025-26**

Report of The Executive Director, Environment.

For Information

13. ***PORT HEALTH FOOD SAFETY ENFORCEMENT PLAN AND PORT HEALTH SERVICE PLAN 2025/26**

Report of the Executive Director, Environment Department.

For Information

14. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**

15. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

16. **EXCLUSION OF PUBLIC**

MOTION - That under Section 100A(4) of the Local Government Act 1972, the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A of the Local Government Act.

For Decision

Part 2 - Non Public Reports

17. **NON PUBLIC MINUTES**

To agree the non-public minutes of the previous meeting held on 9 May 2025 as a correct record.

For Decision
(Pages 165 - 166)

18. **NON PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**

19. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE BOARD AGREES SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

HEALTH AND WELLBEING BOARD

Friday, 9 May 2025

Minutes of the meeting of the Health and Wellbeing Board held at Committee Rooms - 2nd Floor West Wing, Guildhall on Friday, 9 May 2025 at 11.00 am

Present

Members:
Gail Beer
Matthew Bell
Dr. Stephanie Coughlin (External Member)
Deputy Helen Fentimen OBE JP (Chair)
Deputy Marianne Fredericks
Judith Finlay
Jed Francique (External Member)
Sarah Gillinson (Deputy Chair)
Dr. Sandra Husbands
Gavin Stedman
Deputy Ceri Wilkins

In Attendance
Deputy Henry Pollard (Chief Commoner)

Officers:

Emmanuel Ross	-	City and Hackney
Nickie Brazell	-	City and Hackney
Froeks Kamminga	-	City and Hackney
Chris Lovitt	-	Community and Children's Services
Ian Tweedie	-	Community and Children's Services
Rachel Cleave	-	Healthwatch
Preet Desai	-	Town Clerk's
Gemma Stokely	-	Town Clerk's
Callum Southern	-	City Bridge Foundation

At the Outset of this meeting Mr Matthew Bell moved Deputy Marianne Fredericks into the Chair until the appointment of the Chair at agenda item 4, which was uncontested.

1. **APOLOGIES FOR ABSENCE**

There were no apologies.

2. **DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

There were no declarations.

3. **ORDER OF COURT OF COMMON COUNCIL**

The Board received the Order of the Court of Common Council dated 25 April 2025, which appointed the Board and approved its Terms of Reference

4. **ELECTION OF CHAIRMAN**

The Board elected a Chairman in accordance with Standing Order 28. The Town Clerk informed the Board that Deputy Helen Fentimen, being the only Member expressing their willingness to serve, was duly declared Chairman of the Health and Wellbeing Board for the ensuring year and took the Chair for the remainder of the meeting.

RESOLVED, that – Deputy Helen Fentimen be elected Chairman of the Health and Wellbeing Board for the ensuing year.

It was moved by Deputy Marianne Fredericks, seconded by Mattew Bell and RESOLVED UNANIMOUSLY, That - at the conclusion of her two-year term of office as their Chairman, the Members of the Health and Wellbeing Board wish to extend to:

Mary Durcan

their sincere thanks and appreciation for her commitment to addressing the physical and mental health and wellbeing needs of all City of London residents, workers and visitors.

Since Mary's election as Chairman in 2023, several essential and wide-reaching projects have been taken forward through the Board's proactive partnership work. These include supporting the health and wellbeing of the City of London's hidden and essential workers, suicide prevention, supporting the development of the Homelessness and Rough Sleeping Strategy and the Joint Local Health and Wellbeing Strategy, as well as tackling health inequalities across the Square Mile.

The Board wishes to place on record its recognition of Mary's dedication to the health and wellbeing of the City of London's residents, workers and learners. Her work ethic and compassionate nature have significantly contributed to the Board's achievements. Her colleagues wish to express their gratitude and offer their best wishes for the future.

5. **ELECTION OF DEPUTY CHAIRMAN**

The Board proceeded to elect a Deputy Chairman in accordance with Standing Order No. 29. The Town Clerk informed the Board that Sarah Gillinson, being the only Member expressing their willingness to serve, was duly declared Deputy Chairman of the Health and Wellbeing Board for the ensuring year.

RESOLVED, that – Sarah Gillinson be elected Deputy Chairman of the Health and Wellbeing Board for the ensuing year.

Under this item the Chair made the Board aware of the City of London vacancy on the Integrated Care Board (ICB) and it was agreed that the Deputy Chairman, Sarah Gillinson, would occupy this vacancy.

6. **MINUTES**

RESOLVED, that –the public minutes and non-public summary of the previous meeting held on 7 February 2025 be approved as a correct record.

Matters arising

- The report seen previously from the Local Government Association, which detailed a focus on the role of the Health and Wellbeing Board, was also reviewed by the Health and Social Care Scrutiny Committee and the both the Committee and Board meet to discuss the forward plan to encourage better alignment of the works of both the Health and Wellbeing Board and Health and Social Care Scrutiny Committee.

  Officers highlighted to the Board of the requirement to keep the roles of the Board and Committee separate, and suggested that it was for the Chairs of these Boards/Committees to meet rather than the Committee and Board themselves. Officers would review the Forward Plan of both the Board and Committee and then arrange to meet with the Chairs to discuss, to which Members of the Board agreed.

- The Chair sought the approval of the Board to arrange a joint meeting with the Hackney Health and Wellbeing Board, alongside the integrated Health and Care Partnership Board, to discuss health inequalities, how best to work with the voluntary sector and to discuss the changes to NHS resourcing and its impact on services within neighbourhoods. The Board approved with a view to arrange this meeting for Autumn 2025.

7. **BETTER CARE FUND PLAN 2025/26**

Items 7 and 8 was received as one item.

The Board received a report from the Executive Director, Community and Children's Services in respect of the Better Care Fund (BCF) programme which supports local systems to deliver the integration of health and social care in a way that supports person centred care, sustainability and better outcomes for people and carers. The report sought the approval of the Board to approve the revised City of London Better Care Fund Plans 2025/26 and approve the Better Care Fund Quarter 3 2024/25 return.

Officers provided an overview of the Better Care Fund Plan for 2025-2026, explaining that it supports the integration of health and social care through a pooled budget from the ICB and local authorities. The plan is based on a policy framework and guidance from NHS England and the Department of Health and Social Care.

The Board were informed that the Q3 covered expenditure to date and essentially all funds would be used and there would be no overspend in any area. A small amount of the Improve Better Care Grant that the City Corporation would be carrying over into 2025/26. However, other schemes would be delivered on plan and there was no concern over the delivery of metrics given the City's small population which effected its rate from Quarter to Quarter. Officers advised Board that within the Q3 report there was a high number of complex cases admitted to hospital over the winter period which all required residential placements, although this caused significant delays with some hospitals being situated outside London. Work was being done with commissioning colleagues to address potential surges of this kind in the future.

A Member noted the 2% growth to forecast demand for 2025-26 and asked officers if it was a reasonable estimation and officers advised that the NHS Business Intelligence Team had forecasted 2% growth within the Health System, however this could play out differently in respect of local authority demand such as packages of care and residential placements, and officers were aware of increasing demand for intermediate care (and other short-term care across North East London.

Officers were asked to provide further information on the development of the Transfer of Care Hub and a Member noted that some patients experienced difficulties when being discharged from UCLH and the Royal London Hospital and encouraged officers to work to address this. The Member also highlighted the objective to prioritise alternative pathways through of hospital care, and raised the issue of those patients with long term health conditions being admitted to the wrong hospital, due to an emergency issue, and then being delayed with a discharge as they await for an ambulance service to redirect them to correct hospital, and encouraged work to be done in conjunction with Healthwatch to address this issue. In respect of working with other hospitals, officers advised the Board that the Better Care Fund could be used for the care navigator service and these hospitals which had already received positive feedback. Leaflets were also displayed at these hospitals to advise patients of how the City and services could support discharges.

A Member was concerned about the Disabled Facilities Grants (DFG) and noted that there not much funds available for this and noted that there would be a new home improvement agency and asked if this was being done to assist those above the means tested threshold. Officers confirmed that the amount available were subsidised by carryovers due to an underspend from previous years and that the new housing assistance policy would assist those who were outside the financial thresholds for a DFG and to have the project management support to undertake adaptations to help prevent needs developing or escalating. Officers were hoping to see an increase uptake of the DFG.

Regarding the statistics on discharge, Members were keen to know how long the delay is in hospital before they granted a patient's discharge and whether there were any improvements made. Officers confirmed that this would be investigated further under the BCF Plan 2025/26, however retrospectively it was approximately seven days per person.

A Member encouraged officers to ensure that City Residents were aware that the BCF was available to those City Residents in need and that the Board ensured that it met its targets, with an ongoing action tracker being mentioned. Officers confirmed that funds had been spent on prevention and early intervention, and officers already produced a quarterly return which tracked what KPI' were being measured across all the BCF services.

The Chair noted that reports could better detail the objectives of the Board and determining which services need better promotion, and how the different contributions to neighbourhoods are being made and its impact. Officers highlighted a report concerning prevention and early intervention across the City and Adult Social Care which might help those to understand the work and impact of the City and Hackney Partnership in health and wellbeing, and would submit this report to the Board if requested. The Executive Director, Community and Children's Services agreed that this would be appropriate along with the City Corporation's Adult Social Care Strategy.

The Deputy Chair was interested to know of the definition within the City Corporation of the term 'Neighbourhood' and wanted to know whether a neighbourhood model was operational. Officers confirmed that although there was positive engagement with Shoreditch Park and City Neighbourhood forums it was not always focused solely on the needs of the City and its residents. Work had been undertaken to establish a multi-disciplinary meeting bespoke for the City and the term 'Neighbourhood', in the context of the report, referred to the whole of the City. Members were keen for City residents to understand the objectives and impacts of Neighbourhoods Engagement Involvement and for it to be reviewed to note its achievements.

RESOLVED, that – Members approved the revised City of London Better Care Fund Plans 2025/26.

8. **BETTER CARE FUND 2024/25 Q3 RETURN**

Items 7 and 8 was received as one item.

The Board received a report from the Executive Director, Community and Children's Services in respect of the Better Care Fund (BCF) Programme which sought the approval for the Q3 2024/25 Better Care Fund return.

RESOLVED, that – Members approved the Better Care Fund Quarter 3 2024/25 return.

9. ***HEALTH IMPACTS OF VAPING**

Professor Anne McNeil presented the latest evidence on the health impacts of vaping, emphasizing that vaping posed only a small fraction of the risks of smoking and was an effective tool for smoking cessation.

During the presentation Members were advised of the concerns of adolescent vaping, noting that whilst there was some increase in vaping among never-smoking youth, there was an importance of a regulatory framework to be established which maximized the benefits of vaping for smoking cessation while minimizing the risks of uptake among youth and never smokers.

Concern was raised about the effect of chemical flavouring and additives associated with vaping, and its ties to the tobacco industry. Professor Anne McNeil explained that it should be encouraged to inform those that there are widespread differences between vaping and tobacco smoking but both still presented impacts on health, however for those who smoke it should be encouraged that they use legal regulated nicotine products to limit harm where possible. A Member asked why other forms of holistic ways to stop smoking, such as hypnotherapy, was not suggested as an alternative way to stop smoking, and it was highlighted that generally methods that are shown to be effective is what is offered as listed in the report. The Stop Smoking Service offered a variety of evidence based methods to quit tobacco smoking and vapes were considered to be a part of a wider toolkit as nicotine replacement therapy and other methods. Officers also confirmed that this service did provide holistic treatment through behavioural support.

The Deputy Chair asked how the overall risks of tobacco smoking and the use of vaping as smoking cessation tool to quit tobacco smoking was communicated to the public and officers advised the Board of the Vaping Communications Plan which was aimed specifically at smokers which noted the popularity and effectiveness of vaping as a quit aid.

A Member asked about the impact of Snus on health and it was confirmed that long term epidemiological evidence which suggested that the use of Snus presented a lower risk to health compared to tobacco smoking.

RESOLVED, that – Noting that Deputy Marianne Fredericks abstained from this endorsement, the remainder of the Board endorsed the evidence-based City and Hackney vaping position statement, which was co-developed with the local Tobacco Control Alliance (TCA).

10. ***HEALTHWATCH CITY OF LONDON PROGRESS REPORT**

The Board received a report of the Healthwatch, City of London in respect of the Healthwatch City of London report.

The Chair, Healthwatch provided an update on Healthwatch City of London's activities, including the launch of the digital apps in healthcare report, the 'Patient Advice and Liaison Service (PALS) report, and the Bart's Centre review.

The Board were advised of the issues surrounding PALS and complaints received regarding the access to this service, and there was a need for further for oversight and scrutiny on the PALS to determine what could be done to provide a better service for those who utilise PALS. A Member asked if PALS fit for purpose and the Chair, Healthwatch confirmed that PALS is a mechanism to be used by patients or their family to raise their concerns about the standard of

service and if it is not fit for purpose then this should be reviewed. In respect of the Bart's Centre Review, the Board were made aware of the issue at St Bartholomew's Hospital regarding cardiology.

The Chair, Healthwatch mentioned various engagement activities, including patient panels, the Health Mella event, and planned activities for the upcoming quarter, and highlighted the importance of these activities in gathering feedback and engaging with the community. Another City of London Healthwatch event was in expected to take place in the coming weeks.

The Chair thanked City Healthwatch for all the work that they have undertaken and encouraged the Board to the note the recommendations made and incorporate these into the Health and Wellbeing Board's work plan. The Chair noted the absence of the representative for St Bartholomew's Hospital and advised the Town Clerk to remind Members of their Membership of the Board to encourage better attendance at the following meetings.

The Executive Director, Community and Children's Services raised a question in relation to the Adult Social Care reference group and the struggle to find participants and asked for an update regarding this. The Chair, Healthwatch confirmed that work was being done to address this and an event was due to be held at Guildhall to encourage further participation. Further work on mobility aids and home adaptation was also expected to be undertaken.

RESOLVED, that – the report and its contents be noted.

11. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**

There were no questions.

12. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

There were no urgent items of business.

13. **EXCLUSION OF PUBLIC**

RESOLVED, – That under Section 100(A) of the Local Government Act 1972, the public be excluded from the meeting for the following item(s) on the grounds that they involve the likely disclosure of exempt information as defined in Part 1 of the Schedule 12A of the Local Government Act.

14. **SEXUAL HEALTH SERVICES IN THE CITY OF LONDON**

The Committee received a report of the Director of Public Health in respect of the sexual health services in the City of London.

RESOLVED, that – the report and its contents be noted.

15. **NON PUBLIC QUESTIONS ON MATTERS RELATING TO THE WORK OF THE BOARD**

There were no non-public questions.

16. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE BOARD AGREES SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

There were no non-public urgent items of business.

The meeting ended at 12.49 pm

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Chairman

Contact Officer: Emmanuel.Ross@cityoflondon.gov.uk - Agenda Planning
rhys.campbell@cityoflondon.gov.uk - Governance Officer/Clerk to the Board

City of London Corporation Committee Report

Committee(s): Health & Wellbeing Board	**Dated:** 11/07/2025
Subject: Adult ADHD Service Update	**Public report:** For Information
This proposal: **N/A**	
Does this proposal require extra revenue and/or capital spending?	No
If so, how much?	N/A
What is the source of Funding?	N/A
Has this Funding Source been agreed with the Chamberlain's Department?	N/A
Report of:	City and Hackney ADHD Service and Autism Service
Report author:	Emmanuel Ross Public Health Projects and Programmes Officer On behalf of John Bradley Operational Lead, City and Hackney ADHD Service and Autism Service

Summary

In the City (and Hackney), demand for ADHD services far exceeds the system's capacity to deliver them.

The attached presentation sets out the service context, caseload and challenges around this challenging workstream.

Recommendation(s)

The attached presentation is intended to provide Board members with an insight into the issues facing service providers and people seeking support for their condition.

Members are asked to:

- Note the report.

Main Report

Background

1. Resource to this service has not materially increased since the City and Hackney ADHD Service and Autism Service was founded over 10 years ago.

2. Waiting time for patients is currently at around six years and the current caseload is circa 2000 people.

Current Position

3. Service leads are taking measures to try to mitigate the high demand and inadequate resource, as set out in the presentation.

Options

4. Members will have the opportunity to explore available options after this presentation.

Proposals

5. Not yet known

Corporate & Strategic Implications

Financial implications

- None

Resource implications

- None

Legal implications

- None

Risk implications

- None

Equalities implications

- To be confirmed

Climate implications

- None

Security implications

- None

Conclusion

6. This report was prompted by a request from members of the Health & Wellbeing Board.

Appendices

• Appendix 1 – Presentation from John Bradley: City and Hackney Adult ADHD Service Update

Emmanuel Ross

City Public Health Programmes & Projects Officer

emmanuel.ross@cityoflondon.gov.uk

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City and Hackney
Adult ADHD Service Update

June 2025

John Bradley
Operational Lead
City and Hackney ADHD Service and Autism Service

ADHD Service Context

- Started as a clinic in 2014 by Dr Jide Morakinyo.
- Provides diagnostic assessments, medication reviews, treatment optimisation and post-diagnostic support to patients with a City and Hackney address.
- Commissioned staffing:

  0.2 WTE Consultant Psychiatrist

  0.5 WTE Senior ADHD Practitioner

  0.5 WTE Band 4 Admin
- Other (non-commissioned) staffing: Manager; Administrator; 0.7 Special interest Drs/Speciality doctor

NHS
East London
NHS Foundation Trust

Referral process

- 2 part referral form, completed by (Part A) the referrer and (Part B) the patient.
- Referrals are sent via the Single Point of Access (SPA) (PCL Team/Neighbourhood Team, formally known as CHAMHRAS)
- For those with access use the e-Referral service. Otherwise email elft.ch.spa@nhs.net

Referral Process

- Patients with an existing ADHD diagnosis from elsewhwere can be referred to the service for medication reviews, but **we require a copy of the original diagnostic assessment or equivalent evidence**.
- 12 month annual reviews are now completed by GP's as they are now being funded for this. The exception to this is patients who present complexity – these patients will still come to our service.
- Resources for those on waitlist - https://www.elft.nhs.uk/adult-adhd-services/support-available

NHS
East London
NHS Foundation Trust

Assessment Process and Treatment

- New diagnostic assessments - 2-3 clinic appointments.
- Medical reviews (existing diagnosis) - 1-2 clinic appointments.
- Medication optimization, 6-10 appointments.
- Currently appointments are conducted mainly face to face.
- Patient resource pack given once diagnosis confirmed.
- We have a non-pharmacological offer, including ADHD coaching, groups and educational workshops

NHS
East London
NHS Foundation Trust

Shared Care Agreement

- Once the patient is stable on medication they are handed back to the local GP to continue prescribing as per the shared care agreement. GPs are not obliged to share care.
- SCAs do not cross borders. This causes issues.
- Patients can be referred back to the clinic by their GP if there is an issue with their medication.
- GPs can refer previously known patients directly to the clinic by email : elft.adhdservice@nhs.net

East London NHS Foundation Trust

Wait times and other issues

- Demand exceeds capacity – our waiting time is 6+ years.
- Referrals were increasing pre-pandemic and then they increased exponentially. Resource has not increased since inception.
- All new referrals are now being sent by GPs via private assessment through NHS Right To Choose.
- Current caseload is 2100. Approximately 1500 require new assessment. The remainder require medication review or validation of diagnosis/SCA.
- Patients are understandably unhappy with waiting and issues of access.

NHS
East London
NHS Foundation Trust

What are we doing about this?

- Messaging patients as clearly as possible
- Augmenting sparse resource with Special Interest doctors + sporadic medical time given from slippage in the Medical budget.
- Local GP's taking on Annual ADHD medication reviews
- Training 2 GPwERs to undertake assessments
- Have developed innovative post-diagnostic offer with new Senior ADHD Practitioner post.
- ADHD training/consultation for colleagues.
- Part of cross Trust and cross NEL working groups to decide future of ADHD provision.

East London
NHS Foundation Trust

Your questions

Lastly…

- For feedback, please email: john.bradley7@nhs.net
- Specific patient or referral queries, please email: elft.adhdservice@nhs.net
- Thank you for listening….

We care We respect We are inclusive

City of London Corporation Committee Report

Committee(s): Health and Wellbeing Board	**Dated:** 11/07/2025
Subject: Water stress and health – opportunities to collaborate between partners	**Public report:** For Decision
This proposal: ● Delivers Corporate Plan 2024-29 outcomes	Leading Sustainable Environments Providing Excellent Services Diverse Engaged Communities
Does this proposal require extra revenue and/or capital spending?	N/A
If so, how much?	N/A
What is the source of Funding?	N/A
Has this Funding Source been agreed with the Chamberlain's Department?	N/A
Report of:	Dr Sandra Husbands Director of Public Health Katie Stewart Executive Director Environment
Report authors:	Tim Munday Lead Environmental Resilience Officer, Environment (Presenter) Ratidzo Chinyuku Senior Public Health Specialist, CCS (Presenter) Sam Murphy Environmental Resilience Officer, Environment Jayne Taylor Consultant in Public Health, CCS Rebecca Water Health Improvement and Inclusion Manager, NHS NEL ICB

Summary

Climate change has a significant impact on public health. The most vulnerable residents, such as those living in poverty, low-income workers and those with underlying health conditions, are disproportionately impacted by climate impacts.

Work to mitigate these risks forms an important part of a Just Transition. Continuing earlier Health and Wellbeing Board discussions on climate and overheating, this paper focuses on the implications of water stress on health, and the need for collaboration between partners to mitigate these risks.

Water stress occurs when the demand for water exceeds the available amount during a certain period, or when poor quality restricts its use. Water stress, and the associated risks of regional drought and localised disruption from burst watermains, is an increasing challenge for the City of London and the South-East of England. Current shortages will be exacerbated by climate change, population growth, and aging infrastructure. The associated impacts to health are expected to increase.

London's water supply system has developed over centuries and is part of a wider natural and manmade system. The high concentration of workers in the Square Mile for only part of the day, increases the complexity of water provision.

While responsibility for managing water supply sits outside the remit of the City of London Corporation, there are actions that the City Corporation and partners can take to mitigate the impacts to their organisation and communities.

This paper examines the health and wellbeing risks relating to water stress arising from climate-related impacts. Recommendations for potential actions have been aligned to the Health and Wellbeing Board partners' strategic priorities and existing programmes of work.

Recommendations

Members are asked to:

- Note the report.
- Approve the continued collaboration between system partners on the issues outlined in the report.
- Approve that actions are taken forward through the City of London Climate Action Strategy and NHS Green Plans, and that progress is reported back to the Health and Wellbeing Board annually.

Main Report

Background

1. The impacts of climate change are wide ranging and adversely impact health outcomes – disproportionally impacting certain individuals, communities and groups. Action to mitigate and adapt to climate change present opportunities and risks to direct health outcomes and the social determinants of health.
2. Climate change and its impacts risk adverse outcomes against the three strategic priorities outlined in the Health and Wellbeing Strategy (financial resilience, social connection, and mental health).
3. Responding to the emerging threat of climate change, the Health and Wellbeing Board agreed in November 2023 to table a series of focus-topic agenda items on climate and health. The first focus topic covered overheating and health – it is

proposed to return to a later committee to update on actions arising from this previous item. This report is the second in the series focusing on the implications of water stress on health and considers the overlap between overheating and water stress.

4. The importance of water to our society is so fundamental that the risk posed by limited supplies has significant consequences, with implications for health and wellbeing.
5. Water stress happens when the demand for water is greater than the available supply over a prolonged period, or when poor water quality limits its use. The chances of serious drought and the frequency of burst water mains are increasing with climate change. This is partly due to subsidence, which is the sinking of the ground caused by over extraction of groundwater.
6. As climate change leads to more frequent and severe droughts, reliance on groundwater increases, causing the ground to sink and damaging water infrastructure.
7. Water stress often worsens during droughts and can impact public health in several ways:
    - Limited water affects hygiene, increasing the risk of infectious diseases like gastrointestinal illnesses.
    - People may use untreated alternative sources (e.g. rainwater), raising contamination risks.
    - Low water flow can reduce quality and dilution of pollutants.
    - Drought and reduced vegetation can worsen air quality, adding to respiratory issues and reducing overall wellbeing.
8. As with the other impacts of climate change, water shortages will affect some population groups more than others. These include:
    - those more susceptible to dehydration e.g., the elderly, pregnant and young;
    - individuals and settings that demand greater water usage for infection prevention control;
    - those with compromised immune systems; and
    - those whose employment is dependent on water-use.
9. London's water system is complex. The supply is mainly taken from two rivers (non-tidal Thames and Lea) with a proportion abstracted from the aquifer below the capital. During drought conditions London is reliant on the water stored in its reservoirs and in extreme cases can make use of a limited number of alternative sources (New River, Desalination Plant, etc).
10. Water stress is worsening in the South-East of England. This is being driven by:
    - Population growth as more people move into the area;
    - Aging and the deterioration of existing water infrastructure assets;
    - Changing rainfall patterns driven by climate change; and
    - Behaviour changes in the ways that people use water.

Stronger environmental protections also increase water stress by keeping more water in natural systems.

11. Historically the City Corporation has played a significant part in securing water for the Square Mile. Local water resources are now under the control of Thames Water Utility Ltd and managed regionally by Water Resources South-East.
12. By 2050, supporting population growth, the economy, food production, and the environment will require nearly 5 billion extra litres of water per day, beyond current usage.
13. In the immediate future, the initial focus for water companies, as per the expectation of regional water resource management plans (WRMPs) is to:
    - Save water (using water more efficiently and metering);
    - Reduce leakage; and
    - Explore new supply options such as reservoirs, desalination, water recycling and upgrades to water treatment works.
14. Several interventions outlined in the South-East WRMP can benefit London and the Square Mile. This includes a new reservoir in Oxfordshire and a proposed water recycling scheme in West London.
15. Whilst the responsibility for water management sits with others, the City Corporation, as a Local Authority, has a duty to protect and improve its residents' health and wellbeing, including responding to the emerging threats from climate change, and the cascading effects of water stress. Members of the Board can support and amplify these efforts through enhanced system partner collaboration and coordination.

Current Position

16. The impacts of water stress and drought will affect all aspects of the City Corporation's and Health and Wellbeing Board partners' work. A severe drought is estimated to cost the London economy £500 million a day and water availability could in future become a constraint on development. Water demand places a strain on our natural systems, with drought conditions causing acute and long-term damage to the environment.
17. The City Corporation has been involved with two studies led by the GLA. The Sub-Regional Integrated Water Management Strategy for East London considered a few future growth scenarios and modelled the implications on future water resources. The Beckton Water Demand Study calculated the current and future water footprint of the Square Mile and considered a range of water-saving interventions. The studies are clear: while sustainable development plays a key role in managing water resources, additional action and long-term planning will still be required to meet future demand and ensure resilience. (See Key Data for more information.)
18. The City Corporation already undertakes several activities regarding water management; these are highlighted in Appendix 2.
19. A detailed review of water stress and its related impacts within the Board's scope of activity was carried out across key 'target areas':

- Healthcare settings and their surroundings, provision and services
- Education and libraries
- Housing
- Homelessness and rough sleeping
- Ports and markets

20. Proposed solutions have been aligned with the City of London's Climate Action Strategy, supporting both mitigation and adaptation efforts.
21. The exercise also evaluated the risk for unintended or negative impacts arising from the proposed recommendations. No such risks were identified.

Options

22. Option 1: This option would maintain the current level of engagement between partners, collaborating on a case-by-case basis where shared climate-related interests align in specific projects **(not recommended).**
23. Option 2: Health and Wellbeing Board as a collective body and within their organisations use its influence to strengthen local partnership to address the health impacts of climate change, as outlined in the Proposals section. **(recommended).**

Proposals

24. The Board is asked to approve enhanced collaboration to continue to explore and take forward shared actions to prevent and reduce the harms of the cascading effects of climate, including water stress.
25. Members are asked to consider and advise on the following potential climate-health actions:
    a. **Review of Drought Preparedness:** Collaboratively review the existence and effectiveness of local drought plans, ensuring they accurately reflect the risk of water stress and are up to date with current climate projections and local vulnerabilities.
    b. **Priority Services User Lists:** Work together to promote awareness and uptake of utility company priority services registers, encouraging registration among vulnerable residents and their carers to improve support during service disruptions.
    c. **Drought Emergency Exercise:** Conduct a joint emergency exercise (in collaboration with the City of London's Emergency Planning team) to test and evaluate organisational drought response plans, identifying gaps and opportunities for improved coordination and resilience.
    d. **Water Efficiency Best Practice:** Bring together asset and facilities managers to exchange knowledge and share best practices on water efficiency and management strategies across sites and services.
    e. **Shared Drought Messaging:** Develop collaborative public campaigns to raise awareness of water use and conservation, aligning messaging across partners to maximise reach and impact.

26. It is recommended that these actions are taken forward through the City CAS and NHS Green Plans, and that progress is reported back to the Health and Wellbeing Board annually.

Key Data

27. In 2024 the water demand in London was 2104 ML/d [million litres per day], with a deficit of 143 ML/d. By 2024 demand is expected to have increased by 104 to 2246 ML/d. The deficit is expected to increase to 362 ML/d which is 16% of total anticipated demand.
28. The Square Mile currently uses 9.42 ML/d of which 8.17 ML/d is supplied to commercial premises with the rest used in residential. Without any action this modelled to increase by 14% by 2050. However with high ambition water saving interventions including retrofit and new building development, this could be reduced to 9.12 ML/d whilst accommodating anticipated growth.
29. East London currently experiences 88 days of water stress per year (days in which more water is used than enters the system). Under a high population growth and high investment scenario, water stress is expected to increase to 234 days per year. Under a lower population growth (and therefore limited investment) scenario, water stress is expected to increase to 363 days, practically every day.
30. For the high growth scenario, various interventions have been modelled to reduce the days of water stress - including a water re-use scheme at Deephams Waste Water Treatment scheme (by 100 days), proposed London Wide Water Resources such as new reservoirs (by 97 days), widespread leakage reduction works (by 87 days) and rolling out water metering (by 84 days).
31. There is limited direct evidence that drought and water stress alone lead to increased mortality in England. However, drought conditions can exacerbate heatwaves, which are strongly associated with higher mortality rates, particularly among older adults.
32. The summer of 2022 was notable for England's highest recorded temperature of 40.3°C, prompting the first-ever Level 4 Heat-Health Alert (HHA). During five heat episodes, an estimated 2,985 excess all-cause deaths occurred, with significant mortality concentrated in people aged 65 and above.
33. Ahead of the heatwave that year, water stress was presenting as a challenge with significantly reduced rainfall, below-normal groundwater and river flows. By late August, 17 of 18 water companies had activated drought plans, with five introducing temporary use bans affecting 19 million people. Fortunately, public water supply impacts were relatively short-lived.
34. Implications for health and wellbeing:
    - **Disproportionate impacts on vulnerable groups:** Older adults, young children, people with chronic health conditions, those with disabilities, and people experiencing homelessness or living in poor quality housing are at higher risk from heat and drought related stressors.

- **Increased health and care demands:** Rising temperatures and reduced water availability may lead to increased demand on health and social care services during peak summer / warmer months, affecting service delivery and resilience.
- **Compounding social vulnerabilities:** Low-income households may struggle to afford or implement adaptive measures (e.g., fans or efficient appliances), increasing their exposure to both heat and water insecurity.
- **Mental health pressures:** Chronic environmental stress from water scarcity and extreme heat may heighten anxiety and distress, particularly for isolated or marginalised residents.
- **Importance of integrated planning:** Coordinated water resource management and climate-related health resilience planning is needed to ensure that vulnerable populations are protected, and essential services remain efficient in the face of climate pressures.

Corporate & Strategic Implications

Strategic implications – Progressing work outlined within this paper will contribute towards Corporate Plan aims of Leading Sustainable Environment, Diverse Engaged Communities, and Providing Excellent Services through creating the conditions for places, people and processes to be more resilient to overheating. The work actively fulfils objectives within the Climate Action Strategy and Health and Wellbeing Strategy.

Financial implications – There are no new financial implications arising from the proposal within the paper at this stage.

Resource implications – There are no new resource implications arising from the proposal within the paper at this stage.

Legal implications – None.

Risk implications – The proposals in this paper seek to actively address and mitigate risks arising from climate change and water stress.

Equalities implications – If unmitigated the impacts from overheating will have a disproportionate impact on some groups of people associated with protected characteristics. The Just Transition approach proposed within this paper actively prioritises reducing the impacts on those most vulnerable and worst affected. Subsequent works outlined should it be taken forward may require a full Equality Impact Assessment.

Climate implications – The primary aim of this paper is to further mitigate and adapt to the impacts of climate change, using opportunities to specifically address health related impacts. The proposals outlined would increase climate resilience of the most vulnerable and seek to ensure that climate action minimises potential unintended health disbenefits.

Security implications – None.

Conclusion

35. Water stress is one of the main risks to public health from climate change. Without action, it will have a disproportionate impact on already vulnerable groups. The City of

London has specific challenges due to highly localised demand arising from its concentration of population.

36. This paper seeks to gain high level support from the Health and Wellbeing Board to continue to progress a range of collaborations which would manage the risks from water stress to health.

Appendices

- Appendix 1 (below) – List of existing City Corporation activities relevant to Water Stress

Background Papers

Climate & Health – Opportunities for Collaboration [HWB 24/11/2023]

Overheating and Health – Opportunities to collaborate between partners [HWB 15/11/2024]

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Appendix 1

List of existing City Corporation activities relevant to Water Stress

City Surveyors

Facilities Management

- Maintenance of sites water using assets and remedial works.

Energy and Sustainability

- Water-use contract management.
- Review of continuous flow alarms with contract.

Health and Safety (Property)

- Management of legionaries monitoring in water supplies (with facilities management team)

Property Projects Group

- Specification of new property water-using assets.

Community and Children's Services Department

People

- Severe Weather Emergency Plans in the Homelessness and Rough Sleeping team including for hot weather conditions.

Commissioning and Partnerships

- Departmental risk control and resilience and emergency planning (including in relation to water shortage).

Education and skills

- Water-use in the family of schools.
- Green skills promotion covering water related careers.

Public Health

- Public Health advice including to Business and through community champions programme

Housing and Barbican

- Divisional risk control and resilience and emergency planning (including in relation to water shortage).
- Water use on the Barbican and Social Housing Estates.
- New affordable housing meeting water efficiency requirements.

Barbican and Community Libraries

- Providing GLA registered Cool Spaces in libraries with access to water.

Environment Department

Planning and Development

- Planning policy requirements to meet 110 litres per day per person (in residential)
- Planning for Sustainability SPD guidance on water-use in commercial developments
- District Surveyors enforcing Building Regulation G2

City Operations

- Water fountain programme and Refill scheme
- Climate resilient planting in City Gardens
- Enabling works within the highway
- Emergency response

Port Health and Public Protection

- Environmental Health water quality and legionnaire monitoring

Natural Environment

- Natural Environments Resilience Strategy and natural flood management projects

City of London Corporation Committee Report

Committee(s): Health & Wellbeing Board	**Dated:** 11 July 2025
Subject: MATCH Project on Embedding Health Equity	**Public report:** For Discussion For Decision
This proposal: ● **delivers Corporate Plan 2024-29 outcomes**	Diverse Engaged Communities Excellent Services
Does this proposal require extra revenue and/or capital spending?	No
If so, how much?	N/A
What is the source of Funding?	N/A
Has this Funding Source been agreed with the Chamberlain's Department?	N/A
Report of:	Dr Sandra Husbands City and Hackney Director of Public Health
Report author:	Joia De Sa Consultant in Public Health Anna Garner Head of Performance & Population Health, NEL ICB Jess Veltman Population Health Programme Manager Melissa Matz Public Health Analyst Thomas Shore Grants and Investments Manager

Summary

The City and Hackney Population Health Hub was established in 2021 to support the City and Hackney Place-Based Partnership and wider system partners to reduce health inequalities and improve the health of our population.

The eMbedding heAlth equiTy in City & Hackney (MATCH) programme has been developed as a tool to engage with system partners about health inequalities and population health and to support our workforce to embed a health equity approach.

Each year the MATCH programme looks at key areas where deep health inequalities exist within City and Hackney. We invite partners across the statutory and voluntary, community, and social enterprise sectors to work together in a participatory process collaborating on areas for change.

Recommendation(s)

Members are asked to:

1. Note the summary of MATCH Years 1 and 2.
2. Consider how to represent and include the City of London in MATCH Year 3.
3. Approve the proposed outline for MATCH Year 3

Main Report

Background

1. This report provides an overview of the eMbedding heAlth equiTy in City & Hackney (MATCH) programme, which has been designed by and is led by the City & Hackney Population Health Hub as a ‘tool’ to engage with system partners about health inequalities and population health, and to support our workforce to embed a health equity approach.
2. MATCH aims to identify and reduce inequalities across City & Hackney by working together with partners across the system and City & Hackney residents.
3. The programme supports the Corporate Plan’s aims to build diverse, engaged communities and provide excellent, inclusive services shaped by those who use them.
4. The programme is funded by NEL ICS Health Inequalities funding for four years and is currently in the second year.

Current Position

5. The report provides updates from the five programme areas from year 1: anti-racist commissioning, food poverty, maternity, prevention of poor outcomes from cardiovascular disease and women’s health, including funded change projects. These projects operated across the City & Hackney footprint, as far as possible.
6. The report provides updates from the three programme areas from year 2: mental health support for people seeking asylum, healthy weight pathways and children and young people’s mental health.

7. Emerging findings from the ongoing evaluation show that the value of MATCH lies in the connections, collaboration and trust built across communities and partners. The collaborative and participatory approach that MATCH uses supports the delivery of excellent services and reflects the Corporate Plan's commitment to inclusive engagement and co-creation.
8. A proposed outline for year 3 of the programme is provided.
9. An 'academy' style model and MATCH Playbook is in development to test the replicability of the approach, with reduced input from the City and Hackney Population Health Hub and reduced funding for change ideas
10. We are interested in hearing from the Board on how the City of London would like to be represented in year 3.

Options

11. N/A

Proposals

12. Please see Current Position above

Key Data

13. None

Corporate & Strategic Implications

Strategic implications

The MATCH programme supports the City of London Corporate Plan by working with residents to design services and programmes and strengthening partnerships across the system to reduce inequalities and improve health outcomes. MATCH aligns with the Plan's goals to build engaged communities and deliver excellent services. As MATCH enters year 3, there is an opportunity for the City of London to shape its role and ensure local impact.

Financial implications

None.

Resource implications

None.

Legal implications

None.

Risk implications

There are no significant risks associated with this report. The proposed approach for Year 3 has been developed in response to learning from previous years and in consultations with stakeholders, including the MATCH Steering Group. Potential risks, such as reduced engagement, changes in participants' capacity throughout the years, or delays in delivery, have been considered and will be managed through regular feedback and monitoring of the project.

Equalities implications

The MATCH programme is designed to specifically address health inequalities and embed health equity across services and programmes, with a strong focus on engaging and improving outcomes where there is most need. Each project area within MATCH considers the needs of communities and the participatory approach ensures decisions are informed by residents with lived experience.

Climate implications

None.

Security implications

None.

Conclusion

14. This report provides an overview of the MATCH programme and updates from Years 1 and 2.
15. Emerging findings from the ongoing evaluation of the MATCH programme are presented and learnings from the evaluation are being incorporated into the development of year 3.
16. The Health and Wellbeing Board is asked to comment on the proposed outline for year 3 and consider how the City of London would like to be represented.

Appendices

- Appendix 1 – Presentation Slides
- Appendix 2 – Report: MATCH Years 1 & 2

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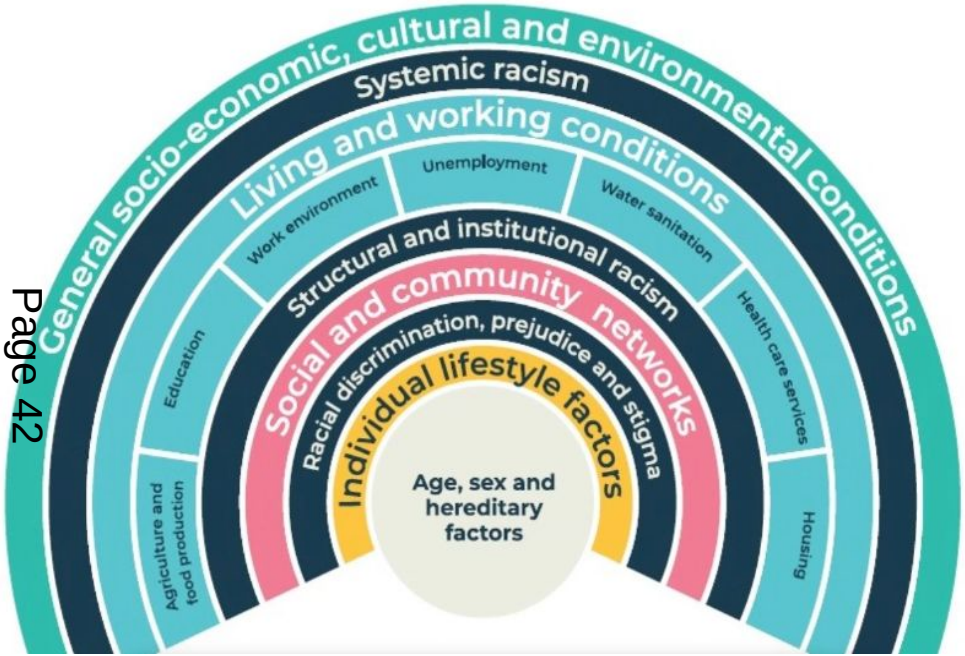
City & Hackney
Population Health Hub

MATCH project on embedding health equity

City of London Health and Wellbeing Board, 11 July 2025

Health equity approach



- The Dahlgren and Whitehead model of health determinants shows the complex interplay of factors that influence health and wellbeing and the need for a system-wide approach to reducing health inequalities.

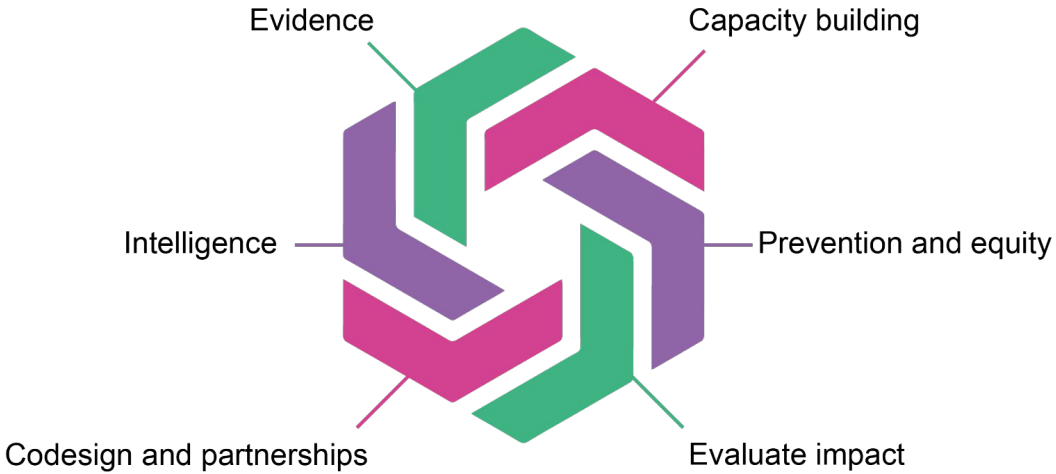
- The e**M**bedding he**A**lth equi**T**y (MATCH) programme has been developed as a tool to engage with system partners about health inequalities and population health, and to support our workforce to embed a health equity approach.

The City and Hackney Population Health Hub

We work to proactively identify what the system needs…

…and also work in partnership on requests for support from stakeholders across the system

Supporting partners, teams and individuals to find joy and sense of purpose in their work



Ask for HWB

1) Bringing this as an update on the work programme
2) Keen to hear feedback from HWB on
   - which parts of the system we could usefully engage with
   - input on the MATCH approach and anything missing
3) **Decision** on the proposed model for year 3

What is MATCH?

City & Hackney
Population Health Hub

How do you feel about tackling health inequalities in your day-to-day work?

25 responses

The development of MATCH

As shown on the previous slide, we noticed that although there was a strong commitment to health inequalities in principle across the system, in practice many people felt they didn't know where to start.

The MATCH programme aims to address this by **supporting teams and services across City & Hackney to embed health equity in their day-to-day work.**

Using non-recurrent NEL Health Inequalities funding, we have developed an approach and a package of training and support to help partners to do this. The programme reports into a steering group formed of stakeholders from across the partnership.

Programme participants identify specific health inequalities to focus on which are relevant to their work and, as part of the MATCH approach, identify areas for change.

The first two years have focused on a more intensive project-based approach to build momentum, and we are proposing a pivot to an 'academy' style model in year 3 to enable more participants to get involved, and to be supported by those who have already been through the process.

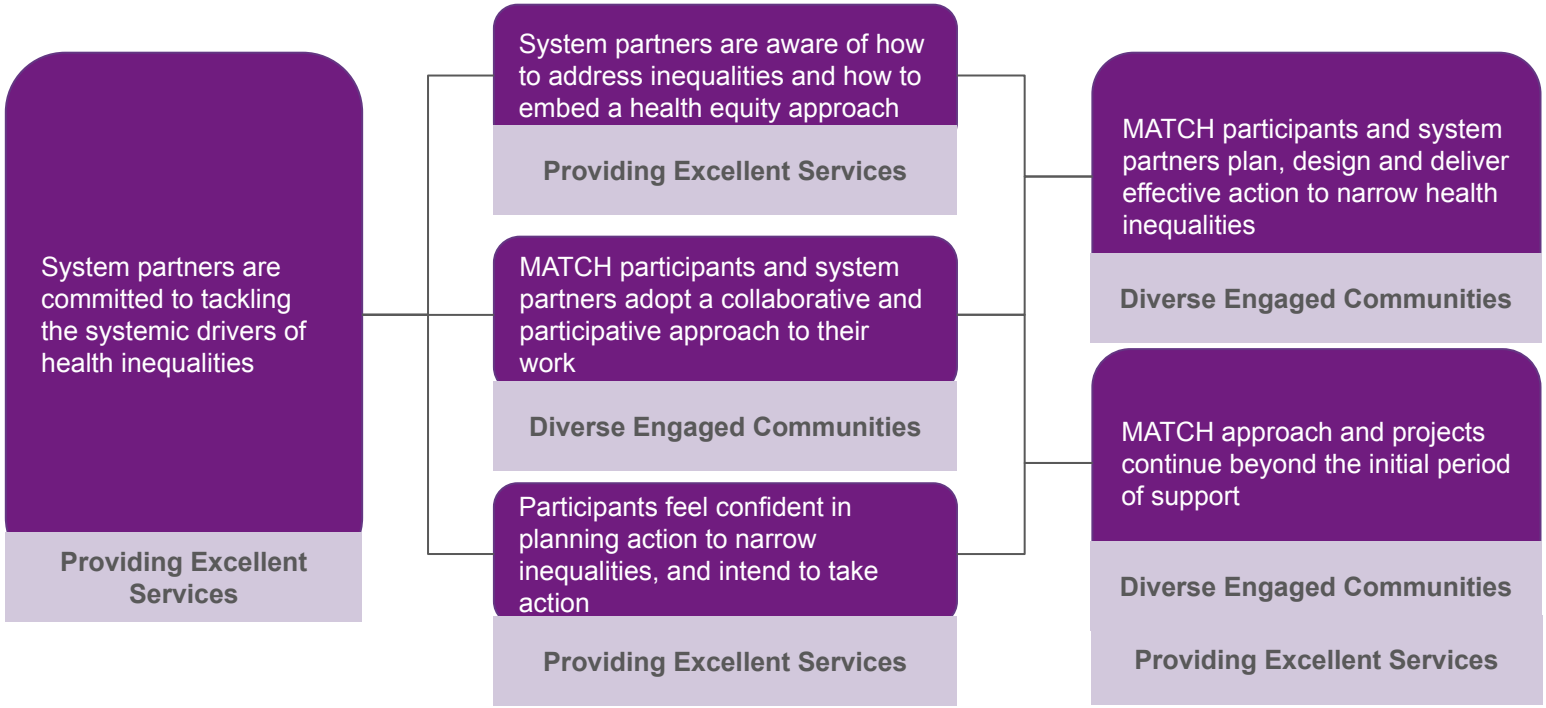
The MATCH programme supports the **City of London's Corporate Plan** outcomes of

Diverse Engaged Communities

Providing Excellent Services

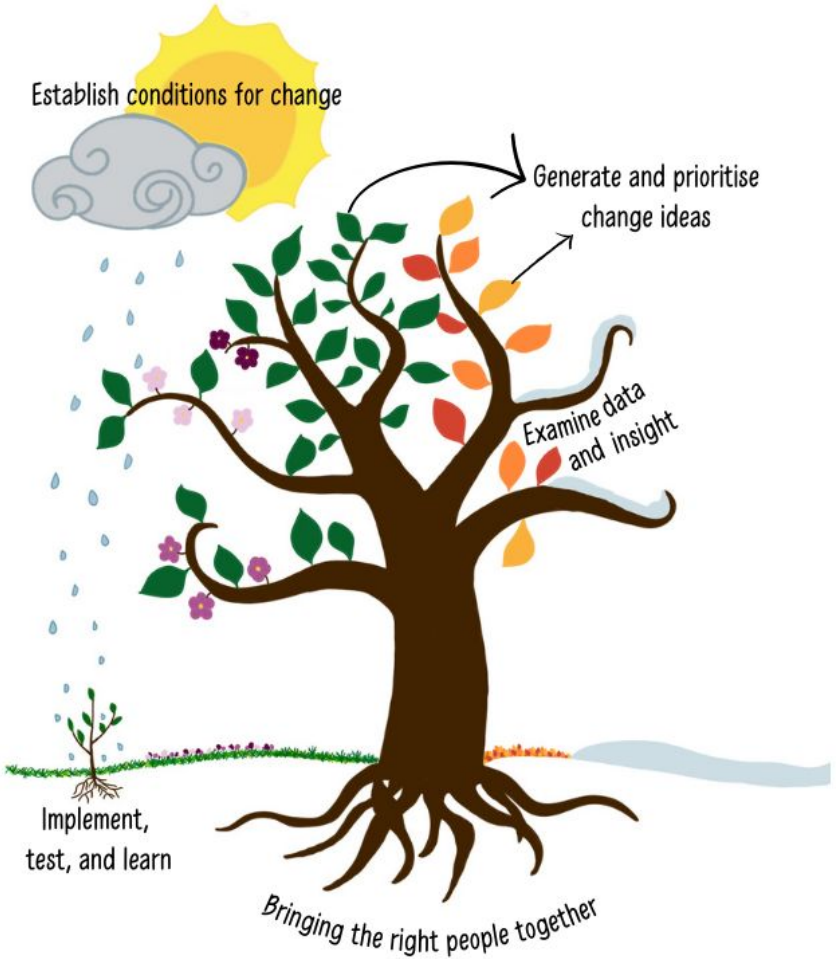
Programme Outcomes

City of London Corporate Plan Outcomes



The MATCH approach

- Bringing the right people together to work collaboratively to design programmes and services
- Examine data & insight, review through different lenses
- Establish conditions for change
- Generate & prioritise change ideas
- Implement, test and learn



More information on the approach

Bring the right people together	Examine data & insight and review pathways	Establish conditions for change	Generate & prioritise change ideas	Implement, test, and learn
				
• Identify the key stakeholders who need to be part of the process • Link with partners such as VCS/HCVS to ensure appropriate resident and community engagement & establish process for inclusive engagement and participation	• Analysis of current data & insight, focusing on inequalities • Ensure that relevant data can be collected going forward • Identify groups that may be underserved and start to identify the levels of need • Review the programme area with stakeholders using tools eg: Kings Fund population health pillars, PHH health inequalities toolkit, strengths based toolkit, prevention focus, anti-racist lens, audit of staff training/competencies, resident health and wellbeing priorities, Marmot principles • Identify any relevant quality standards to the area	• Work with teams to look at barriers to embedding health equity and what needed to sustainably take an equitable approach	• Generate potential change ideas • Work with stakeholders using a prioritisation framework to identify several key actions to take forward • Embed a tiered approach to support	• Implement and monitor • Gather learning and build case studies • Aim to demonstrate progress in 6-12 months • Refine the approach for future programme areas based on learning • In years 1&2 we have been able to use non-recurrent funding to support change ideas

What have we done?

City & Hackney
Population Health Hub

What we have worked on - Year 1

Women's health	How do we support young women to manage their periods (to tackle inequalities in wellbeing, self-management and adverse outcomes from these)?
Maternity	How do we identify and tackle inequalities in maternity outcomes in an inclusive way?
Prevention of poor outcomes from cardiovascular disease	How do we improve prevention of poor outcomes from cardiovascular disease using an anti-racist and health equity approach in C&H neighbourhoods?
Food poverty	How can we support people out of food poverty as well as supporting their health and wellbeing needs?
Anti-racist commissioning	How do we test anti-racist commissioning principles to tackle health inequalities?

The Population Health Hub has worked with each of the funded organisations from Year 1 to agree on a set of outcomes and how these will be measured. The majority of Year 1 projects are due to report on these outcomes in September/October 2025.

What are we working on - Year 2

Mental Health support for Asylum Seekers	How can we better support adult asylum seekers in Hackney with their mental health, both in terms of prevention and resilience, and when they experience illness or crisis?
Children and Young People's Mental Health	How can we refine and then harness the work already done towards developing an Children and Young People's Mental Health needs assessment to identify and implement opportunities for improving Children and Young People's mental health in City and Hackney?
Healthy Weight Pathway	How can we improve access to and better integrate our local weight management pathways to address stubborn inequalities and improve outcomes for high risk populations (those with special educational needs and disabilities (SEND), learning disabilities (LD), mental health conditions, certain age groups and certain global majority communities)?

More detail in narrative report

How can we support people to get out of food poverty while also supporting their health and wellbeing needs?

The MATCH Food Poverty programme area brought together partners working to support City & Hackney's most vulnerable residents experiencing food crisis and food poverty.

Bring the right people together	Examine data & insight and review pathways	Establish conditions for change	Generate & prioritise change ideas	Implement, test, and learn
Involvement of stakeholders via the Food Network. Held steering group meetings and larger in-person and online events with stakeholders.	Information and insight gathered from the Food Network and steering group. Literature review on what has been shown to be effective. Decided not to involve residents directly but to represent their stories.	During in-person and online events, we asked participants what is going well, less well and what is one thing you would change. We then collated all these ideas and updated the steering group on the outcome.	We had around 30 ideas which we shortlisted down to six ideas. Then held another workshop to bring this down to four themes (in report appendix).	The MATCH grants process opened after the final workshop. Grants panel included resident representation. Funded projects: -Weekly cooking club for young people -Veg box subscription model with tiered pricing structure -Conduct research into local food pantry models

How do we identify and tackle inequalities in maternity outcomes in an inclusive way?

The MATCH Maternity programme area brought together teams from the Homerton maternity services, statutory partners within social care and public health, voluntary sector services working in maternity settings, and residents & patients from the Maternity Neonatal Voice Partnership (MNVP), and parent groups to explore how to ensure a fairer service for black and global majority families using maternity services.

Bring the right people together	Examine data & insight and review pathways	Establish conditions for change	Generate & prioritise change ideas	Implement, test, and learn
In partnership with Homerton maternity services, facilitated two mixed stakeholder workshops including residents (lots of resident engagement happened outside of workshops to engage women in community settings too)	Analysed data from births within the Homerton maternity unit and collated information from across North East London. Engagement with of women and families to collect gather local insight.	Worked with stakeholders to explore: - What is working well in maternity services at Homerton - What is not working well - What are potential ideas for changing the elements that are not working well.	Prioritised the key change ideas that stakeholders felt would have the most impact: -Drop in information hubs for women antenatal and postnatal -Community doulas -Compulsory cultural awareness training co-produced with community and staff. -More translation available within maternity units. More information at initial referral.	The Birth Bridge Project have establish a Community Doula service by providing training for 32 local people to become qualified Doulas to work alongside Midwives at the Homerton Hospital. Homerton have translated their maternity information leaflets into six community languages and have also implemented compulsory cultural awareness training.

Is it working?

City & Hackney
Population Health Hub

The Value of MATCH

- Provides time and space to reflect on ways of working
- Builds relationships and networks with wider partners
- Change ideas have been developed with residents
- MATCH process is written down - understanding of where you are
- Time to complete service pathway mapping

Challenges for MATCH

MATCH works in a complex system

MATCH is not that easy to explain - it is not just about funding

More work is required to turn MATCH into a learning system

Meaningful resident participation that is equitable takes time and care

Proposed model for MATCH Year 3

City & Hackney
Population Health Hub

MATCH Year 3

MATCH Programme

In year 3, we will continue to test the MATCH approach but with **reduced project coordination from the City and Hackney Population Health Hub** and **minimal funding for change ideas**, in order to embed the programme in more teams, in a more sustainable way. A **flexible support package** including **training**, **opportunities for peer learning** across different MATCH project areas and **1:1 support** is being developed.

MATCH Playbook

A '**MATCH Playbook**' will be developed to support partners who wish to test the MATCH approach with minimal input from the Population Health Hub.

System Level Approach

In addition to the MATCH Programme and Playbook, the Population Health Hub will continue to lead on one MATCH project, taking a system level approach to a particular inequality, identified based on where there is opportunity for the biggest impact.

Engagement with system partners to promote MATCH

How will the MATCH be delivered in Year 3?

Training

Core training delivered on specific topics

Additional tailored training/support provided based on individual needs

Peer support

In-person group supervision / Action Learning Sets

Dedicated mentor

Resources

Directory of resources / external training and webinars / toolkits

'Matchmaker' directory

Continuous learning

Reflection and action cycles

Showcase to celebrate success and share learning

Feedback on programme to inform next cohort

Programme Structure

- **Monthly in-person sessions** incorporating theory and opportunities to put this into practice with project specific work
- **Monthly group supervision**
- **1:1 support from mentor every 2-4 weeks**

City of London specific MATCH project

Scoping is underway to explore ideas for a City of London specific MATCH project. Initial ideas which have been put forward include:

- Project led by Healthwatch City of London focussing on Portsoken ward
- Project led by the City Action Group focussing on one of the three priorities from the Joint Local Health and Wellbeing Strategy

Ask for HWB

1) Bringing this as an update on the work programme
2) Keen to hear feedback from HWB on
   - which parts of the system we could usefully engage with
   - input on the MATCH approach and anything missing
3) **Decision** on the proposed model for year 3

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MATCH Project on Embedding Health Equity

11 July 2025

Ask for Health and Wellbeing Board:

1) Bringing this as an update on the work programme
2) Keen to hear feedback from HWB on
   - which parts of the system we could usefully engage with
   - input on the MATCH approach and anything missing
3) **Decision** on the proposed model for year 3

Background

Context

The City and Hackney Population Health Hub was established in 2021 to support the City and Hackney Place-Based Partnership and wider system partners to reduce health inequalities and improve the health of our population. We know that there is a complex interplay of factors that influence health and wellbeing, hence the need for a system-wide approach to reducing health inequalities.

The development of MATCH

The e**M**bedding he**A**lth equi**T**y in **C**ity and **H**ackney (MATCH) programme has been developed as a tool to engage with system partners about health inequalities and population health, and to support our workforce to embed a health equity approach.

After discussion with system partners, we noticed that although there was a strong commitment to health inequalities in principle across the system, in practice many people felt they did not know where to start.

The MATCH programme aims to address this gap by **supporting teams and services across City & Hackney to embed health equity in their day-to-day work.**

The MATCH programme supports the City of London's Corporate Plan's outcomes of building diverse, engaged communities by involving residents and partners in shaping more equitable services, and to deliver excellent services by equipping teams to respond more effectively to the needs of all communities.

Using non-recurrent NEL Health Inequalities funding, we have developed an approach and a package of training and support to help partners to do this. The programme reports into a steering group formed of stakeholders from across the partnership.

Programme participants identify specific health inequalities to focus on which are relevant to their work and, as part of the MATCH approach, identify areas for change.

The first two years have focused on a more intensive project-based approach to build momentum, and we are proposing a pivot to an 'academy' style model in year 3 to enable more participants to get involved, and to be supported by those who have already been through the process.

What is the MATCH approach?

The MATCH approach is intended to be flexible and non-linear, adapting to the needs of the specific teams and area of work while supporting the City of London's Corporate Plan outcomes to build diverse, engaged communities and provide excellent, inclusive services.

The MATCH approach involves:

- Bringing the right people together: health care professionals, service providers, statutory partners, VCS organisations and residents with lived experience work collaboratively to design programmes and services
- Examining the data and insight available on the topic and reviewing this information through different lenses
- Establishing conditions for change: working with teams to look at barriers to embedding health equity and what is needed to sustainably take an equitable approach.
- Generating and prioritising change ideas
- Implementing, testing and learning from the prioritised change ideas

Through the MATCH approach, the MATCH programme aims to achieve the following outcomes:

- System partners are committed to tackling the systemic drivers of health inequalities
    - System partners are aware of how to address inequalities and how to embed a health equity approach
    - MATCH participants and system partners adopt a collaborative and participative approach to their work, reflecting the Corporate Plan's focus on engaging communities in co-creating better services.

    - Participants feel confident in planning action to narrow inequalities, and intent to tack action
- MATCH participants and system patterns plan, design and deliver effective action to narrow health inequalities and improve service quality for all.
- MATCH approach and projects continue beyond the initial period of support, contributing to sustained improvement in inclusive service delivery.

What have we done?

MATCH Year 1

During the first year of the programme there were five programme areas, each with a specific aim:

1. **Anti-racist commissioning**: How do we test anti-racist commissioning principles to tackle health inequalities?
2. **Food poverty**: How can we support people out of food poverty as well as supporting their health and wellbeing needs?
3. **Maternity**: HJow do we identify and tackle inequalities in maternity outcomes in an inclusive way?
4. **Prevention of poor outcomes from cardiovascular disease**: How do we improve prevention of poor outcomes from cardiovascular disease using an anti-racist and health equity approach in City & Hackney neighbourhoods?
5. **Women's health**: How do we support young women to manage their periods (to tackle inequalities in wellbeing, self-management and adverse outcomes from these)?

MATCH Year 2

For the second year of MATCH, there are three programme areas:

1. **Healthy weight pathways**: How can we improve access to and better integrate our local weight management pathways to address stubborn inequalities and improve outcomes for high risk populations?
2. **Mental health support for people seeking asylum**: How can we better support adult asylum seekers in Hackney with their mental health, both in terms of prevention and resilience, and when they experience illness or crisis?
3. **Children and young people's mental health**: How can we refine and then harness the work already done towards developing a Children and Young People's Mental Health needs assessment to identify and implement opportunities for improving children and young people's mental health in City & Hackney?

Appendix 1 shows progress for year 1 and 2 programme areas and **Appendix 2** provides case studies on the Food Poverty and Maternity programme areas.

Emerging findings from the ongoing MATCH evaluation

The interim evaluation report highlights specific areas of value of the MATCH programme:

- MATCH provides the time to reflect on a specific public health issue or concern with wider stakeholders and residents - it creates space to pause and evaluate ways of working. MATCH requires learning by doing - stakeholders learn to embed a health equity approach in their day to day work by doing this in a specific programme area with MATCH.
- Though MATCH currently provides a small amount of funding to each programme area to develop and design change projects, there is greater value in the relationships and networks that are built during the MATCH programme between wider stakeholders and residents working together.
- The change ideas have been developed in partnership with the residents they will serve.
- The MATCH approach is similar to the standard public health approach but there is value in having it written down - you can see where you are in the approach and understand that it is not linear.
- Some programme areas have taken time to complete pathway mapping of services in their area - this has been useful for stakeholders to understand the existing pathways better and identify any gaps and/or barriers along the pathway that residents might face.

The interim report has identified a few challenges for the MATCH programme:

- MATCH is working within a wider system - it may be able to push the boundaries some, but it does not control all aspects of the system that drive the wider determinants of health.
- The MATCH programme is not easy to explain and this has caused some difficulty for MATCH participants - MATCH is a complex system itself rather than a grants funding programme (as it is often misunderstood to be).
- Resident participation is essential for embedding a health equity approach and MATCH aims to involve residents in the work equitably and efficiently. Each MATCH programme area has addressed resident participation differently and is learning by doing. It is a challenging task that requires time and care.
- More work is needed to develop MATCH as a learning system.

Proposed outline for MATCH Year 3

In Year 3 of the programme, we will continue to test the MATCH approach but with reduced project co-ordination from the City and Hackney Population Health Hub and reduced funding for change ideas, in order to embed the programme in more teams, in a more sustainable way. We would like to test the replicability of this approach, by system partners, outside of the current programme structure.

A flexible support package including training, opportunities for peer learning with other MATCH project leads and 1:1 support is being developed. This approach does not intend to duplicate existing training in the area of health inequalities, the focus will be on supporting the practical application of existing frameworks and methodologies within a local context.

Scoping is underway to explore ideas for a City of London specific MATCH project. Initial ideas which have been put forward include a project led by Healthwatch City of London focussing on Portsoken ward and a project led by the City Action Group focussing on one of the three priorities from the Joint Local Health and Wellbeing Strategy.

We will develop a ‘MATCH Playbook’, aimed at partners who require minimal support but would like a framework for embedding health equity within their day-to-day work.

In addition to the MATCH Programme and the MATCH Playbook, the Population Health Hub will lead on one MATCH project, taking a system level approach to a particular inequality, identified based on where there is opportunity for significant impact.

Appendix 1 - more detail on projects from Years 1 & 2

The Population Health Hub has worked with each of the funded organisations from Year 1 to agree on a set of outcomes and how these will be measured. The majority of Year 1 projects are due to report on these outcomes in September/October 2025.

MATCH Year 1

MATCH Programme Area	Prioritised Change Ideas	Funded Change Ideas	Reflections
Anti-racist commissioning: How do we test anti-racist commissioning principles to tackle health inequalities? Run and managed by Hackney CVS following a tendering process.	Address the obstacles experienced by young black people to having mental wealth. Support young black people to achieve resilience and success in their mental wealth. Embody an ecological and village approach, rather than an individual one, to supporting the mental wealth of young black people. Have a lived experience approach to supporting the mental wealth of young black people.	Young Black People's Mental Wealth Fund	The groups working with Hackney CVS have reported satisfaction with the process of funding and the ability to carry out work which isn't often the focus of funding. The monitoring & evaluation has proved tricky and Hackney CVS have reported that if they were to do this again they would start with a framework as groups were a bit overwhelmed with being asked to design the whole process. A safe space to discuss the mental impact this work has on organisations was run by ELFT was offered but this wasn't taken

			up by many groups due to them being unsure exactly what the offer was. Some groups also expressed concerns that those running the space were not black themselves. Hackney CVS have said more work needed to be done to establish this group when projects were being delivered.
Food poverty: How can we support people out of food poverty as well as supporting their health and wellbeing needs?	Projects that link residents and community food providers with guidance, training and support on nutrition, health and wellbeing. Projects that deliver cooking classes to youth clubs Projects that gather evidence and research that supports increased insight into food poverty and/or food pantry models. Projects that build business models for sustainable food distribution.	Weekly cooking club for youth club members and their families Community veg box scheme with tier pricing structure Researching food pantry models and adapting findings to pilot a sustainable, affordable and culturally appropriate food pantry to reduce reliance on food banks.	Different approaches from the three projects have helped explore different areas of combating food poverty and supporting residents. The projects provide valuable learning to support the move from traditional food bank approaches to more sustainable models..
Maternity: How do we identify and tackle inequalities in maternity outcomes in an inclusive way?	Drop-in information hub - antenatal and postnatal information for women Community doulas	Bridge Birth Project - a community doula service providing training to local people to become qualified doulas to	Doulas have been recruited and trained - started supporting women A dashboard to monitor

	Cultural awareness training co-produced with community and staff More translation available within maternity units. More information available at initial referral.	work alongside midwives at Homerton Multilingual Maternity project allowing Homerton Maternity service to translate key digital patient information into the top 6 languages of patients	inequalities in maternity outcomes and measure the impact of the work has been developed.
Prevention of poor outcomes from cardiovascular disease: How do we improve prevention of poor outcomes from cardiovascular disease using an anti-racist and health equity approach in City & Hackney neighbourhoods?	Utilise existing community infrastructure to deliver activities that improve heart health and build capacity and knowledge within the community to take action. Take tailored, whole of person approaches to increase communication, awareness and understanding of the barriers and enablers to good heart health and key local support services. Provide information and training for people on lower incomes in their workplaces.	Women, Weights, and Wellness - physical activity sessions using weight and functional movement, with wellness sessions using relevant and culturally appropriate practices to address stress and mental health Health health in our hands - online heart health talks and information sessions, women's walking group and Zumba classes Love and Maintain Your Heart - One-to-one and group support sessions focusing on healthy lifestyles, gentle physical exercise, and blood pressure checks Carib Beats - fitness sessions, health talks, dance activities, and	Specialist Clinical Pharmacist delivering Blood Pressure@Home service is providing support and capacity building to the funded organisations, including basic training on heart health, advice on key messaging and signposting. Monthly meetings have been held for funded organisations to share challenges and best practice.

		health MOT checks to the community	
Women's health: How do we support young women to manage their periods (to tackle inequalities in wellbeing, self-management and adverse outcomes from these)?	Support for school pupils -Continuation of peer support around periods delivered to primary schools with sixth formers: "Well Talk" programme -Improve information and support within schools e.g. schools period charter -Inclusion of period support in Super Youth Hubs Maximise attendance at existing menopause support including Menopause Cafes Review existing information and revise to make information more accessible (use of Health Literacy toolkit); including information on periods, cancer screening, how to manage GPs. -Support practices to better support women manage their health (existing support via Women's Health Hub PCN clinicians)	Supporting women in the post-natal period to look after their health - Charedi women, Black women and Muslim women Peer support sessions for women with difficult periods (heavy/painful)	Two post-natal workshops have occurred, with efforts made to encourage attendance by women who may not usually access similar classes. Interest in the peer support project is strong, and efforts are being made to ensure women who might not know about or attend similar classes are invited. .

For the second year of MATCH, there are three programme areas.

MATCH Programme Area	Prioritised Change Ideas	Reflections
Mental Health support for Asylum Seekers: How can we better support adult asylum seekers in Hackney with their mental health, both in terms of prevention and resilience, and when they experience illness or crisis?	Projects that deliver social and leisure activities and facilitate peer support between participants (people seeking asylum, specifically those living in hotels run by the Home Office)	There is a lot of value in the ideas that do not require funding, but these ideas can be easily overlooked. Work to support asylum seekers experiencing illness or crisis has continued outside of MATCH.
Children and Young People's Mental Health: How can we refine and then harness the work already done towards developing an Children and Young People's Mental Health needs assessment to identify and implement opportunities for improving Children and Young People's mental health in City and Hackney?	*In progress*	Residents appreciate that their ideas are not only listened to but also implemented. The MATCH approach is a more holistic approach to understanding the needs of a population than a traditional needs assessment.
Healthy Weight Pathway: How can we improve access to and better integrate our local weight management pathways to address stubborn inequalities and improve outcomes for high risk populations (those with special educational needs and disabilities (SEND), learning disabilities (LD), mental health conditions, certain age groups and certain global majority	Projects that increase awareness of and/or improve access to information about healthy eating and/or physical activity for people from priority groups. Projects that are tailored or targeted interventions to support people from priority groups to adopt and maintain healthier habits related to diet and physical activity. Projects that help to increase the knowledge,	There were several overlapping themes in the prioritised change ideas between the prioritised communities/groups. Residents with lived experience who were involved valued being able to participate and share their ideas and views. Health professionals/service providers appreciated working with residents and other professionals.

communities)?	skills, and confidence of people working with priority groups about how to eat healthily and/or be more active. Projects that involve delivering activities (including those under objectives 1-3) in community locations and/or settings used and trusted by priority groups or focus on increasing peer or social support around healthy eating and physical activity.	

We are currently assessing funding applications for change projects for the healthy weight pathways programme area and applications are currently open for the funding of change projects for the mental health support for asylum seekers programme area.

We are working with stakeholders and residents to refine recommendations and change ideas for the children and young people's mental health programme area.

Appendix 2 - Case studies

How can we support people to get out of food poverty while also supporting their health and wellbeing needs?

The MATCH Food Poverty programme area brought together partners working to support City & Hackney's most vulnerable residents experiencing food crisis and food poverty.

Bring the right people together	Examine data & insight and review pathways	Establish conditions for change	Generate & prioritise change ideas	Implement, test, and learn
Involvement of stakeholders via the Food Network. Held steering group meetings and larger in-person and online events with stakeholders.	Information and insight gathered from the Food Network and steering group. Literature review on what has been shown to be effective. Decided not to involve residents directly but to represent their stories.	During in-person and online events, we asked participants what is going well, less well and what is one thing you would change. We then collated all these ideas and updated the steering group on the outcome.	We had around 30 ideas which we shortlisted down to six ideas. Then held another workshop to bring this down to four themes (in report appendix).	The MATCH grants process opened after the final workshop. Grants panel included resident representation. Funded projects: -Weekly cooking club for young people -Veg box subscription model with tiered pricing structure -Conduct research into local food pantry models

City & Hackney Population Health Hub

How do we identify and tackle inequalities in maternity outcomes in an inclusive way?

The MATCH Maternity programme area brought together teams from the Homerton maternity services, statutory partners within social care and public health, voluntary sector services working in maternity settings, and residents & patients from the Maternity Neonatal Voice Partnership (MNVP), and parent groups to explore how to ensure a fairer service for black and global majority families using maternity services.

Bring the right people together	Examine data & insight and review pathways	Establish conditions for change	Generate & prioritise change ideas	Implement, test, and learn
In partnership with Homerton maternity services, facilitated two mixed stakeholder workshops including residents (lots of resident engagement happened outside of workshops to engage women in community settings too)	Analysed data from births within the Homerton maternity unit and collated information from across North East London. Engagement with of women and families to collect gather local insight.	Worked with stakeholders to explore: - What is working well in maternity services at Homerton - What is not working well - What are potential ideas for changing the elements that are not working well.	Prioritised the key change ideas that stakeholders felt would have the most impact: -Drop in information hubs for women antenatal and postnatal -Community doulas -Compulsory cultural awareness training co-produced with community and staff. -More translation available within maternity units. More information at initial referral.	The Birth Bridge Project have establish a Community Doula service by providing training for 32 local people to become qualified Doulas to work alongside Midwives at the Homerton Hospital. Homerton have translated their maternity information leaflets into six community languages and have also implemented compulsory cultural awareness training.

City & Hackney Population Health Hub

City of London Corporation Committee Report

Committee(s): Homelessness and Rough Sleeping Subcommittee Health and Wellbeing Board	**Dated:** 10/07/2025 11/07/2025
Subject: Meeting Health Needs for People Rough Sleeping in the City of London	**Public report:** For Information
This proposal: ● **delivers Corporate Plan 2024-29 outcomes** the strategic implications section]	Corporate Plan Outcomes: ● Diverse Engaged Communities ● Providing Excellent Services
Does this proposal require extra revenue and/or capital spending?	No
If so, how much?	N/A
What is the source of Funding?	N/A
Has this Funding Source been agreed with the Chamberlain's Department?	N/A
Report of:	Judith Finlay Director of Community & Children's Services
Report authors:	Will Norman Head of Homelessness, Prevention & Rough Sleeping Nana Choak Homelessness Health Coordinator Andrew Trathen Consultant in Public Health Cindy Fischer Senior Manager, Unplanned Care NHS North East London Dr Padma Wignesvaran

	Clinical Director – Homeless & Inclusion Heal, Greenhouse Practice

Summary

This paper presents an overview of support offered across the City of London to address the health needs of the rough sleeping population, both in the context of local services and wider policy developments at the North East London level. It outlines some of the challenges that rough sleepers face in accessing services and changes underway in the ICB designed to address them.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. People experiencing homelessness in London often also experience significant health inequalities driven by overlapping social determinants such as poverty, unstable housing, substance use, and mental health issues. These challenges create compounded healthcare needs, generally known under the umbrella term of "tri morbidity," which includes physical illness, mental health challenges, and both illicit substance and alcohol use. Key examples include:
    - early-onset geriatric conditions: homeless individuals in their 50s often display health profiles akin to housed individuals in their 70s or 80s, suffering from frailty, chronic diseases, and cognitive decline.
    - unplanned hospital admission: homeless populations are disproportionately admitted to hospitals for preventable conditions, with extended stays due to discharge complexities.
    - mortality rates[1]: homeless men and women have average life expectancies of 45 and 43 years, respectively, compared to 76 years for the general population.
2. The sole GP practice within the Square Mile is the Neaman Practice, which primarily serves the residential population. Where registered with a GP, City of London rough sleepers are generally registered with practices like the Greenhouse Surgery (Hackney), Health E1 (Tower Hamlets), and the Dr Hickey Surgery (Westminster). These surgeries are located outside the City of London

[1] Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England - PubMed, crisis_homelessness_kills_es2012.pdf

and for reasons of distance, complex needs and chaotic lifestyles, can be challenging for rough sleepers to access. Current practice is to signpost new and/or unregistered rough sleepers encountered in the Square Mile to the Greenhouse Surgery.

3. Mobile healthcare models aim to reduce barriers that prevent rough sleepers from accessing traditional healthcare settings. By delivering care directly to underserved locations, mobile units provide both physical healthcare and welfare support such as food, clothing, and hygiene products.

Current Situation

4. Our primary data source for rough sleepers is the Combined Homelessness Information Network (CHAIN). This database is commissioned by the Greater London Authority (GLA) and managed by Homeless Link. People are counted as having been seen rough sleeping if they have been encountered by a commissioned outreach worker bedded down on the street, or in other open spaces or locations not designed for habitation, such as doorways, stairwells, parks or derelict buildings. The report does not include people from "hidden homeless" groups such as those "sofa surfing" or living in squats, unless they have also been seen bedded down in one of the settings outlined above.
5. This means that although the intelligence from this database is informative, it is difficult to draw definitive conclusions as not all individuals will be captured, and there may be inconsistency in obtaining and recording information during these encounters.
6. Between 2020 and 2024, CHAIN data indicate that 1,523 unique individuals were recorded rough sleeping in the Square Mile, with 656 of those seen in 2023/24 alone (data for 2024/25 has not yet been published).
7. Of the 1,523 unique individuals, only 477 have accurate support needs recorded on the database. Among them, 10% (47) reported disabilities, 119 had medium or high physical health needs, and 194 had medium or high mental health needs. Additionally, 38 had medium or high needs across all areas, while 187 (40%) had medium or high needs in three areas.
8. Despite the significant levels of need, barriers like mistrust, mobility, and eligibility concerns often prevent people from engaging with traditional healthcare services. This has led to the development of an outreach offer. This has recently been facilitated by the Community Wellbeing Team (CWT), a mobile unit capable of supporting a range of logistical needs that allow us to tackle these barriers and connect people with the healthcare system.

Community Wellbeing Team

9. The City of London has deployed mobile health delivery to help address the challenges in accessing care that are rough sleeping.

The aims are to:

- Improve health outcomes: address the specific health challenges faced by the homeless population by delivering targeted and effective primary care.

- Increase access to health care: overcome barriers such as mobility, digital exclusion, or distrust of traditional healthcare systems by bringing care directly to individuals in need.

- Address wider needs: provide holistic support that goes beyond health, by recognising and responding to the interconnected challenges of homelessness, health, immigration, and many others.

10. The Community Wellbeing Team has four members and uses mobile outreach vehicles to support people in City and Hackney. The team uses flexible outreach methods to engage vulnerable residents and provide support, advice, and harm reduction resources to people who are experiencing homelessness and who use substances problematically.
11. Since February 2023, the CWT has operated in the City of London on Wednesdays from 0900 - 1200. CWT work with the Greenhouse to provide a space which offers basic health checks to people rough sleeping. Health checks typically include blood pressure, wound inspection, prescriptions, GP registrations and questions around general wellbeing and mental health. Turning Point also offers drug and alcohol support with a non-medical prescriber.
12. The service currently operates at Puddle Dock, Baynard Castle, which is identified as a high-impact rough sleeping area by City of London Joint Working Group Meeting. On-the-ground intel is provided by the City outreach team provided by Thames Reach and the City Navigator Team provided by St Mungos.
13. Depending on the need, the service has previously rotated between Monument, Peninsular House, White Hart Court, and Moorgate or adopted a targeted roving model with Turning Point offering Opiate Substitution Therapy (OST) restarts to rough sleepers.
14. CWT also supports Guy's and St Thomas Health Inclusion nurse (HIT), which is funded by the Homelessness and Rough Sleeping Team at City of London, by providing the trailer outside Snow Hill Court because the building does not have a clinical space. The HIT service runs from 1000 - 1400 on Mondays to provide access to primary care, which includes full health assessments, blood tests, prescriptions, vaccinations, screenings, wound care, frailty assessments, and referrals into secondary care to residents in the assessment centre. They are joined by Hackney Harm Reduction Hub who do outreach across the City offering harm minimisation and BBV testing.
15. Aside from the core offer, the team have also worked with the smoking cessation service, Open Doors, Praxis, Groundswell, Hep C Trust, and Barts Liver Van. These services have joined in addition to the GP and Non-Medical Prescriber (NMP).

Challenges

16. The service in the City of London faces many challenges specific to the locality. Despite the relatively small geographical area, individuals are reluctant to walk short distances to engage with the services offered. There appear to be several reasons for this that the team has recorded anecdotally, including not wanting to leave a begging spot or sleep spot. The time of day has been noted as a possible boundary to engagement because it coincides with the morning commuter rush. Discussions are ongoing around deploying at different times however, service resources are limited, and The Greenhouse is unavailable outside of normal working hours of 8am to 6.30pm.
17. The CWT's mobile health delivery model is wellbeing focussed and equipped with a private consultation room. However, it does not offer a full clinical space specified with the necessary supporting equipment such as printers. Therefore, clients need to travel to the Greenhouse or another physical premises for access to primary care, follow up treatment, consultation and other clinical interventions.
18. Recruitment and retention of suitable clinical staff has been challenging due to shift requirements and working practices.
19. While there are obvious benefits to mobile delivery models – targeting specific groups or locations for example, lacking a fixed location misses a potential opportunity to establish a consistent and predictable service offer.

Greenhouse and Other Health Partners

20. The Greenhouse Practice provides care to people living in hostels or supported accommodation, rough sleepers, and people who spend a significant amount of time on the street or in other public places in the Hackney and the City. The mission of the practice is to improve access to good health care for vulnerable people. The service is part of the East London Foundation Trust (ELFT)
21. The clinic is based in Hackney and shares a building with the Hackney Housing team who provide housing support for single homeless people in Hackney.
22. The Greenhouse clinic provides the following services:
    - GP
    - Nurse
    - Health Care Assistant (HCA)
    - Health and wellbeing coach
    - Social prescriber
    - Citizens advice legal advisor
23. The Greenhouse team also work with other health professionals and teams to provide a range of services inhouse including:
    - Podiatry
    - Diabetic nurse specialist
    - First Contact Physiotherapy

- Hep C Trust

24. There are a range of challenges which limit Greenhouse in terms of the scope of provision. The practice only has three clinical rooms available, which constrains the number of services the team would ideally wish to provide. Funding is available for a single full time GP, which has remained constant despite increases in patient registrations. The location of the site is outside of the City, and this can mean patients do not access all of the support that Greenhouse may be able to offer them.
25. During COVID, ELFT were commissioned to provide outreach to the homeless population in hotels. In 2022 outreach services were combined with Greenhouse to provide outreach into these hotels and the 'Change Please' homeless bus. This contract drew to a close in 2024 and was extended into 2025 and is currently under review. City of London has not used the 'Change Please' element of the contract since October 2022. Clinical capacity was redirected towards the City Assessment Service which was initially located at the Youth Hostel Association site on Carter Lane and then later at the City Inn Express on Mare St in Hackney.
26. The team currently provides outreach care into Snow Hill Court Assessment Centre and supports the City Outreach Team. Outreach is only available during opening hours of Greenhouse, 8am to 6.30pm.
27. Two GP outreach sessions are spent in the City of London. Working closely with the City Outreach Team (Thames Reach) and other stakeholders, the outreach offer has been developed specifically to support the needs of City Clients:
    - Currently on Wednesday mornings we have a GP working with a health advocate from Groundswell doing street outreach with City Outreach to target patients of concern.
    - The GP is then based on the Community wellbeing van to provide services in a fixed place with Turning point. The GP then provides in-reach into Snow Hill Court.
28. The Greenhouse team works closely with City Outreach, Navigators, RAMHP, Turning point and the Pathway team to provide targeted support for vulnerable clients.
29. The City of London have dedicated Social Worker and Strength Based Practitioner roles integrated into the Rough Sleeping Team. These roles work closely with outreach services and the Snow Hill Court Assessment Centre to enable greater equity of access to Care Act assessments and general coordination of social care interventions. Access to underserved groups such as rough sleepers at larger encampments can be safely facilitated through the CWT.
30. The outreach work is currently out of contract, and the future of the service alongside any developments will be part of wider planning and negotiations at the NEL ICB level.

ICB Perspective

31. East London NHS Foundation Trust has been providing the outreach service since May 2020 in City and Hackney. This has been over and above the service delivered through their homeless practice (the Greenhouse). The population in scope has extended to include a large refugee and asylum seeker population (though this is less an issue for the City of London), and a growing street homeless population in the City.
32. The Alternative Provider Medical Services (APMS) inclusion practice contract with the Greenhouse also contains an element of outreach activities in addition to the services offered at the practice site.
33. Over time, the Greenhouse has flexed the delivery model in terms of allocation of clinical resources, time, and locations visited, and this has evolved since the service commenced and is in response to changing needs.

34. The ICB has developed a NEL Homeless Health Strategy which was approved in May 2025. Development of the strategy and engagement with system partners has highlighted that limited or inconsistent outreach services can further exacerbate health inequalities in the homeless population. Therefore, developing NEL principles for outreach services for people experiencing homelessness is an agreed action within pillar 2 of the strategy. This is a complex piece of work, and it is important to continue service provision while this is developed.
35. The proposal is to commission interim outreach services to cover gaps in City and Hackney, Newham, Tower Hamlets and Waltham Forest while a NEL wide service is developed. These interim arrangements will build on services provided by existing providers and ensure that current levels of service are maintained to ensure continuity of care.
36. The ICB is working with the East London Foundation Trust to finalise arrangements for interim outreach services for 2025-26. There will be the option to extend by a further 6 months if required to ensure that there is continuity of service to homeless patients.
37. Having these interim arrangements in place will give us time to move to the NEL wide service once the model has been finalised which will lead to a more equitable service provision across NEL.

Options

38. None

Proposal

39. None

Key Data

40. As per main report

Corporate & Strategic Implications

Financial implications

None

Resource implications

None

Legal implications

None

Risk implications

None

Equalities implications

None to consider at this stage

Climate implications

None

Security implications

None

Conclusion

41. People rough sleeping in the City face a range of barriers to accessing care, against a background of high levels of need for their physical and mental health. There are numerous reasons that individuals may not visit a GP including geography, anxiety about leaving a specific location, mistrust of services, negative previous experiences, concerns about eligibility and more.
42. A key element in our response to these issues comes from outreach provided by the CWT, the Greenhouse and other ELFT services. Bringing services to people where they are at aims to connect individuals with the services they need and also aims to build better relationships between clients and professionals.
43. The benefits of this approach are recognised in the new NEL homeless health strategy. Work is now underway to improve both core primary care provision and outreach coverage across the region, with suitable stakeholder engagement to ensure the unique needs in the City are met.

Appendices

- Appendix 1 – NEL Homelessness and Rough Sleeping Strategy

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North East London Health & Care Partnership

NEL Homeless Health Strategy 2025 – 2030

Working together to improve health outcomes for people experiencing homelessness.

Contents

Introduction

Our vision as an integrated care system (ICS) is to create meaningful improvements in health, wellbeing and equity for everyone living in north east London (NEL). This means partners across the neighbourhoods and communities, places and partnerships of NEL working together to tackle today's challenges and ensure sustainable services for the future. We are driven by a focus on prevention, early intervention, reducing health inequalities and supporting the most vulnerable and excluded people to improve their health outcomes.

Health inequalities, the avoidable, unfair and systematic differences in health outcomes, exist between NEL and the rest of the country and between our places and communities; reflecting broader societal inequalities. Underpinned by national guidance such Core20PLUS5,[1] [2] the national framework for inclusion health,[3] as well as NICE guideline for integrating health and care for people experiencing homelessness,[4] our system has co-designed the NEL Homeless Health Strategy.

Evidence shows people experiencing homelessness and those in 'inclusion health groups'[5] face social exclusion, multiple overlapping risk factors for poor health (such as poverty and complex trauma), stigma and discrimination and are not consistently accounted for in electronic records. As an umbrella term, 'inclusion health' describes groups of people who experience multiple health issues, such as mental and physical ill health and substance dependence issues, combined with deep barriers to accessing health and care services. This results in extremely poor health outcomes which are often much worse than the general population, including a significantly lower average age of death.

The decision to develop the NEL Homeless Health Strategy builds on a strong history of partnership work and best practice in supporting people experiencing homelessness, intensified during and after the COVID-19 pandemic, when the need for collaboration was amplified and actioned in many ways. To strengthen and build this approach, following a robust process of co-design and engagement, we are proud to present the NEL Homeless Health Strategy 2025-2030.

> The strategy is a call to action to convene the system around the most important areas of joint focus for the population (with a wide definition of homelessness) and provide a strategic framework to support place and neighbourhood partners to develop plans to address this population's needs over five years.

The strategy is presented alongside the 'North East London Homeless Health Strategy: A Case for Change', an extended document providing a comprehensive narrative of the evidence, data and context steering the strategic priorities and areas of focus in the strategy.

Executive summary

Our purpose

The NEL Homeless Health Strategy is a call to action to convene the system around the most important areas of joint focus and improvement for the population (with a wide definition of homelessness) over 5 years. It provides a strategic framework to support place and neighbourhood partners to develop plans to address the needs of people experiencing homelessness.

Our ambition

Driven by a range of underpinning evidence, policy and guidance and our extensive co-design process, the **overarching ambition** of the NEL Homeless Health Strategy is to:

> Improve health and social outcomes for people experiencing homelessness through integrated health, care and housing pathways and a focus on the wider determinants of health.

Our approach

We will deliver our ambition by working together towards five **homeless health pillars** and three **cross cutting themes,** underpinned by the **key strategic opportunities** identified.

Our homeless health pillars

The goals of the **five homeless health pillars** are to:

1. Improve pathways for hospital admission, discharge and ‘step-down’,
2. Improve equitable access, increase engagement in and ensure high quality primary and community care services,
3. Develop innovative approaches to deliver proactive, personalised care and enhance access to mental health, substance misuse, and end-of-life care and support,
4. Strengthen a preventative approach to reduce the risk of poor health outcomes for families living in temporary accommodation,
5. Develop the infrastructure to support people seeking asylum and refuge to understand, access and be supported by health, care and wider services.

Each homeless health pillar has a defined set of priorities, shaped by evidence and lived experience insights about the context, issues and solutions that can drive change. The priorities aim to strengthen core provision (mainstream and specialist services), guide key projects, and create opportunities to test, learn, and scale impactful, sustainable solutions.

Our cross-cutting themes

Representing key areas of focus across all pillars, our cross-cutting themes both support specific pillar priorities and address broader issues essential to improving health and social outcomes for people experiencing homelessness.

The **three cross-cutting themes** of the Homeless Health Strategy are:

- **Safeguarding:** Ensuring the health, wellbeing and human rights of people experiencing homelessness are effectively protected through safeguarding
- **Workforce development:** Building and supporting a skilled, compassionate workforce, while creating employment opportunities for people with lived experience.
- **Data, intelligence and evaluation:** Using better data, evidence and evaluation to drive change for people experiencing homelessness and inclusion health groups.

Our key strategic opportunities

The strategy is underpinned, steered and enabled by four key strategic opportunities (see Our opportunities)

- Building our call to action through integration and collaboration across NEL and within places and neighbourhoods
- Working with local people and communities
- Greater focus on prevention, early intervention and the wider determinants of health
- Equitable access to core services and specialist support

Transformation, system delivery and financial approach

Importantly, the strategy will not stand alone. It must influence and be embedded across NEL strategic commissioning programmes and priorities, including long-term conditions, primary, secondary and urgent care, mental health, substance misuse, and housing and health priorities.

In addition, wider NEL system strategies, such as the Anti-Racist Strategy and the People and Culture Strategy set shared ambitions that support and strengthen our work, creating further opportunities to improve health and social outcomes for people experiencing homelessness at system, place and neighbourhood levels.[6] [7]

Transforming and integrating services to address health inequalities is essential but complex, particularly under financial pressures. With the cost of inaction increasingly clear, achieving meaningful change demands balancing limited resources with innovative, sustainable solutions that ensure equitable access to high-quality care and support for all. Achieving the ambitions of the NEL Homeless Health Strategy will require a robust financial strategy: building clear investment cases, evidencing population and system impact, demonstrating return on investment, securing partnership funding and maximising external grant opportunities to drive lasting change.

Defining homelessness

Homelessness is not static and takes many forms. Nationally, homelessness is defined widely, recognising the complexity of people's lives, that experiences change over time and that homelessness is often hidden or not in plain sight.[8] People can experience homelessness in the following ways, all of which can have a detrimental impact on health:

- Rooflessness – people living without shelter and sleeping rough on the streets.
- Houselessness – people who have temporary places to sleep, including people living in local authority temporary accommodation or in institutions, shelters or provided accommodation, for example people seeking asylum.
- Living in insecure accommodation – people threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends known as 'sofa surfing.'
- Living in inadequate housing – people living housing that is in poor condition and disrepair, for example without electricity, water and heating, or housing that is overcrowded and unsuitable.

Scope of the NEL Homeless Health Strategy

Whilst homelessness is broad and changeable, the strategy takes a targeted strategic commissioning-based approach to improving health and social outcomes by focusing on the most pressing needs within these population groups and the opportunities available within the ICS. Guided by national and local evidence, including insights from those with lived experience, the NEL Homeless Health Strategy focuses on the following groups:

- People who are rough sleeping - particularly those experiencing prolonged and more complex rough sleeping
- Families with children living in temporary accommodation
- People seeking asylum and refuge

The strategy considers improving access to primary care a universal need for all people experiencing homelessness. Furthermore, the focus of the strategy supports the overlapping needs of other inclusion health groups, including people in contact with the criminal justice system, sex workers, people with drug and alcohol dependence and Gypsy, Roma and Traveller communities.

The case for change

Population summary and challenges

Homelessness is driven by the cost of living, availability and cost of housing, mental and physical health problems, job insecurity and the significant increase in people seeking asylum. This section presents a high-level profile of people experiencing homelessness, their health needs, the challenges faced when accessing health and care services, as well as a summary of the cost of inaction. Data on homelessness is often limited, meaning we have drawn on wider sources of evidence. Where local evidence for NEL exists, it is included throughout the strategy.

- **London is the epicentre of the national homelessness crisis**. London Councils estimate more than 175,000 Londoners are homeless and living in temporary accommodation – equivalent to one in 50 residents of the capital.[9]

- The number of people **sleeping rough** in NEL in 23/24 was 2,636 (up 12.5% from 22/23).[10]
- It is estimated that **13% of people rough sleeping are women**. Women experience homelessness differently to men; they are more vulnerable to the dangers, less visible and their experiences are more challenging to understand.[11]
- Disproportionate levels of homelessness are seen in **people from ethnic groups**[12] and it is estimated that 12% of people experiencing homelessness are **autistic**[13] (compared with around 2% of the general population).
- People with a history of imprisonment or **contact with the criminal justice system**[14] [15] are at higher risk of homelessness and evidence suggests a notable intersection between homelessness and **engagement in sex work**,[16] [17] particularly among vulnerable populations.
- Romany Gypsy, Roma and Irish Traveller communities are disproportionately affected by homelessness,[18] and face life expectancies of **ten to 25 years shorter** than the general population.[19]
- The numbers of households living in temporary accommodation in NEL continues to rise (19,195 in March 24) and 70% of these households have children. **16% of all households living in temporary accommodation in England are in NEL.** [108]
- The **number of people seeking asylum is rising** nationally and in NEL, with around 7,000 people seeking asylum living in NEL as of the end of 2024.[20] Evidence suggests that over **50% of people sleeping on the streets are non-UK nationals.**[21]
- People experiencing homelessness are more likely to experience common health conditions and often at a higher level of severity than the general population, creating **frailty at a much younger age.**[81]
- People sleeping rough have a **life expectancy of around 45 years** and **extremely high levels of untreated and chronic conditions** such as TB, hepatitis C, epilepsy or heart disease.[53] [84] People are much more likely to have **mental health and substance misuse problems**, or a combination of both.[174]
- This population has experienced and experiences **high levels of trauma.**[22]
- **Access to health and care services is challenging** for a range of reasons including – staff incorrectly requiring ID when people seek to register with a GP, inflexible services lacking capacity and not designed to meet needs, communication and language barriers, problems navigating services, digital exclusion, people moving locations frequently, stigma and discrimination.[174]
- People experiencing homelessness and wider inclusion health groups are **not consistently recorded in health, care and wider datasets** when interacting with services.[58] This means the data and evidence used for service design and evaluation is insufficient and lacking in consistency and quality, exacerbating the fact that services do not meet their needs.
- Whilst people experiencing homelessness often **struggle to access a GP,**[60] they are much more likely to **attend accident and urgent care**, be admitted to hospital, stay longer and be re-admitted in a short space of time.[23]

The cost of inaction

Homelessness has a significant human cost, affecting people's health and life outcomes, and homelessness creates financial pressure on health, care, and wider public services. National guidance shows that, given these costs, most interventions to address homelessness are likely to be cost-effective or even cost-saving for public services.[4]

Data and intelligence show that:

- The estimated public sector **costs of a person experiencing homelessness is approximately £40,000 per year** in England (based on 2019/20 prices), whilst preventing homelessness for one year would reduce that cost by £10,000 per person.[24]

- Estimates suggest the NHS spends **£4,298 annually** on someone who is homeless, **four times** as much as the general population who are housed.[25]
- Preventing rough sleeping for a year could **reduce public spending by over £115 million** and if other forms of homelessness were included, these cost savings would be substantially higher.[26]
- Prior to the COVID pandemic, health inequalities were estimated to cost the NHS an **extra £4.8 billion annually**.[27] As the pandemic exacerbated health inequalities, it is reasonable to conclude that the cost of inequalities to the NHS had increased.
- In 2023, **delays to discharge from hospital cost the NHS £1.89bn.**[28] People experiencing homelessness are more likely to be admitted and face complex discharges, and data from specialist homeless hospital teams in NEL shows that targeted interventions can reduce hospital attendance, admissions, delays, and discharges to the street.

Our opportunities

Amid these challenges, there are significant opportunities to work together within and beyond NEL ICS to address the health inequalities people experiencing homeless face and create meaningful improvements in health, wellbeing and equity. These opportunities align with a national[29] and local focus[30] on reducing health inequalities, improving outcomes for inclusion health groups, preventing ill-health and a shift to doing more in neighbourhoods and communities, driven through strategic commissioning. We are encouraged by recent strengthened cross-government commitments to end homelessness, alongside investment to tackle its root causes[31] and new regional focus.[32] Evidence, guidance and national positioning show the need to achieve sustainable and lasting change by using a range of opportunities to do things differently and better.[33]

Key strategic opportunities

Building our call to action through integration and collaboration across NEL and within places and neighbourhoods.

- Through co-designing the strategy, we continue to strengthen the knowledge, momentum and commitment that through taking a population health approach and addressing health inequalities together, we can make a systematic difference for people experiencing homelessness.
- We will strengthen integration across health, care, local authorities, policing and the voluntary, community, faith and social enterprise (VCFSE) sector, creating trust and a shared focus on what matters to people, addressing needs holistically and sharing resources to reduce the long-term impact of homelessness.
- Visible leadership across partners, neighbourhoods and services is critical to advocate for inclusion health at every level and drive action from the top. Integrated neighbourhood working offers new opportunities to better support those with the most complex needs with the communities.[34]

Working with local people and communities

- We will work with people with lived experience of homelessness to understand needs, co-create solutions, and shift power towards those most affected, through strong partnerships with VCFSE organisations.
- Experts by experience will help design, deliver and evaluate projects and services, building opportunities for influence, skill development and work experience, and opportunities to support other people experiencing homelessness.[35] [4]

Greater focus on prevention, early intervention and the wider determinants of health

- We will drive a stronger, evidence-led focus on preventing ill-health and intervening earlier for people at risk of homelessness, addressing trauma, mental health needs, and barriers to accessing care and support.[36]
- Tackling wider structural drivers such as housing insecurity, economic vulnerability, and involvement with the criminal justice system, will be essential to achieving lasting change.
- As NHS priorities shift towards digital innovation, there are opportunities to address the digital exclusion people experiencing homelessness face, ensuring digital access becomes a tool for inclusion, not a further barrier.[37] [38]

Equitable access to core services and specialist support

- There is need to both improve equitable access to mainstream services and invest in consistently funded specialist support; preventing people experiencing homelessness from falling through the gaps.[4] [69]
- This means investing more in sustainable specialist services and interventions that evidence improved population and system outcomes. Specialist services should be person-centred, trauma-informed, multi-disciplinary and flexible; delivered by consistent staff and shaped by people with lived experience of homelessness.
- Transforming access to mainstream services such as primary care is fundamental, for example, normalising access to GP services to manage people's health and reduce reliance on secondary care.
- Integration is crucial, ensuring a 'no wrong door' approach; every contact with a service should be an opportunity to engage people and connect them to wider support.[39] [4] [69] Neighbourhood working and co-location of teams is vital for health equity, delivering accessible, holistic and cohesive services in shared places.[40]

Co-designing the strategy

The NEL Homeless Health Strategy has been co-designed with stakeholders across health, care, community, local authority, VCFSE, and people with lived experience of homelessness. This inclusive, evidence-led approach ensures the strategy meets the needs of people experiencing homelessness in north east London, while aligning with ICS goals and national priorities.

- The **NEL Homeless Health Strategic Reference Group**, established during the COVID-19 pandemic, drives joint working on homeless health, shares best practice, and initiated the call for a strategy, which it will now oversee.
- In May 2024, we hosted the **NEL Homeless Health Symposium**, bringing together over 100 system colleagues and people with lived experience to build the case for system-wide action and formally launch strategy engagement.
- Following the symposium, the strategy was co-designed through five **Pillar Working Groups**, each focused on a strategic pillar. Guided by a lead and a facilitated structure, groups (consisting of 12–26 colleagues, including sector representatives and people with lived experience) met three times to shape strategic priorities, timelines, and outcome measures using data and evidence.
- Alongside the pillar groups, we **engaged widely across the system**, presenting the strategy at over 30 NHS, place-based and sector meetings and forums.
- The **voice of people with lived experience was embedded throughout the design process**. Groundswell and Cardboard Citizens first helped frame the strategic pillars, contributed creatively at the Symposium, and later worked with us to review and validate priorities. People's lived experience also shapes current delivery, for example we partnered with the Magpie Project to undertake procurement.

The strategy has been positively received and supported across the system, making it the first ICS Homeless Health Strategy in the country. Co-designed with the system and individuals with lived experience, it represents an evidence-led, committed and evolving effort to address the health needs of the homeless population in north east London through continuous collaboration.

Pillar 1 – Improve pathways for hospital admission, discharge and 'step-down'

'*Your discharge summary goes in the bag along with your other belongings. Not once was the discharge summary read out to me, it was taken for granted that I understood all of the medical terms. One discharge summary literally said "discharged back to streets.*"'
Centre for Homelessness Impact, 2020.[41]

Nationally, people experiencing homelessness are six times more likely to attend A&E, three times more likely to be admitted, and stay in hospital three times as long.[42] They are more likely to have unscheduled care that costs eight times more than the general population, have the poorest experiences of health services and are often discharged to the streets.[43] [44]

A sub-set of data for NEL inner boroughs* shows 22,000 A&E attendances in 2023, with 50% of people attending more than once. Where recorded, attendances are often linked to alcohol, substance misuse, and mental health needs, though many leave before being seen or go undiagnosed. Notably, 35% of people reattend within seven days. Emergency admissions show a similar trend: 2,162 people were admitted in 2023, often repeatedly, for complex, chronic conditions such as substance misuse, chest pain, COPD, and serious mental illness. Nearly 20% were readmitted within 30 days.[45]

People often stay in hospital longer than needed due to the complexity of their ongoing needs, including lack of accommodation, ongoing care or access to benefits.[46] Coming into and being discharged from hospital should be an opportunity to assess and support people holistically through multidisciplinary teams, including housing and healthcare professionals, working together to address and prevent homelessness, reduce harm and the system impact of repeat admissions.[47] [48] [49] [50] [51] [52] [53] [54]

When leaving hospital, 'step-down' community-based intermediate care can offer short-term accommodation and support, aiding recovery and access to services, while reducing discharges to the streets, hospital use and associated costs of acute services[55]

Some NEL boroughs have specialist teams supporting people in hospital and post-discharge in the community, showing positive results in reducing hospital use and improving outcomes.[56] [57] However, there's no consistent approach across NEL to identify, record, or support people experiencing homelessness in hospital. Often, homelessness is only identified at discharge, hindering people's complicated needs and prolonging stays. Hospitals are not suitable places for major life decisions. Through the development of specialist multi-disciplinary teams, discharge support, and step-down options, we aim to support more people in the community. Working with partners across NEL – hospital leads, discharge planners, and local authorities – and informed by national guidelines and legal duties, we've identified key priorities to improve hospital admission, discharge, and step-down pathways for people experiencing homelessness, aiming to prevent readmission and worsening health. We will:

- Work with key partners to **create and implement guidelines and principles for hospital admission and discharge** in NEL for people experiencing homelessness,
- Develop a **NEL discharge model to support people to leave hospital** when they are well enough but still need care (discharge to assess),
- Develop a **bed model to enable people to leave hospital** and access accommodation where they can receive ongoing care and rehabilitation (step-down care),
- Promote and embed the use of **health record systems and templates** that capture information about people experiencing homelessness and wider inclusion health groups (shared with Pillar 2).

'...it's easier to find A&E and for a lot of people, it's a warm place to stay.'
Groundswell Peers steering the NEL Homeless Health Strategy, 2025

* Hackney, Newham and Tower Hamlets

Pillar 2 - Improve equitable access, increase engagement in and ensure high quality primary and community care services

Whilst pillar one illustrates the high use of acute and emergency hospital services by people experiencing homelessness, the reverse is often true for preventative primary and community care, leading to untreated health needs that escalate in severity. General practice plays a critical role in enabling access to wider health and care services, including mental health support and long-term condition management. Yet people experiencing homelessness and other inclusion health groups face significant barriers accessing these essential services, painting a complicated picture of inequality.[58]

Despite NHS guidelines on universal access,[59] GPs often refuse to register people experiencing homelessness;[60] [61] citing lack of ID, address, or immigration status, barriers many people in inclusion health groups cannot overcome.[62] [63] Wider barriers include long wait times, inflexible systems, communication challenges and digital exclusion.[64] Stigma and discrimination foster mistrust and deter engagement and people seeing asylum or refuge face increased personal and structural barriers accessing and benefiting from healthcare, including general practice.

A NEL study found even with knowledge of registrations requirements, some practices were reluctant to register patients without documentation, influenced by moral judgements or perceptions of burden.[65] The Doctors of the World Safe Surgeries programme supports general practice to address barriers and promote inclusive access, with NEL places already implementing the model.[66] Underpinning these challenges is a lack of consistent data and understanding of the population, driven by poor data capture, analysis and sharing.[67]

Whilst mainstream services should support people, the barriers faced mean specialised, person-centred, multi-disciplinary services, that go to where people are (outreach), can meet their needs more holistically.[68] [69] [70] [71] Our engagement with Groundwell and Cardboard Citizens highlighted the importance of support for basic needs including clothing, personal care, wound treatment and foot health. A NEL pilot has shown how community-based services can reduce rates of preventable diseases.[72] Growing evidence supports the effectiveness of specialist primary care for people experiencing homelessness, emphasising the role of outreach,[73] flexible models, and trust built through consistent staffing.[74] [75] However, dental and mental health needs often remain unmet.[76] [77] [78]

Drawing on our key strategic opportunities, Pillar 2 presents the clear case improving access to universal, mainstream primary care[79] alongside delivering specialist and community-based care where population needs require it; seeking to prevent poor health outcomes and reduce reliance on urgent and hospital services. Across NEL, a range of specialist and outreach services currently support people experiencing homelessness, with the need to more comprehensively understand population needs, the impact of current services and opportunities for new best practice. To improve equitable access, increase engagement in and ensure high quality primary and community care services, with a focus on mainstream and specialist services, we will:

- Design, agree and implement a **NEL model for primary care services** for people experiencing homelessness,
- Support every general practice in NEL to join the **Safe Surgeries programme**, removing registration barriers and creating equitable access to mainstream primary care,
- Define and develop **principles for 'outreach' services** that support people experiencing homelessness where they are, and commission these services across NEL,
- Promote and embed the use of **health record systems and templates** to capture information about people experiencing homelessness and wider inclusion health groups (shared with Pillar 1).

'You are homeless, you don't have proof of address, its hard to get a GP. So when you come to [specialist homeless GP] they must work with you, they count you as a human.'
Groundswell focus group participant – Healthy London Partnership, 2019 [69]

Pillar 3 – Develop innovative approaches to deliver proactive, personalised care and enhance access to mental health, substance misuse and end of life care and support

People experiencing homelessness, particularly in the form of rough sleeping, are likely to have high levels of physical and mental health issues, at higher level of severity than the general population.[80] This creates vulnerability, ill health and frailty at a much younger age;[81] [82] [83] meaning people die younger,[84] and live in poor health at a much earlier age than the rest of the population.[85] This pillar aims to tackle these issues through two core themes: proactive and personalised care, and integrated support for mental health, substance misuse, and end-of-life care; offering a range of new approaches to address some of the most complex and systemic issues of multiple deprivation and homelessness.

Proactive care, traditionally used to support older populations, can be adapted to support the impact of homelessness[86] using multidisciplinary planning,[87] care coordination, and integrated neighbourhood teams to manage premature frailty. There is a clear need for more research and application of tailored proactive care models to improve outcomes. Personalisation empowers people with choice and control through approaches such as social prescribing, personalised budgets, and care planning.[88] [89] Personalisation has been shown to improve health and wider outcomes for people experiencing multiple disadvantage, focusing support on what matters most to them.[30] [90] [91] [92] [93] NEL projects (such as the T1000 Personal Health Budgets project) have evidenced how personalised support and budgets can address not just health needs but also support with housing, daily essentials, and wellbeing.[94] Tools like the Universal Care Plan can[95] ensure individuals' preferences guide care across all stages, including end of life.[96]

'This is the best I have felt in over five years and I am so thankful for all the help. I feel much more hopeful and human since being helped by the project and I can start to see a future for myself as a chef again.'
NEL T1000 Personal Health Budget Pilot, mid-point evaluation, January 2025

Homelessness is often a consequence of and results in ongoing trauma, having a major impact on mental health and increasing vulnerability to and the misuse of alcohol and drugs.[97] [80] This second theme addresses the treatment gap in mental health and substance misuse services, exacerbated by fragmented systems and restrictive access criteria.[39] [98] [99] [100] [101] [102] [103] The majority of people experiencing homelessness face barriers accessing mental health services and over half report difficulties accessing drug and alcohol services.[104] National and regional reforms, including the forthcoming co-occurring conditions action plan and London's mental health strategy offer timely opportunities to improve integration, focusing on inequalities in access and outcomes for the most underserved populations.

'…many people have alcohol, drugs and also mental health problems. They are often told that they have to deal with the alcohol or whatever first, but it doesn't work for people, so treating people for both conditions at the same time, would make a lot of difference…'
Groundswell Peer steering the NEL Homeless Health Strategy, 2025

End-of-life care remains a critical yet neglected area.[58] End of life is not often recognised and many people die in unsuitable environments, impacted by stigma and a lack of specialist support.[105] With less involvement from family and friends, people's wishes for care and practical arrangements are rarely known or met.[106] There's an urgent need for compassionate, person-centred services that recognise the unique needs of this group and enable planned, dignified care. Peer involvement and specialist outreach must underpin this approach.[3]

'…some of the things that really bother me are "will I get the right kind of funeral, will they play the songs I want at my funeral, will the people I know be informed that I am dead?"'
Groundswell Peer steering the NEL Homeless Health Strategy, 2025

This pillar focuses on new approaches and critical developments aimed at tackling the complex, systemic issues of multiple deprivation and homelessness that lead to frailty and premature death, particularly among those sleeping rough. Achieving meaningful change will require collaboration across a wide range of partners, each committed to acting.

In NEL, current proactive and personalised care projects provide valuable evidence and momentum. At the same time, national and regional developments in mental health and substance misuse services present important opportunities to close treatment gaps. In end-of-life care, we will build on existing expertise and practice to support people differently at this most vulnerable stage. Through this pillar of the strategy, we will:

- Identify and understand where **personalised and proactive care** can provide greatest potential impact on health and system outcomes, learning from approaches within and beyond NEL and building evidence of what works,
- Develop a **NEL personalised care and support planning template** that embeds co-ordinated, multi-professional interventions to address the person's range of needs including end of life care,
- Strengthen collaboration between **mental health and drug and alcohol treatment services** to deliver high quality personalised treatment and better outcomes for people with co-occurring substance use and mental health conditions,
- Develop a **consistent approach to providing end of life care** across NEL that takes learning from current provision.

Pillar 4 - Strengthen a preventative approach to reduce the risk of poor health outcomes for families living in temporary accommodation

Temporary accommodation (TA) refers to short-term housing provided by local authorities for people experiencing or at immediate risk of homelessness.[107] Doubling nationally since 2011, the number of households living in TA in NEL in 2023/34 was 19,1195, nearly 16% of all TA households in England.[108] 70% of those households have children; approximately 1 in 17 children in NEL live in TA. While TA is intended as a short-term solution, many live in TA for extended periods, sometimes years.[109] In the last decade nationally, the number of households being located outside their home borough has increased by more than 100%, making supporting these households challenging.[110]

The relationship between living in TA and poor health and social outcomes is becoming clearer.[111] Living conditions including overcrowding and a lack of basic facilities often exacerbate and impact the physical and mental health of adults and children,[112] [113] [114] [111] preventing children from receiving the 'best start in life' and hindering development.[115] Families are often relocated outside their local areas, leaving social networks, communities, workplaces and schools.[112] [116] Lived experience insights from the NEL based Magpie Project[117] shows frequent moves have an impact on children with special educational needs and disabilities (SEND) and acutely, TA can increase the risk of sudden infant death syndrome (SIDS) due to difficulty creating safe sleeping spaces.[118]

As with other forms of homelessness, people living in TA struggle to access primary care, often due to relocation and turn to emergency services more often.[111] [113] [119] Housing is a well-established determinant of health[120] and equipping organisations and front line workers with tools for holistic support can clarify roles, improve continuity of care and reduce the cycle of homelessness.[71] [121] [122] [123] Best practice shows the value of a consistent point of contact, psychologically informed approaches, and minimum standards for children in TA, alongside support with benefits, relocation and legal advice. This is especially vital for people with disabilities, neurodivergence, complex mental health needs, or people who do not speak English as their first language.[111] [124] [121] Debt is both a cause and consequence of homelessness, often worsening in TA, especially for women who may borrow to meet basic needs. Rent arrears are a leading trigger of family homelessness and a barrier to social housing. Lasting financial strain makes access to debt and benefits advice critical to prevention and recovery.[125] [126]

'I have moved twice in the past 3 months, I don't know where the letters are going...'
'I was afraid they would judge my babies lack of warm clothes…'
'I didn't want to tell the professional that I didn't understand what they were telling me…'
Experiences of women with children, The Magpie Project [117]

This pillar focuses on families in TA, reflecting the growth of this population in NEL and the emerging evidence base. A family is defined as one or more parents or carers (including grandparents) living with children aged 18 or under. Less is known about the health needs of single adults living in TA, presenting a future system area of focus. This pillar was shaped by colleagues from health, housing, public health, and the VCFSE sector. Drawing on our strategic opportunities, in particular building a call to action through system collaboration, early intervention and prevention, and tackling wider determinants of health, we aim to strengthen a preventative approach to reduce the risk of poor health outcomes for families living in temporary accommodation. We will:

- Develop NEL **best practice guidance on what holistic health and wellbeing support** looks like for families living in TA,
- Explore and test the use of a **NEL system to inform and notify local services** about new homeless situations for families, including a focus on health and wellbeing, to prevent further inequalities,
- Identify and implement ways to include **benefit and debt advice** in women's health services to prevent homelessness,
- Continue to **strengthen partnership working** to understand and support the health and wellbeing needs of people living in TA.

Pillar 5 – Develop the infrastructure to support people seeking asylum and refuge to understand, access and be supported by health, care and wider services

'We kind of exist below the healthcare system here. I have no idea what's going on and when I'm going to know something. So, I don't know if the UK system is good or bad, but I know it's so complicated.'

Qualitative Health Needs Assessment: Exploring the health and healthcare experiences of asylum seekers living in London hotels, London Borough of Newham, 2023

In 2024, approximately 123 million people globally were forcibly displaced due to persecution, conflict, violence, and human rights violations; 40% were children, with numbers continuing to rise.[127] Around 7,000 people seeking asylum were living in NEL in 2024, with the highest numbers of people in Newham, Tower Hamlets, and Redbridge; Newham ranking highest in London.[128] While awaiting an asylum decision, people are unable to work, claim benefits and have limited access to public services, relying on Home Office-provided accommodation and a subsistence allowance.[129] People granted refugee status are often at risk of homelessness and destitution; having low or no income, a lack of knowledge of rights and difficulty accessing housing services.[130] [131] The short window for moving on from asylum accommodation often leads to homelessness, increasing vulnerability to exploitation, modern slavery, and worsening health outcomes.[130] [132]

People seeking sanctuary often have complex health and wellbeing needs linked to experiences in their home countries, during their journeys, and after arrival. These include untreated communicable diseases, long-term conditions, trauma-related mental health issues, social isolation, and safeguarding concerns.[133] [134] [135] Access to healthcare, education, employment, housing, and security are fundamental to thriving in the UK, but systemic barriers often prevent social connection, service access, and sustained wellbeing.[136] [137] NEL research evidenced how important health is for people seeking asylum; a core asset to building a new life.[138]

Whilst people seeking asylum and granted refugee status are entitled to health services without charge,[139] [140] the policies are complicated, vary based on people's status and are poorly understood; meaning people are often refused care, are asked to pay upfront or avoid using because of fear of being charged or detained.[141] [142] The 'no recourse to public funds' (NRPF) condition imposed on people with temporary immigration status[143] can put people who can be discharged from hospital but require further support, at risk of homelessness, with access to social, welfare and legal advice reducing the risk of homelessness and pressure on services.[47] [144] [145] [146]

'Someone with a complex condition which hasn't been monitored for several years, I'd normally refer to the specialty team, but then they might get charged. These are the patients I go to bed thinking about.'

Dr Lucy Langford, Newham GP [147]

Pillar 5 has been shaped by a longstanding NEL partnership of local authorities, health, and the VCFSE sector, working to support people seeking asylum and refuge. This population's complex needs and the persistent barriers they face means tackling these inequalities must be a priority across all pillars and cross-cutting themes of the strategy. As experts and service leaders, the NEL partnership will continue to guide this work and lead key priorities and projects to build the infrastructure that enables people seeking asylum and refuge to understand, access, and be supported by health, care, and wider services. We will:

- Work to become an **'ICS of Sanctuary'** through the City of Sanctuary award.
- Build an understanding of the **population**, **their health and wellbeing needs, and gather evidence** to design, deliver and evaluate projects and services.
- Develop and implement a **NEL approach** to provide **social, welfare and legal advice** to support people to be safely discharged from hospital, including those with **no recourse to public funds**.
- Establish and pilot interventions to **support refugees into employment, volunteering and learning opportunities**.
- Continue to strengthen how **people and partners in NEL work together** to support and improve outcomes for people seeking asylum and refuge.

Cross-cutting themes

The three homeless health cross-cutting themes are fundamental areas of focus required across each of the five pillars, as well as being important areas of focus in their own right to support and enable improved health and social outcomes for people experiencing homelessness.

Safeguarding

Safeguarding health, wellbeing and human rights is essential to high-quality care and a shared responsibility. People experiencing homelessness face increased risks of harm, exploitation, and neglect, exacerbated by trauma, complex health needs, and barriers to support. As such, safeguarding is a core theme of the NEL homeless health strategy, embedded across its pillars to prevent harm and improve lives. Our broad definition of homelessness highlights the importance of safeguarding adults and children, including a focus on women who are rough sleeping, families facing domestic violence, vulnerable migrant households, and unaccompanied asylum-seeking children.[148] [149]

Safeguarding for people experiencing homelessness is an area of development.[150] Safeguarding adult boards (SABs) have been guided to adopt a more strategic approach by appointing leads for homelessness and establishing shared governance, in line with best practice.[151] [152] Analysis of safeguarding adult reviews raise concerns about homelessness being seen as a lifestyle choice and shortcomings in understanding lived experience.[153] Work with the Groundswell London Participation Network[154] revealed people with lived experience of homelessness often feel disempowered by safeguarding; seen as a risk rather than being vulnerable to risks. Conflicting organisational approaches further confuse individuals, especially around legal rights and recourse.

Across all pillars of the NEL strategy, from hospital discharge to end-of-life care, and in targeted support for specific populations, safeguarding is essential. To strengthen our approach, through this cross-cutting theme we will:

- Strengthen the **strategic focus on all forms of homelessness in safeguarding** by working with partners through the Safeguarding Adults Boards and beyond, committing to new areas of development and practice,
- Bring together people working on safeguarding and homelessness to **develop knowledge, relationships and practice, strengthening collaboration and collective focus** on the population,
- Capture what's happening across the NEL system to see where **best practice** could be spread and improvements achieved.

Workforce development

Workforce development is a NEL ICS priority and a key principle in the national inclusion health framework,[3] [155] steering the importance of; developing workforce structures to deliver integrated health and care, developing skills to reduce health inequalities, improving wellbeing and retention and creating local employment opportunities[30] [156] [157]

As set out in our key strategic opportunities, supporting people experiencing homelessness requires core services to become more inclusive, accessible and prevention focused, and specialist services to be sustainably funded and staffed, improving retention and the vital consistency needed in staff and services.[4] [58] [69] [158] [159] [160] [161]Staff training around health inequalities, inclusion health and homelessness is crucial, must be tailored to service type and include knowledge of population needs, care entitlements, safeguarding, trauma, and digital inclusion.[3] [4] [161] [162] [163] Given the emotional demands of supporting excluded populations, and the added risk of burnout under service pressures or among staff with lived experience, reflective practice and peer support are vital.[160] [164] [165] [166]

Creating employment and development opportunities for people with lived experience of homelessness brings mutual benefits. For organisations, it fosters deeper understanding, trust, and more relevant services. For individuals, it can provide income, stability, and personal growth, while tackling stigma and exclusion.[167] [168] [169] We will enable workforce development across our homeless health pillars and utilise our system workforce strategies and priorities, along with wider evidence and best practice to:

- Increase the **knowledge, understanding and system leadership of the value and impact of consistently funded, high quality, specialist services** to support people experiencing homelessness, making the case for strategic investment,
- Scope and establish a **learning and development programme** that will equip people in mainstream and specialist services with the knowledge and skills to reduce health inequalities and improve outcomes for people in inclusion health groups, building on what exists or is being established, such as learning around trauma informed care,
- Work with colleagues across NEL to **scope and implement interventions to support staff wellbeing**; based on evidence of what works and what people say would be impactful,
- Work with system partners to **create opportunities into employment and career development** for people with experience of or who are at risk of homelessness.

Data intelligence and evaluation

Data and intelligence around people experiencing homelessness and wider inclusion health groups is often limited, incomplete and doesn't articulate the full extent of people's needs and experiences; people are often 'invisible' or under-represented in health data.[170] Barriers to accessing care, including being refused GP registration, digital exclusion, stigma, and mistrust, contribute to gaps in data. Many people also hesitate to share personal information due to fear of discrimination, further impacting data quality.[171] [172] [173] [174]

Inconsistent recording and classification of homelessness and housing status across systems adds to the problem, especially for people experiencing hidden homelessness or insecure housing. Data is often siloed, limiting visibility even for individuals who are in contact with services. Current analysis methods, which rely heavily on postcodes or protected characteristics,[175] often fail to capture the needs of people facing the greatest health inequalities.[170] [174] A proposed solution to this issue is a better system for recording housing status as a proxy for identifying people in inclusion health groups.[176]

Importantly, understanding what matters to people and what works must be captured in a range of ways, beyond quantitative data. This requires collaborating with people who have lived experience of homelessness (see 'our opportunities') and using creative, broad evidence collection—employing qualitative research, varied evaluation approaches, and engaging tools to share insights effectively.[3] [8] High quality data, intelligence, and evaluation are vital to understanding population needs to prevent and address health inequalities. By improving data collection, sharing, and analysis we can identify those most at risk, including those not accessing services, and provide more targeted, evidenced-based interventions in alignment with our NEL ICS Joint Forward Plan.[30]

Through this cross-cutting theme we will:

- Collaborate with partners to **develop an inclusion health needs assessment** that encompasses the broad definition of homelessness to build understanding of the health needs of the inclusion health population in NEL,
- Embed a **unified definition of inclusion health across NEL and implement standardised coding practices** in both primary and secondary care settings to enhance data capture, quality, and comparability,
- Improve **data sharing between sectors and organisations** to enable holistic, personalised and joined up care planning through the Universal Care Plan, a pan-London digital care plan that puts the patient at the centre of their care, ensuring their wishes and preferences are always considered by health professionals caring for them,
- Identify **key outcome measures** to determine which metrics are most relevant to understand and measure the impact of interventions, informing strategic action,
- Develop and support the **use of a range of research and evaluation methods** to evidence population needs and the impact of services.

Remaining meaningful and areas of developing focus

Over the next five years, the strategy will evolve with national and local developments to stay meaningful, dynamic, and aligned with changing priorities and community needs. While its ambitions are broad and demand sustained focus, emerging risks and opportunities will also require attention, including:

- The impact **climate change** has on the most vulnerable populations.[177] [178] [179] People who are rough sleeping are exposed not only to severe winter weather but also increasingly hotter summers, particularly in urbanised areas such as London; impacting their health and increasing the risk of hospitalisation.[180] [181]
- ICSs are in a key position to deliver this strategy by further strengthening **collaboration between health, care, and housing,** particularly with a focus on the most excluded populations.[182] We are proud that housing and health partnerships are recognised explicitly in pillar four and beyond the ICS, we will work with wider partners, including the **police and criminal justice system**, to better align and meet the needs of people experiencing homelessness.
- The **strengthening of prevention and population health** in the ICS through strategic commissioning; doing more to address the underlying causes of homelessness and supporting people at risk of homelessness. In Barking and Dagenham, partners are piloting a predictive analytics tool that links disconnected datasets to spot early warning signs of homelessness, such as missed utility payments or health issues, using this intelligence to trigger wraparound support before crisis hits. Set for rollout in 2025/26, the pilot will be evaluated to determine its potential for scaling up across the ICS.

Conclusion and next steps

Due to the cumulative impact of austerity, cost-of-living increases, and the national housing crisis, more people in NEL are facing the insecurity of becoming homeless. The impact of this on individuals and our wider system is profound and this strategy sets out how as the NHS, we are working strategically with our partners to achieve change to ensure people are supported at their most vulnerable time.

As this strategy is being published at a time of transition for Integrated Care Boards (ICBs), the role of strategic commissioning becomes more prominent and there is an increased emphasis on neighbourhood-level working. This presents valuable opportunities to implement the strategy at Place, while the ICB maintains a strategic role in measuring impact and ensuring that the call to action is heard and acted upon. The strategy will be approved, monitored, and periodically renewed by the ICB Board. A development plan will underpin its delivery and will be regularly refreshed to align with evolving policy and service-level changes. With many areas of focus in the strategy already underway and much best practice across NEL, we need to be bold as a system to achieve more together and we are excited to formalise this commitment through the NEL Homeless Health Strategy.

Contact us

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North East London Health & Care Partnership

NEL Homeless Health Strategy – Case for Change

Full report of evidence, analysis and insights informing the 2025 – 2030 strategy

Contents

Introduction

This Case for Change sets out a comprehensive narrative of the evidence, data and insights that underpin and steer the North East London Homeless Health Strategy 2025–2030. It expands on the summary strategy document, offering a detailed view of the context, challenges, and opportunities that shape our shared vision, approach and priorities.

Our vision as an integrated care system (ICS) is to create meaningful improvements in health, wellbeing and equity for everyone living in north east London (NEL). This means partners across the neighbourhoods and communities, places and partnerships of NEL working together to tackle today's challenges and ensure sustainable services for the future. We are driven by a focus on prevention, early intervention, reducing health inequalities and supporting the most vulnerable and excluded people to improve their health outcomes.

Health inequalities, the avoidable, unfair and systematic differences in health outcomes,[1] exist between NEL and the rest of the country and between our places and communities; reflecting personal and social inequalities in society at large. Inequalities in health are the result of differences in the social and economic conditions and structures in which people are born, grow, live and age. People facing exclusion often experience the largest barriers to accessing care, including not feeling heard, not knowing how to access services and experiencing discrimination.[2] The wider determinants of education, income and housing, greatly affect and influence the health outcomes of our population. Everyone in our system has a role to play in reducing health inequalities; creating health equity should be embedded across programmes and services within communities and across NEL.

Underpinned by national guidance such Core20PLUS5,[3] [4] the national framework for inclusion health,[5] as well as NICE guideline for integrating health and care for people experiencing homelessness,[6] our system has co-designed the NEL Homeless Health Strategy. The evidence is clear that people experiencing homelessness and people who are described as being in an 'inclusion health group'[7] are socially excluded, experience multiple, overlapping risk factors for poor health (such as poverty, violence and complex trauma), face stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). As an umbrella term, 'inclusion health' describes groups of people who frequently suffer from multiple health issues, such as mental and physical ill health and substance dependence issues, coupled with deep barriers to accessing health and care services. This results in extremely poor health outcomes which are often much worse than the general population, including a lower average age of death.

The decision to develop and agree our NEL Homeless Health Strategy is born from a strong history of working in partnership to support people experiencing homelessness, strengthened through the Covid-19 pandemic, when people were supported into accommodation and to receive vaccinations. With the pandemic exacerbating already wide health inequalities,[8] the need for the system to work together differently to address the extremely poor health and social outcomes for people experiencing homelessness was amplified and actioned in a many different ways. To strengthen and build on this approach, following a robust process of partnership co-design and engagement, we are proud to present, the NEL Homeless Health Strategy 2025-2030.

The strategy is a call to action to convene the system around the most important areas of joint focus for the population (with a wide definition of homelessness) and provide a strategic framework to support place and neighbourhood partners to develop plans to address this population's needs over five years.

Executive Summary

Our purpose

The NEL Homeless Health Strategy is a call to action to convene the system around the most important areas of joint focus and improvement for the population (with a wide definition of homelessness) over 5 years. It provides a strategic framework to support place and neighbourhood partners to develop plans to address the needs of people experiencing homelessness.

Our ambition

Driven by a range of underpinning evidence, policy and guidance and our extensive co-design process, the **overarching ambition** of the NEL Homeless Health Strategy is to:

> Improve health and social outcomes for people experiencing homelessness through integrated health, care and housing pathways and a focus on the wider determinants of health.

Our approach

We will deliver our ambition by working together towards five **homeless health pillars** and three **cross cutting themes,** underpinned by the **key strategic opportunities** identified.

Our homeless health pillars

The goals of the **five homeless health pillars** are to:

1. Improve pathways for hospital admission, discharge and 'step-down',
2. Improve equitable access, increase engagement in and ensure high quality primary and community care services,
3. Develop innovative approaches to deliver proactive, personalised care and enhance access to mental health, substance misuse, and end-of-life care and support,
4. Strengthen a preventative approach to reduce the risk of poor health outcomes for families living in temporary accommodation,
5. Develop the infrastructure to support people seeking asylum and refuge to understand, access and be supported by health, care and wider services.

While the definition of homelessness is broad and how people experience homelessness is not static, this strategy takes a targeted approach to improving health and social outcomes for specific groups as follows:

- People who are rough sleeping —particularly those experiencing prolonged and more complex rough sleeping (Pillars 1 and 3),
- Families with children living in temporary accommodation (Pillar 4),
- People seeking asylum and refuge (Pillar 5),

The strategy considers the work to improve access to primary and community care (Pillar 2) a universal offer for all people experiencing homelessness.

Each **homeless health pillar** has a **defined set of priorities,** steered by what evidence and involvement tell us about the context, issues and solutions that can make a difference and contribute to achieving the goal of the pillar. The pillar priorities seek change to core provision (be that mainstream or specialist services), steer fundamental projects and give opportunity for testing and learning about the types of solutions that can have an impact and be scaled to be sustainable.

Our cross-cutting themes

The **three homeless health cross-cutting themes** represent important areas of focus that horizontally fit across each of the five pillars. The cross-cutting themes either support specific priorities in the pillars or represent important thematic areas of focus that are required to improve health and social outcomes for people experiencing homelessness. The three cross-cutting themes of the homeless health strategy are:

- **Safeguarding** – ensuring the health, wellbeing and human rights of people experiencing homelessness and multiple disadvantage are effectively protected through safeguarding.
- **Workforce development** –a holistic focus on workforce to invest in, structure and deliver accessible and high-quality services; support, develop and retain staff with a focus on wellbeing and the skills need to support the population and; creating opportunities for employment and development for people experiencing homelessness.
- **Data, intelligence and evaluation** – improve our understanding of the needs of people experiencing homelessness and wider inclusion health groups through better data collection, sharing and analysis, ensuring evidence and evaluation drive meaningful change.

Our key strategic opportunities

The strategy is underpinned, steered and enabled by four key strategic opportunities (see Our opportunities)

- Building our call to action through integration and collaboration across NEL and within places and neighbourhoods
- Working with local people and communities
- Greater focus on prevention, early intervention and the wider determinants of health
- Equitable access to core services and specialist support

Transformation, system delivery and financial approach

Importantly, the strategy will not stand alone. It must influence and be embedded across NEL strategic commissioning programmes and priorities, including long-term conditions, primary, secondary and urgent care, mental health, substance misuse, and housing and health priorities.

In addition, wider NEL system strategies, such as the Anti-Racist Strategy[9] and the People and Culture Strategy[10] set shared ambitions that support and strengthen our work, creating further opportunities to improve health and social outcomes for people experiencing homelessness at system, place and neighbourhood levels.

Transforming and integrating services to address health inequalities is essential but complex, particularly under financial pressures. With the cost of inaction increasingly clear, achieving meaningful change demands balancing limited resources with innovative, sustainable solutions that ensure equitable access to high-quality care and support for all. Achieving the ambitions of the NEL Homeless Health Strategy will require a robust financial strategy: building clear investment cases, evidencing population and system impact, demonstrating return on investment, securing partnership funding and maximising external grant opportunities to drive lasting change.

Defining homelessness

Homelessness is not static and takes many forms. Nationally, homelessness is defined widely, recognising the complexity of people's lives, that experiences change over time and that homelessness is often hidden or not in plain sight.[11] People can experience homelessness in the following ways, all of which can have a detrimental impact on health:

- Rooflessness – people living without shelter and sleeping rough on the streets.
- Houselessness – people who have temporary places to sleep, including people living in local authority temporary accommodation or in institutions, shelters or provided accommodation, for example people seeking asylum.
- Living in insecure accommodation – people threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends known as 'sofa surfing.'
- Living in inadequate housing – people living housing that is in poor condition and disrepair, for example without electricity, water and heating, or housing that is overcrowded and unsuitable.

Scope of the NEL Homeless Health Strategy

Whilst homelessness is broad and changeable, the strategy takes a targeted strategic commissioning-based approach to improving health and social outcomes by focusing on the most pressing needs within these population groups and the opportunities available within the ICS. Guided by national and local evidence, including insights from those with lived experience, the NEL Homeless Health Strategy focuses on the following groups:

- People who are rough sleeping - particularly those experiencing prolonged and more complex rough sleeping
- Families with children living in temporary accommodation
- People seeking asylum and refuge

The strategy considers improving access to primary care a universal need for all people experiencing homelessness. Furthermore, the focus of the strategy supports the overlapping needs of other inclusion health groups, including people in contact with the criminal justice system, sex workers, people with drug and alcohol dependence and Gypsy, Roma and Traveller communities.

The case for change

Summary of challenges

London is the epicentre of the national homelessness crisis, with London Councils estimating that more than 175,000 Londoners are homeless and living in temporary accommodation – equivalent to one in 50 residents of the capital.[12] Homelessness is driven by the cost of living, the availability and cost of housing, mental and physical health problems, job insecurity and the significant increase in people seeking asylum.

The data and information in this section presents a high-level profile of people experiencing homelessness, their health needs, the challenges faced when accessing health and care services and a summary of the cost of inaction. The availability and quality of data about people experiencing homelessness is poor, meaning we need to consider wider sources and different types of evidence. Where data and evidence is available for NEL, this is included throughout the strategy.

Population overview

Homelessness does not impact people equally

- Black people are over three times more likely to experience homelessness and Asian people are more likely to experience 'hidden homelessness' such as living in over-crowded housing.[13] There is also evidence that LGBT+ people are significantly over-represented among people experiencing homelessness.[14]
- New evidence suggests 12% of people experiencing homelessness are autistic, much higher than estimates for the overall population at around 1-2%.[15]
- People with a history of imprisonment or contact with the criminal justice system are at higher risk of homelessness; for example it is estimated that 15% of people are homeless when sentenced to time in prison and 30% are homeless on release.[16] [17] [18]
- Evidence suggests a notable intersection between homelessness and engagement in sex work, particularly among vulnerable populations; one study showed a quarter of young homeless women have engaged in sex work to fund accommodation or in the hope of getting a bed for the night.[19] [20]
- Romany Gypsy, Roma and Irish Traveller communities are disproportionately affected by homelessness,[21] and face some of the starkest health inequalities when compared to other minority ethnic groups, including barriers to accessing healthcare.[22] Roma and Traveller people face life expectancies between ten to 25 years shorter than the general population,[23] experience a higher prevalence of long-term illness, and the health of those in their 60s is comparable to an average White British person in their 80s.[24]

Rough sleeping

- The numbers of people sleeping rough in London and NEL is rising, with nearly 12,000 people sleeping rough in London and 2,636 people in NEL in 23/24, up 19% and 12.5% from the year before.[25]
- All places in NEL, except Havering, have seen an increase in the numbers of people sleeping rough between 2022/23 and 2023/24. Newham and the City of London have some of the highest numbers of people sleeping rough in England.[26]
- It is estimated that around 13% of people rough sleeping are women.[27] In order to be safe, women's rough sleeping is often hidden, transient and intermittent, meaning their experiences are harder to understand and it is more challenging for services to support them.[28]

Temporary accommodation

- The number of households living in temporary accommodation in NEL continues to rise from 15,583 in June 2022 to 19,195 as of March 2024; representing 16% of the total households living in temporary accommodation in England.[29] Of the households living in temporary accommodation, 13,504 (70%) are households with children.
- 65% of Londoners living in temporary accommodation are women.**Error! Bookmark not defined.**

Seeking refuge and asylum

- There were around 7,000 people seeking asylum living in NEL as of October 2024, housed in Home Office asylum accommodation across our places. The numbers of people has risen steadily over recent years, with around 2000, 1500 and 1000 people living in Newham, Tower Hamlets and Redbridge respectively.[30]
- Evidence suggests that over 50% of people sleeping on the streets are non-UK nationals.[31]

Health needs

- People experiencing homelessness are more likely to experience common health conditions, at a higher level of severity than the general population, creating frailty at a much younger age.[32] [33] [34] They also experience poorer diagnoses of physical and mental health conditions.[35]
- People experiencing homelessness, particularly in the form of rough sleeping have extremely high levels of undiagnosed and untreated chronic, long-term conditions (including TB, Hepatitis C, heart disease and epilepsy)[36] [37] and have an average life expectancy of 43 for women and 45 for men, around 30 years below the overall population.[38]
- Furthermore, there has been a rise in the numbers of deaths of people experiencing homelessness.[39]
- People experiencing homelessness are at high risk of brain injury as a result of trauma, alcohol use or health issues. Brain injury is also a factor in the causes of homelessness, as it can change a person's behaviour and compromise the skills they need to function effectively in daily life.[40]
- Data shows that this population is much more likely to have mental health problems (54%), substance misuse problems (63%) or a combination of both (43%).[41] Homelessness is lonely, stressful and often traumatic, having a major impact on mental health and as a result, people are far more vulnerable to alcohol and drugs.[42] [43] 32% of all deaths among people experiencing homelessness in England in 2017 were a result of drug poisoning, compared to 1% of the general population.[38]
- The health needs of people seeking refuge and asylum are complex and often related to experiences prior to leaving their home country, during transit and after arrival in the UK. Common health challenges are untreated communicable diseases, poorly controlled chronic conditions, accessing maternity care, and health and specialist support needs. Barriers to accessing health and care services, further exacerbate people's complex health needs.[44]

From a NEL perspective, our data and insights tell us that:

- Almost 50% of people using specialist homeless primary care services in inner NEL* have at least one long term condition and 14% have three or more - with the most common conditions being depression (20%), hypertension (11%) and diabetes (7.5%).[45]
- The rate of serious mental illness is seven times higher for people experiencing homelessness, compared with the whole population of NEL.[45]
- Around 40% of deaths of people experiencing homelessness in NEL were considered avoidable or treatable, compared to 22% for the same population nationally. These avoidable deaths are most commonly attributed to substance related conditions, cancer, chronic obstructive pulmonary disease (COPD) and self-harm.[45]

* Hackney, Newham and Tower Hamlets

Access to services and support

- Accessing appropriate health and care services is a challenge for those who are experiencing homelessness. Service provision is complicated and fragmented, with multiple entry points and pathways into and between services, but little coordination to enable holistic care.[46] [47]
- Core services are not designed for or lack capacity to comprehensively support the needs of people experiencing homelessness and specialist services are frequently funded in short term ways. This undermines the ability of services to recruit and retain staff with the right experience to deliver and develop the service.[48] [49]
- Evidence suggests that two-thirds of GPs refuse to register homeless patients[50] and primary care services are often unable to offer the care people need.[51]
- People face stigma and discrimination when interacting with health and care services, reporting dehumanising and traumatic experiences, entrenching health inequalities further.[52]
- Without good access to primary and community care and early, preventive support, people turn to acute services. Nationally, people experiencing homelessness are six times more likely (than the whole population) to attend A&E, three times more likely to be admitted, and stay in hospital three times as long. They are more likely to have unscheduled care that costs eight times as much as the general population, have the poorest experiences of health services and are often discharged to the streets.[53] [54]
- People experiencing homelessness, as well as wider inclusion health groups, are not consistently recorded in health, care and wider datasets when interacting with services. This means the data and evidence used for service design and evaluation is insufficient and lacking in consistency and quality, exacerbating the fact that services do not meet their needs.[55]

The system cost of inaction

Homelessness has a human cost; impacting people's health and life outcomes across the board and not preventing and addressing the impact of homelessness has a financial impact to the health and care system and wider public services. National guidelines illustrate that given the financial implications of homelessness to society, most interventions that address homelessness are likely to be cost effective or even cost saving for public services.[6] Data and intelligence show that:

- The estimated public sector **costs of a person experiencing homelessness is approximately £40,000 per year** in England (based on 2019/20 prices), whilst preventing homelessness for one year would reduce that cost by £10,000 per person.[56]
- Estimates suggest the NHS spends **£4,298 annually** on someone who is homeless, **four times** as much as the general population who are housed.[57]
- Preventing rough sleeping for a year could **reduce public spending by over £115 million** and if other forms of homelessness were included, these cost savings would be substantially higher.[58]
- Prior to the COVID pandemic, health inequalities were estimated to cost the NHS an **extra £4.8 billion annually**.[59] As the pandemic exacerbated health inequalities, it is reasonable to conclude that the cost of inequalities to the NHS had increased.
- In 2023, **delays to discharge from hospital cost the NHS £1.89bn.**[60] People experiencing homelessness are more likely to be admitted and face complex discharges, and data from specialist homeless hospital teams in NEL shows that targeted interventions can reduce hospital attendance, admissions, delays, and discharges to the street.

Our opportunities

With these challenges as our context, there are significant opportunities to work together within and beyond NEL ICS to address the severe health inequalities people experiencing homeless face and create meaningful improvements in health, wellbeing, equity for our populations. These opportunities are set within a national[61] and local[62] context that as a clear focus on addressing health inequalities, improving outcomes for inclusion health groups, preventing ill-health and a shift to doing more in neighbourhoods and communities,[63] delivered through strategic commissioning.

We are encouraged by recent strengthened cross-government commitments to end homelessness, alongside investment to tackle its root causes[64] as well as what it will mean for collaboration at a regional level.[65] Evidence, guidance and national positioning show the need to achieve sustainable and lasting change by using a range of opportunities to do things differently and better.[66]

Key strategic opportunities

Building our call to action through integration and collaboration across NEL and within places and neighbourhoods.

- Through co-designing the strategy, we continue to strengthen the knowledge, momentum and commitment that through taking a population health approach and addressing health inequalities together, we can make a systematic difference for people experiencing homelessness.
- This means continuing to strengthen collaboration and integration between health, care, local authorities, policing and voluntary, community, faith and social enterprise (VCFSE) organisations; creating trust in coming together to focus on what matters to people, addressing people's needs holistically through integrated services and sharing resources to reduce the long-term impact of homelessness. Integrated neighbourhood working[67] presents new opportunities to address health inequalities and support people with the most complex needs at a community level, including people experiencing homelessness and wider inclusion health groups.
- Furthermore, the call to action must be driven and built by visible leadership across partners, places, neighbourhoods and areas of service delivery; advocating for inclusion health at every level and building knowledge and momentum to act from the top.

Working with local people and communities

- The voices and involvement of members of our communities who are socially excluded are often unheard and their needs invisible. Through developing trusted and effective relationships with local partners including VCFSE organisations, we will work with people who have lived experience of homelessness to understand their needs, develop informed solutions together and rebalance power and control towards them.
- The involvement of people who are 'experts by experience' can range from designing and developing projects and services to carrying out participatory research or directly delivering health and care interventions. This gives people opportunities to have an influence, develop their own skills and work experience and support other people experiencing homelessness.[6] [68]

Greater focus on prevention, early intervention and the wider determinants of health

- We will drive a stronger, evidence-led focus on preventing ill-health and intervening earlier for people at risk of homelessness, addressing trauma, mental health needs, and barriers to accessing care and support.[69]

- Opportunities to address the root causes of homelessness include a focus on trauma and mental health needs, improving access to health, care and support services including drug and alcohol services and tackling wider structural issues such as housing, criminal justice, employment and economic vulnerability.
- In focussing on new NHS wide priorities, including 'analogue to digital'[70] there are opportunities to address the digital exclusion that people experiencing homelessness face; for example less access to reliable devices, consistent internet connections, and the necessary digital skills, primarily caused by financial constraints, lack of a fixed address, and instability in living situations.[71]

Equitable access to core services and specialist support

- National and regional guidelines recognise that both equitable access to core services and consistently funded specialist support are opportunities that need to be harnessed to improve health outcomes for people experiencing homelessness, reducing the likelihood that people fall through the gaps.[6] [72]
- This means investing more in sustainable specialist services and the most effective interventions that improve health outcomes and contribute to reducing overall system costs over time, addressing health inequalities through a range of transformation areas. In practice specialist services need to be person-centred, multi-disciplinary, flexible and trauma informed; provided by consistent and enabled staff, alongside being steered, supported or delivered by people with lived experience of homelessness.
- Alongside this recognition of the investment needed in specialist services is the fundamental need to address the barriers of access to mainstream services. For example, normalising access to a GP to ensure people are supported and managed in primary care with the aim of preventing or reducing ill health and deterioration, and the need to then rely on be supported by secondary care.
- People experiencing homelessness take many routes into and between the complex service landscape and therefore integration and links between services are vital. Taking a 'no wrong door' approach,[73] contact with any service should be used as an opportunity to engage people with the wider set of services available and support should be available to navigate the system, regardless of where they first seek support from.[6] [74] Neighbourhood working and co-location of teams is vital for health equity, delivering accessible, holistic and cohesive services in shared places.[75]

Co-designing the strategy

The NEL Homeless Health Strategy has been co-designed with stakeholders across health, care, community, local authority, VCFSE, and people with lived experience of homelessness. This inclusive, evidence-led approach ensures the strategy meets the needs of people experiencing homelessness in north east London, while aligning with ICS goals and national priorities.

- **The NEL Homeless Health Strategic Reference Group** was established to support a joint COVID response. The group created opportunities for joint working on homeless health and provides a platform for sharing learning and best practice. This group called for the creation of the NEL Homeless Health Strategy and will oversee its delivery and progress.
- In May 2024, we held the **NEL Homeless Health Symposium**, bringing together over 100 colleagues from across the system, alongside individuals with lived experience of homelessness. The event served as a platform to build a case for system-wide action and marked the formal launch of engagement for the strategy.
- Following the symposium, the strategy was co-designed through five **Pillar Working Groups**, each focused on a strategic pillar. Steered by a facilitated structure and a lead, each group (consisting of 12-26 colleagues from various sectors as well as representatives of those with lived experience) met three times, using data and evidence to shape the strategic focus and priorities of the pillars, as well as outlining timelines, levels of priority and outcome measures.
- In addition to the pillar working groups, **extensive engagement across the system** has been conducted; presenting the strategy at over 30 groups within the NHS, at Place level, and with subject matter experts in the voluntary sector.
- To ensure the strategy truly reflects the needs of those experiencing homelessness, **the voice of people lived experience of homelessness was integrated throughout the design process**. This began with a focused session with Groundswell, attended by ten peers with lived experience of homelessness, to frame the strategic pillars. At the NEL Homeless Health Symposium, three peers from Cardboard Citizens performed creative pieces, sharing their experiences of homelessness. Once strategic priorities were established through the working groups, we collaborated with Groundswell and Cardboard Citizens through dedicated workshops to review and validate the proposed priorities for each pillar. Additionally, we've ensured the voice of people with lived experience continues to shape ongoing projects, for example two women supported by the Magpie Project contributed to the commissioning of the NEL Initial Health Assessment Outreach Service for asylum seekers under Pillar 5.

The strategy has been positively received and supported across the system, making it the first ICS Homeless Health Strategy in the country. Co-designed with the system and individuals with lived experience, it represents an evidence led, committed and evolving effort to address the health needs of the homeless population in north east London through continuous collaboration.

Pillar 1 – Improve pathways for hospital admission, discharge and 'step-down'

'*Your discharge summary goes in the bag along with your other belongings. Not once was the discharge summary read out to me, it was taken for granted that I understood all of the medical terms. One discharge summary literally said "discharged back to streets."'*
Centre for Homelessness Impact, 2020.[76]

The realities of the way people who experience homelessness use and need support from hospital urgent and emergency care services, alongside the capacity and structure of these services to holistically support their needs, highlights a deeply entrenched societal challenge. Nationally, people experiencing homelessness are six times more likely to attend A&E, three times more likely to be admitted, and stay in hospital three times as long.[77] They are more likely to have unscheduled care that costs eight times more than the general population, have the poorest experiences of health services and are often discharged to the streets.[78] [79]

Using data from the specialist homeless GP services in the inner boroughs of NEL,† 22,000 A&E attendances were recorded for people experiencing homelessness in 2023, with over 50% of people attending more than once.[80] The most frequently recorded reasons for attending A&E were related to alcohol and substance misuse and mental health needs. For many people a diagnosis is not given in A&E or they leave before being seen, but 35% of the time people reattend A&E within seven days. The picture is as stark for emergency hospital admissions; in NEL in 2023, 2,162 people experiencing homelessness (and using the specialist GP practices) were admitted to hospital, often more than once; over 70 people had five or more emergency admissions. People were admitted to hospital for a range of complex, chronic and long-term conditions including alcohol and substance misuse, chest pain, chronic obstructive pulmonary disease (COPD), asthma, epilepsy and serious mental illness. Almost 20% of all emergency admissions for people experiencing homelessness resulted in a readmission within 30 days.

People experiencing homelessness have high levels of undiagnosed and untreated health condition.[35] Evidence suggests that individuals experiencing homelessness develop geriatric conditions decades earlier than those with stable housing.[81] Those in their 40s and 50s are more likely to experience frailty, including cognitive impairment, functional decline, and loneliness.[82] Research showed that people experiencing homelessness, with a mean age of 56 years, have frailty scores comparable to those of 89-year-olds in the general population.[83]

People typically have much longer stays in hospital after they become medically fit to leave due to the complexity of their ongoing needs and the ability of services to meet them. They often need further care and support from wider services, appropriate accommodation. Delays occur from the need to obtain evidence as eligibility for benefits or support; this is particularly relevant for people with restricted or uncertain eligibility for public funds, who often require legal advice.[84]

Coming into and being discharged from hospital should be seen as a window of opportunity to understand and support people's needs holistically and ensure services are working well together to address and prevent homelessness and further inequalities and ensure people's safety.[85] [86] This includes the 'duty to refer'[87] people who may be homeless or at risk of homelessness to local authority services and presents opportunities for multidisciplinary working, putting people and their needs in the centre of assessments, decision making and wrap around support. A multi-disciplinary approach, within and beyond hospital can help people rebuild their lives as well as reduce pressures and costs on services caused by repeat attendance, readmission and delays to finding further support for people.[88] [89] [90] [91] [92]

When leaving hospital, a growing body of evidence shows the positive impact of intermediate care based in the community, which is often called 'step-down' care. This intermediate care can provide safe, short-term accommodation and help people to heal and recover, alongside support to access wider health and care services and find long-term accommodation. The national 'Out-of-Hospital Care Models (OOHCM) Programme' provided funding to 17 places to plan, deliver and learn from approaches that enable people experiencing homelessness to leave hospital and be supported by specialist services in the community. [93]

† Hackney, Newham and Tower Hamlets

Programme evaluation reinforced evidence that shows wide benefits of this approach; a stay in intermediate care can significantly reduce the number of people discharged to the streets or other unsuitable places, reduce hospital visits and admissions, improve people's quality of life outcomes and reduce costs. However, the national programme did not deliver the capacity needed in a sustainable way, suggesting recurrent investment in these type of specialist services is needed.

Within NEL, there are specialist teams in the inner London boroughs of Tower Hamlets, Hackney and Newham,[94] [95] supporting people experiencing homelessness in hospital settings to leave hospital and access further support, as required, in the community, with evidence building to show the positive impact on patient and system outcomes, including reductions in hospital attendance, admittance and length of hospital. In other boroughs and hospital settings, there are some processes and individuals supporting people experiencing homelessness when in hospital and to leave hospital, however across NEL, there is no one consistent approach to identifying, recording and supporting people when they come into hospital, holistically meeting their needs and safely discharging them with provision of step-down and wrap around support. Feedback indicates that homelessness is often not recognised until the discharge planning stage, which can hinder the management of people with the most complex needs, and increase length of stay in hospital.

A hospital is not the right place for somebody to make long-term life decisions, and through the development of specialist teams, discharge support and step-down community arrangements, we aim to support more people, with a range of needs, in the community. Working with partners across NEL, including hospital and discharge planning leads and local authority colleagues, drawing on national guidelines and legal frameworks, we have established the following priorities to improve pathways for hospital admission, discharge and step-down for people experiencing homelessness across NEL. The aim is to reduce the need for future re-admission and prevent further deterioration of multiple health and wellbeing needs:

To improve pathways for hospital admission, discharge and step-down, we will:

- Work with key partners to **create and implement guidelines and principles for hospital admission and discharge** in NEL for people experiencing homelessness,
- Develop a **NEL discharge model to support people to leave hospital** when they are well enough but still need care (discharge to assess),
- Develop a **bed model to enable people to leave hospital** and access accommodation where they can receive ongoing care and rehabilitation (step-down care),
- Promote and embed the use of **health record systems and templates** that capture information about people experiencing homelessness and wider inclusion health groups (shared with Pillar 2).

'...it's easier to find A&E and for a lot of people, it's a warm place to stay.'
Groundswell Peers steering the NEL Homeless Health Strategy, 2025

"A&E is open 24 hours a day and quite often the chaotic lifestyle of someone experiencing homelessness, just getting to a doctor in surgery hours is not going to be feasible. You can tend to only see your doctor about one thing, at least with A&E you can go in, talk to someone about one thing, stay there and chip away at what you've got. It's more convenient, saves on lots of journeys. I suppose as well, it's a little bit more impersonal, which can be a good thing, and you can talk about things that maybe you sort of don't want others to hear about. So I suppose yeah, a big and bustling A&E, it might be easier to be a bit anonymous."
Groundswell Peer steering the NEL Homeless Health Strategy, 2025

Pillar 2 - Improve equitable access, increase engagement in and ensure high quality primary and community care services

Whilst we see from pillar one that people experiencing homeless use acute and emergency hospital services much more than people who are not homeless, the reverse is often true for preventative, primary and community care services; meaning people's health and care needs often remain untreated, becoming more serve and complex.[96] Being able to access and be supported by primary and community services comprehensively is a fundamental bedrock of the health and care system, but capacity of these services to meet growing population needs is stretched.[97] Commitments of the government continue a focus on transforming primary care, emphasising the vital importance prevention, community services and place-based approaches.[98]

General practice plays a fundamental role in enabling access to wider health and care services including mental health, preventative interventions and secondary care for treatment for diseases or long-term conditions. People from inclusion health groups, including people experiencing homelessness, face many barriers in accessing general practice.[48] [96] [99] These barriers start with registration, with evidence showing that around two-thirds of GPs in London refuse to register people in this population[100] [101] and more widely, 18% of people experiencing homelessness have been refused registration to a GP or dentist.[42]

Contrary to NHS guidance,[102] practices often incorrectly refuse registration due to lack of proof of identification, address and immigration status at registration, which many people in inclusion health groups do not have.[48] [103] [104] Many people experiencing homelessness are unaware that this is incorrect or have the confidence to enforce their rights. National[6] and regional[72] guidance place a clear focus on ensuring people who are experiencing homelessness can register with a GP in line with primary care policy, steering that this fundamental barrier should be understood and addressed.[105]

Barriers go beyond GP registration, painting a complicated picture of inequality. People experience long wait times to be seen, inflexible systems such as short and set appointment times, communication and language barriers, problems understanding and navigating services and digital exclusion such as not having or being able to use a smart phone.[99] [106] [107] The move to more remote and online working for general practice can create challenges for people experiencing homelessness and maintaining registration is hard for people who move location often.[48] [108] For people experiencing homelessness, health needs are often competing against more immediate needs or substance dependency[106] and the evidence is clear that stigma and discrimination leads to negative experiences, with people lacking trust and not accessing services for these reasons.[109] A study in NEL showed that even with knowledge of registration requirements, there was a reluctance to register people without documentation, linked to perceptions of people as burdensome or moral judgements being made about deservedness to finite resources.[110]

All people, regardless of immigration status, are entitled to register with a GP.[102] People seeking asylum and refuge face increased personal and structural barriers to accessing and making the most of health care including general practice, for many of the reasons summarised, as well as lacking knowledge of their rights and how public services work.[111] The Safe Surgeries programme,[112] operated by Doctors of the World, supports general practice to tackle the barriers faced by many migrants in accessing health services and ensure communities are not excluded; with places in NEL already working to implement Safe Surgeries effectively.

Underpinning and a further consequence of the barriers to equitable access, is the cross-cutting theme of a lack of consistent data and understanding of the population and therefore their needs, driven by the inability to currently capture people accurately across health, care and wider data sets.[113] See the 'Data, evidence and evaluation' cross-cutting theme for more context.

Whilst people should be supported by mainstream primary and community care, the barriers faced by people experiencing homelessness in accessing these services means that specialised, multi-disciplinary services, that go to where people are, can meet their needs more holistically.[6] [72] [114] Taking care and support out to people (often known as 'outreach') means going to and providing services in places such as hostels and asylum accommodation, day centres, community and faith settings, and on the streets.[6] Integrated, person-

centred services that take a 'making every contact count'[115] approach means physical and mental health needs can be supported, services can work with people to prevent poor health (for example through vaccinations, smoking cessation or nutrition advice) and wider needs can be supported such as benefits, housing and legal advice. Our engagement with Groundwell and Cardboard Citizen's highlighted the importance of support with basic needs such as clothing, personal care and showers, as well as support for wound care and foot health. People experiencing homelessness are at increased risk of blood-born and sexually transmitted infections such as Hepatitis B, C and HIV and infectious diseases such as TB, with services in community settings being able to test, screen and support people to reduce rates of preventable diseases.[116]

Evidence is growing on the effectiveness of different models of primary and community care provision for people experiencing homelessness. The HEARTH study reviewed four models of primary care provision for people who are homeless; dedicated centres, specialist GPs, mobile outreach and normal GP care.[117] The study, whilst small, showed positive outcomes from dedicated and specialist services and highlighted the importance of flexible 'drop in' services and confidence built through specialist services and continuity of staff.

Outreach services can reduce barriers to access by taking care to people,[118] overcoming competing priorities that may prevent people from addressing a health need and creating an environment of trust and safety. Consistency in staff and continuity of care across models has been shown to be an important factor,[119] again linked creating trust.[106] Across all types of provision, the HEARTH study showed that dental needs were unaddressed and staff reported poor availability of mental health services.

Access to dentistry is low[120] [121] and homelessness can significantly increase dental health problems, with flexible, community-based services, offering ways to support oral health with education and clinical intervention.[122] [123] [124]

Drawing on our key strategic opportunities, Pillar 2 presents the clear case for making universal, mainstream primary care services more accessible to people experiencing homelessness and wider inclusion health groups. It also shows the importance of designing and providing specialist and community based services where population needs require it; which will contribute to preventing poor health outcomes and reducing the use of urgent and hospital care services.[125] We need to ensure that services now, and in the future, can meet the needs of our diverse and growing population[126] and that through those services, we capture data about the population and their needs. Across NEL currently, a range of different specialist and outreach services exist for people experiencing homelessness, with the need to more comprehensively understand population needs, the impact of current services and opportunities for new best practice; establishing a more equitable and consistent approach across our places.

To improve equitable access, increase engagement in and ensure high quality primary and community care services, with a focus on mainstream and specialist services, we will:

- Design, agree and implement a **NEL model for primary care services** for people experiencing homelessness,
- Support every general practice in NEL to join the **Safe Surgeries programme**, removing registration barriers and creating equitable access to mainstream primary care,
- Define and develop **principles for 'outreach' services** that support people experiencing homelessness where they are, and commission these services across NEL,
- Promote and embed the use of **health record systems and templates** to capture information about people experiencing homelessness and wider inclusion health groups (shared with Pillar 1).

'You are homeless, you don't have proof of address, its hard to get a GP. So when you come to [specialist homeless GP] they must work with you, they count you as a human.'
Groundswell focus group participant – Healthy London Partnership, 2019 [72]

Pillar 3 – Develop innovative approaches to deliver proactive, personalised care and enhance access to mental health, substance misuse and end of life care and support

'…many people have alcohol, drugs and also mental health problems. They are often told that they have to deal with the alcohol or whatever first, but it doesn't work for people because they often say that they self-medicate, so treating people for both conditions at the same time, I'm sure, would make a lot of difference…'

Groundswell Peer steering the NEL Homeless Health Strategy, 2025

The impact of experiencing homelessness and multiple disadvantage is extreme. As summarised in the case for change, people experiencing homelessness, particularly in the form of rough sleeping, are likely to have high levels of physical and mental health issues, at a higher level of severity than the general population. This creates vulnerability, ill health and frailty at a much younger age; meaning people die younger, and live in poor health at a much earlier age than the rest of the population.[32] [91] [127] [128]

This pillar of the homeless health strategy focusses on two themes. The first theme explores opportunities to use approaches such as proactive care and personalisation to address the multiple disadvantages that create frailty and premature death, particularly for those sleeping rough. The second theme focuses on improving access and better integrating the key service areas of mental health, substance misuse and end of life care, that are vital in managing exacerbations of ill health and preventing episodes of crisis. Together the two themes offer a range of new approaches to address some of the most complex and systemic issues of multiple deprivation and homelessness.

Proactive care, an approach to providing care and support for people with moderate to severe frailty, predominantly in the aging population[129] can be applied to people experiencing frailty and premature aging due to the impact of homelessness. Frailty in people experiencing homelessness (comparable to people 30 years older in the general population) is impacted by risk factors such as drug and alcohol use and dependence, loneliness and poor nutrition and has been shown to include conditions commonly associated with old age including falls, visual, mobility and cognitive impairment, alongside a much higher rate of long term conditions than even the oldest people in the general population.[34] [83] [128] People experiencing homelessness are seven times more likely to die from falls, and when this happens the average age of the person is 45.[130] Adopting proactive care approaches, that are needs-based rather than aged-based, can improve the health outcomes of people experiencing homelessness in its most severe forms. This means adopting specific approaches for defined groups of people including the use of care plans, care coordinators, multi-agency support, as well as planning and interventions delivered through integrated neighbourhood teams.[32] [129] More needs to be done to understand the prevalence, risks and outcomes of frailty in people experiencing homelessness, as well as the interventions that can be put in place to address it through proactive care approaches.[34] [131]

Personalisation, a cross-cutting theme of the NEL Joint Forward Plan,[132] is an integral approach to tackling health inequalities; empowering people with complex needs to draw on their own strengths and have greater choice and control over the care and support they receive.[133] There is strong evidence that Personalisation improves health and wider outcomes for people experiencing multiple disadvantage, tailoring support to focus on people's needs, based on what matters most to them.[134] [135] [136] Personalisation approaches include social prescribing, personal health budgets, and personalised care planning and review.[137] [138] NEL based-evidence has shown the ways in which personalised support and budgets enable trust, choice, control and positive outcomes such as moving to stable accommodation.[139]

A current NEL project has shown positive benefits of personal health budgets, with people who have been rough sleeping for a long-time using budgets to support a range of needs including housing and tenancy sustainment, general needs such as clothes, personal care and travel and hobbies including physical activity (T1000 Personal Health Budgets project). Proactive and personalised care approaches can be enabled through solutions such as the Universal Care Plan,[140] a pan-London digital care plan that puts the patient at the centre of their care, ensuring their wishes and preferences are always considered by the range of services caring for and supporting them, including at end of life. [141]

'This is the best I have felt in over five years and I am so thankful for all the help. I feel much more hopeful and human since being helped by the project and I can start to see a future for myself as a chef again.'
NEL T1000 Personal Health Budget Pilot, mid-point evaluation, January 2025

Experiencing homelessness is often a consequence of and results in ongoing trauma, having a major impact on mental health and increasing vulnerability to and the misuse of alcohol and drugs. [42] [43] Around half of all people experiencing homelessness have a combination of mental health and substance misuse needs.[41] The consequence of these co-occurring conditions result in a much higher rate of death, for example by drug poisoning or suicide.[142] [143] The pressures faced by mental health, drug treatment and recovery services in meeting population needs is recognised nationally,[144] [145] and although there has been recent focus and investment has in these services[146] [147] [148] the majority of people experiencing homelessness face barriers accessing mental health services and over half report difficulties accessing drug and alcohol services.[46] [149] [150] This means people's needs are often not met with preventative focus, early enough, leading to crisis.[151] This treatment gap, underpinned by fragmented services and long wait times is worsened by restrictive eligibility criteria and thresholds, including for example needing to resolve substance use problems before accessing mental health services and vice versa.[46] [152]

The forthcoming national co-occurring conditions action plan, focused on people experiencing homelessness, will be led by the principle of 'no wrong door', emphasising that regardless of where people access care, their needs should be met, eliminating the barriers of where people should go for help. Furthermore, the soon to be published mental health strategy for London is expected to include a priority focused on tackling inequalities in access, experience and outcomes and effective integration with physical health care. It will prioritise the most underserved communities, with a more strategic focus on improving pathways of care for people with co-existing substance use needs. These related developments offer opportunities to strengthen collaboration between mental health and drug and alcohol treatment services to deliver high quality personalised treatment and better outcomes for people with co-occurring substance use and mental health conditions.

Research shows that many people experiencing homelessness die in unsupported, undignified situations, often without the involvement and support of palliative care services. This stems not only from the sudden nature of some deaths but also through a lack of funding for specialist end of life care, and the way in which services are designed without the complex needs of people experiencing homelessness in mind. Being too young for care homes designed for the aging population, and many requiring drug and alcohol support, results in people remaining in hostels and temporary accommodation as their health deteriorates. This inability to provide support for a dignified and planned death is further compounded by the lack of support for front line and accommodation staff who are ill equipped to identify, support and care for the seriously ill with limited outreach provision from health or social care services.

Knowing when to involve end of life services can be hard as people are often not recognised as suffering from terminal illness, alongside being less likely to have support from family or friends who can act as advocates, meaning people's wishes for care, support and practical arrangements are rarely known or met. Stigma and complexity around substance misuse creates more barriers. End of life care and support for people experiencing homelessness is a good example of where specialist, person-centred services, steered by peer involvement, can address and support some of the most complex and systemic issues of multiple deprivation and homelessness.[5] [48] [153] [154] [155] [156]

'…some of the things that really bother me are "will I get the right kind of funeral, will they play the songs I want at my funeral, will the people I know be informed that I am dead?"'
Groundswell Peer steering the NEL Homeless Health Strategy, 2025

The focus of this pillar is driven by new approaches and vital developments that seek to address some of the most complex and systemic issues of multiple deprivation and homelessness that create frailty and premature death, particularly for those sleeping rough. This will take a range of partners, focused on different areas, committing to action and change. Already in NEL, there are projects underway using proactive and personalised care, creating evidence to develop from.

National and regional developments in mental health and substance use services offer much needed opportunities to address the needs of people experiencing homelessness and the treatment gap that currently exists. Furthermore, to focus on end-of-life care, we will draw on the expertise, practice and knowledge that currently exists, to make a change in an area of care that must support people differently at this most vulnerable stage of life.

Through this pillar of the homeless health strategy we will:

- Identify and understand where **personalised and proactive care** can provide greatest potential impact on health and system outcomes, learning from approaches within and beyond NEL and building evidence of what works,
- Develop a **NEL personalised care and support planning template** that embeds co-ordinated, multi-professional interventions to address the person's range of needs including end of life care,
- Strengthen collaboration between **mental health and drug and alcohol treatment services** to deliver high quality personalised treatment and better outcomes for people with co-occurring substance use and mental health conditions,
- Develop a **consistent approach to providing end of life care** across NEL that takes learning from current provision.

'...as an example, if I wanted to get some mental and physical health support, I swim a lot because this helps me a lot. I used to be able to get it through my GP… but now I pay for it. But actually, that's something that I would say benefits me, you know, a swim a day would be a huge difference to me and it costs nothing compared to saying come and see this service… and [swimming] costs £200 for the whole year.'

Groundswell Peer steering the NEL Homeless Health Strategy, 2025

Pillar 4 - Strengthen a preventative approach to reduce the risk of poor health outcomes for families living in temporary accommodation

The national housing crisis[157] is having a significant impact on health, which is particularly true for people in inclusion health groups who face the multiple disadvantages of housing precarity, destitution and poor health.[158] Temporary accommodation (TA) refers to short-term housing provided by local authorities for individuals experiencing homelessness or those at immediate risk of homelessness.[159] The number of households living in TA in England has doubled since 2011. Similarly, reflecting the national picture, 19,195 households are living in TA in NEL as of 2023/24. This accounts for nearly 16% of the total households in TA across England.[160] Of those households in NEL, 70% have children, and the number of children living in TA in NEL has risen by more than a quarter between 2022 and 2024, reaching 28,488 children.[161] This represents approximately 6% or 1 in 17 children in NEL. In the last decade nationally, the number of households being located outside their home borough has increased by more than 100%, making supporting these households challenging.[162]

While TA is intended as a short-term solution, many people now find themselves living in TA for extended periods, sometimes even years.[163] This, combined often with poor living conditions such as overcrowding, a lack of basic facilities such as cooking, bathing and play areas, or poor quality housing stock, can have a detrimental impact on health.[164] There are also significant social consequences of living in TA. Due to the shortage of housing, families are often relocated outside their local areas, leaving behind their social networks, communities, schools, and workplaces.[165] This displacement can lead to social isolation, weakened community ties, and a loss of social capital. For vulnerable groups, especially children, those with disabilities, and those with mental health issues, the lack of stable housing can severely affect their well-being.[166]

'I have moved twice in the past 3 months, I don't know where the letters are going...
'I didn't want to tell the professional that I didn't understand what they were telling me…'
Experiences of women with children, The Magpie Project [167]

A growing body of evidence, particularly focusing on families and households with children, highlights the connection between living in TA and poor mental and physical health for both adults and children.[168] Research indicates that 66% of people living in TA report their living conditions negatively impacting their physical and mental health, with mental health issues such as stress and anxiety being particularly exacerbated.[169] [170] Additionally, a significant proportion of people in TA experience physical health problems, and these conditions can worsen or even be triggered by their living conditions.[168] [169]

Living in TA has a detrimental effect on the health and well-being of children, preventing them from receiving the 'best start in life.'[171] Children living in TA are more likely to experience disruptions in education due to frequent relocations, resulting in poorer educational outcomes and lower levels of well-being compared to peers.[164] The conditions of TA can hinder child development, impacting both psychological and physical growth,[171] including higher prevalence of respiratory infections, poor nutrition, unhappiness and depression[172] Lived experience insights from The Magpie Project in Newham tell us that frequent moves often between catchment areas make it difficult to track and attend to special educational needs and disabilities (SEND), leading to late diagnosis of SEND conditions and mothers struggling to follow their children's diagnostic journey.[167] More acutely, TA can increase the risk of sudden infant death syndrome (SIDS) because it can make it difficult for families to create a safe sleeping space for their babies. This has led to national calls for a stronger focus on deprivation, the number of babies and young children living in TA and the risk of SIDS.[173]

As with other forms of homelessness, individuals in TA face barriers to accessing timely healthcare and support. Many rely on healthcare services from the areas where they were previously accommodated, making it difficult to establish continuity of care.[168] Research by Shelter found that 40% of people living in TA struggle to access primary care appointments due to the distance to GP and other healthcare services.[174] Consequently, families often turn to emergency services, with 70% of families in TA visiting A&E more than once a year, and 23% visiting more than three times a year.[172] Emergency services are ill-equipped to address the complex, ongoing needs of frequent users. Access to primary care that offers continuity of treatment would better support these families and help reduce health inequalities.[175]
The role of housing as a determinant of health is well established,[176] and the lack of holistic, person-centred health and wellbeing support for families living in TA can contribute to the cycle of homelessness, further

exacerbating inequalities.[177] Equipping organisations and frontline workers on what comprehensive and holistic support looks like for these families can help clarify roles, responsibilities, and opportunities, making services and pathways more clear, which in turn will facilitate continuity of care, especially for those moved out of their borough.[11] [47] [178] In taking a holistic approach, best practice guidance recommends a focus on a consistent point of contact and psychologically informed approaches, as well as setting minimum standards for children living in TA and the importance of support around benefits, moving and legal advice.[168] [179] Such an approach will be particularly beneficial for individuals living with disabilities, neurodivergence, complex mental health issues, or those who have recently arrived from other countries and do not speak English as their first language.[177]

Debt is a key driver of homelessness, often worsening once an individual becomes homeless.[180] Rent arrears are the primary cause of family homelessness, particularly affecting women (as women tend to experience hidden homelessness, creating a barrier to securing permanent social housing. This leaves families stuck in TA.[180] While in TA, debt often worsens, with women especially resorting to borrowing to meet basic needs like food, rent, travel, and heating. The effects of this debt continue to impact individuals even after their homelessness situation has ended.[180] Access to advice and support around debt and benefits is crucial in preventing and mitigating the impacts of homelessness.[180] [181]

I literally have about £60 to last a month with food.. the thing I don't understand is that the food bank are only there to help people a certain amount of times, but it's a situation that keeps happening.. I do appreciate… Universal Credit but the money is not stretching… I am trying to get myself to understand my entitlements.

The experiences of families in TA in Westminster[182]

The current landscape of health and wellbeing support for people in TA presents significant challenges, but also opportunities for improvement. While existing research provides some insights into the experiences of families with children, there are still gaps in understanding the full range of health and support needs for the broader population in TA. Closer system collaboration is necessary to better understand the needs of those living in TA. This should be driven by holistic approaches, co-designed with people with lived experience, and focus on bridging the gap between health and housing.[176] Furthermore, there has been a significant rise in the number of households living in TA without children[183] and there is a need to understand the challenges faced by single individuals in TA in North-East London and beyond, as the available data remains limited.

There is a strong evidence base focusing on families with children but work is still to be done to understand the experiences of single adults living in TA. For this reason, the focus of this pillar is on families owing to the significant increase in this population living in TA and the growing evidence helping support understanding of some of the health, wellbeing and support needs of this population. We are defining a family as 'a group of one or more parents or carers (including grandparents) living together with children aged 18 years and under.' Our focus and pillar priorities were developed by a working group established of colleagues from heath, local authority housing and public health and the VCFSE.

Drawing on our strategic opportunities, in particular building a call to action through system collaboration, early intervention and prevention, and tackling wider determinants of health, we aim to strengthen a preventative approach to reduce the risk of poor health outcomes for families living in temporary accommodation. We will:

- Develop NEL **best practice guidance on what holistic health and wellbeing support** looks like for families living in TA,
- Explore and test the use of a **NEL system to inform and notify local services** about new homeless situations for families, including a focus on health and wellbeing, to prevent further inequalities,
- Identify and implement ways to include **benefit and debt advice** in women's health services to prevent homelessness,
- Continue to **strengthen partnership working** to understand and support the health and wellbeing needs of people living in TA.

Pillar 5 – Develop the infrastructure to support people seeking asylum and refuge to understand, access and be supported by health, care and wider services

'We kind of exist below the healthcare system here. I have no idea what's going on and when I'm going to know something. So, I don't know if the UK system is good or bad, but I know it's so complicated.'

Qualitative Health Needs Assessment: Exploring the health and healthcare experiences of asylum seekers living in London hotels, London Borough of Newham, 2023[184]

During 2024, around 123 million people globally were forcibly displaced from their homes as a result persecution, conflict, violence, human rights violations or events seriously disturbing public order; 40% of these people were children.[185] When people are displaced, they are much more likely to seek sanctuary in another part of their home country, in a neighbouring country or in low or middle income countries.[185] The UK ranks 20th in Europe in terms of the number of asylum applications per head of population. Countries where most of the world's refugees come from include Syria, Afghanistan, Ukraine, Venezuela, and South Sudan.[186]

London has provided refuge to those seeking sanctuary over many decades.[186] The numbers of people seeking sanctuary and refuge globally, in the UK, London and in NEL, continues to rise. As of the end of 2024, around 7,000 people seeking asylum were living in NEL, with Newham, Tower Hamlets and Redbridge having the highest number of people; Newham the highest in London.[187] While waiting for an asylum decision[188] people cannot work, claim benefits and have limited access to public services; the Home Office provides them with accommodation and a subsistence allowance. Around half of the people seeking asylum in NEL live in 'contingency hotels', provided by a private contractor, Clearsprings Ready Homes.**Error! Bookmark not defined.** People also come to the UK via government resettlement schemes which provide more support than the asylum process, to a much lower number of people.**Error! Bookmark not defined.**

People who are granted the right to stay in the UK through refugee status are often at risk of homelessness and destitution, due to having low or no income, a lack of knowledge of their rights and options and an inability to access local authority housing services.[189] [190] The short window for moving on from asylum accommodation often leads to homelessness[191] and destitution increases the likelihood of other risks, including work exploitation, modern slavery, and poor health.[190] Whilst the numbers of people living in the UK with undocumented migrant status is not clear, people who have been refused asylum, do not understand the asylum system or who been trafficked are at increased risk of homelessness.[192] [193]

People seeking sanctuary often have complex health needs related to experiences prior to leaving their home country, during their journey and after arrival in the UK. As summarised in 'the case for change (add link), untreated communicable diseases such as TB and hepatitis and long term conditions such as diabetes and hypertension are common health challenges.[194] People seeking asylum and refuge are more likely to have experienced trauma and experience mental health problems including depression, anxiety and post-traumatic stress disorder (PTSD), along with social isolation.[194] [195] [196] Perinatal outcomes are worse among migrant women including maternal mortality[197] and one study showed 75% of unaccompanied children arriving in the UK had specific health issues including latent TB, hepatitis B, schistosomiasis (a parasitic disease) and mental health symptoms; a quarter were referred to sexual abuse services.[198]

The Home Office[199] steers the fundamental infrastructure that enables people to thrive in the UK; access to health and care services, education and employment, security and growth and housing, which underpins people's whole life experiences. The current system however creates a range of challenges to building social connections, accessing services, and maintaining health and wellbeing.[200] Access to employment and volunteering opportunities can not only enable income but reduce social isolation and health inequalities, as well as tapping into the diversity of people's skills, talents and experiences.[199] [201] [202] [203] NEL based research evidenced how important health is for people seeking asylum; a core asset to building a new life.[204]

The barriers and inequality of access to health and care services described in Pillar 2, including stigma and discrimination, not understanding the health system or their rights and language or digital access issues, further impact on people's complex health needs.[194] [205] [206]A new health outreach service in NEL, provided by

Doctors of the World[207] supports people living in contingency hotels thorough assessing their health needs and supporting to access GP and wider services. Through the service we can also capture a better understanding of people's health and wellbeing needs, creating evidence for further focus.

Whilst people seeking asylum and granted refugee status are entitled to health care services without charge,[208] [209] the policies are complicated and vary across health services based on people's status. For example, people are who are 'undocumented' can be charged for NHS secondary care deemed not urgent or immediately necessary. The complexity of the system impacts patients; with people often incorrectly being refused care or asked to pay upfront due to staff not being familiar with people's rights.[210] [211] People may also avoid using services because of fear of being charged, detailed or deported.[210] The 'no recourse to public funds' (NRPF) condition imposed on people with temporary immigration status[212] can put people who are able to be discharged from hospital but require further health, care or housing support, at risk of homelessness and impact their health further.[213] Access to social, welfare and legal advice can support and empower people and reduce the risk of homelessness, destitution and poor health and wellbeing, as well as reducing pressure on public services.[214] [215] [216]

This pillar of the strategy was steered by a NEL partnership of colleagues from local authority, health and the VCFSE, which has existed for some time; working together to support people seeking asylum and refuge. Evidence presented here shows that the health and wellbeing needs of people seeking asylum and refugee are complex and that accessing care and support from health and wider services to meet their needs is incredibly difficult. In adopting our wide definition of homelessness, the focus needed to address the health inequalities experienced by this population must happen across the pillars and cross-cutting themes of the strategy. As experts and service leads, our NEL partnership must help steer this, as well as leading the following set of priorities and projects to develop the infrastructure to support people seeking asylum and refuge to understand, access and be supported by health, care and wider services:

'Someone with a complex condition which hasn't been monitored for several years, I'd normally refer to the specialty team, but then they might get charged. These are the patients I go to bed thinking about.'
Dr Lucy Langford, Newham GP [217]

Pillar 5 has been shaped by a longstanding NEL partnership of local authorities, health, and the VCFSE sector, working to support people seeking asylum and refuge. This population's complex needs and the persistent barriers they face means tackling these inequalities must be a priority across all pillars and cross-cutting themes of the strategy. As experts and service leaders, the NEL partnership will continue to guide this work and lead key priorities and projects to build the infrastructure that enables people seeking asylum and refuge to understand, access, and be supported by health, care, and wider services. We will:

- Work to become an **'ICS of Sanctuary'** through the City of Sanctuary award.
- Build an understanding of the **population**, **their health and wellbeing needs, and gather evidence** to design, deliver and evaluate projects and services.
- Develop and implement a **NEL approach** to provide **social, welfare and legal advice** to support people to be safely discharged from hospital, including those with **no recourse to public funds**.
- Establish and pilot interventions to **support refugees into employment, volunteering and learning opportunities**.
- Continue to strengthen how **people and partners in NEL work together** to support and improve outcomes for people seeking asylum and refuge.

"They are not like doctors in our country. They are like friends. It's a secure place. They are so kind. When my husband fell into depression, the doctor was worried. Not just about him, but about me. They hold our hand every time we have an appointment."
Qualitative Health Needs Assessment: Exploring the health and healthcare experiences of asylum seekers living in London hotels, London Borough of Newham, 2023

Cross-cutting themes

The three homeless health cross-cutting themes represent fundamental areas of focus that fit and are evident across each of the five pillars, as well as representing important areas of focus in their own right to support and enable improved health and social outcomes for people experiencing homelessness.

This section of the strategy presents the evidence and the priorities agreed against the NEL Homeless Health Strategy's three cross-cutting themes; **safeguarding, workforce development and data, intelligence and evaluation.**

Safeguarding

The protection of people's health, wellbeing and human rights through safeguarding is an integral part of high-quality health and care services and a collective responsibility. The experience and threat of homelessness often places people at significant risk of harm, exploitation, and neglect, making safeguarding a critical concern. As with all health inequalities, the risk of harm, exploitation or neglect is driven by the complexity of people's health challenges, experiences of trauma and social isolation and deep barriers to accessing services. Safeguarding is therefore a central cross-cutting theme of this strategy, woven through the ambitions and priorities of each of the pillars and other cross-cutting themes, aiming to prevent harm and improve people's lives.

The focus for safeguarding in relation to people experiencing homelessness is more typically focused on adults, however in taking a wide definition of homelessness, safeguarding children is also vital, for example in relation to families at risk domestic violence, vulnerable migrant families and unaccompanied asylum seeking children.[218] Homelessness, particularly rough sleeping is traumatic, lonely, and scary for anyone, but women are more vulnerable to the dangers, facing a high risk of violence, abuse, and exploitation.[28]

The integration and strengthening of safeguarding for people experiencing homelessness is an area of development. [219] London based research has shown that local safeguarding boards are not consistently or collectively focusing on people experiencing homelessness or initiating reviews when people die homeless. Work with the Groundswell London Participation Network in 2023 showed that people with lived experience of homelessness feel the culture of safeguarding practice can be disempowering, with people seen as a risk rather than being vulnerable to risks, reducing trust. [220] Furthermore, different approaches taken by organisations to safeguarding can be confusing, with people often not knowing their legal rights, for example how to challenge treatment or service decisions.

The second national analysis of safeguarding adult reviews (SARs – undertaken when an adult who needs care and support has died or experienced serious abuse or neglect), found a rise in SARs related to self-neglect, domestic abuse and substance dependency.[221] Assumptions of lifestyle choice in cases of self-neglect or homelessness were deemed problematic, as well as shortcomings in understanding lived experience and trauma. Learning from SARs indicates that transitions, including hospital discharge or moving into an independent tenancy, can be positive opportunities for people to move forward in their lives. However, transitions quickly become 'cliff edges' when multi-agency arrangements fail and when people make transitions without appropriate accommodation and support in place.[219]

A joint ministerial letter to safeguarding adults boards in 2024 strengthens requirements for a more strategic approach to safeguarding for people experiencing homelessness, including for boards to have a named lead for homelessness and governance that holds partners collectively accountable. Best practice[221] and regional guidance[222] steers the need for a person-centred, integrated partnership approach to this complex area of safeguarding, that recognises the heightened risks of abuse, neglect, or exploitation faced by people experiencing homelessness and the need to ensure that vulnerable people are protected better. A further call seeks a specific focus on the prevention of premature deaths for people in inclusion health groups, with an explicit focus on their discrete experiences of harm, abuse and neglect (including self-neglect) being crucial to saving lives.[219]

Protecting people's health, wellbeing and human rights through safeguarding is crucial in each of the pillars of the NEL homeless health strategy, whether we're focused on hospital admission and discharge, access to

and support from primary care, the provision of joined-up mental health and substance misuse services, or end of life care. Furthermore pillars 4 and 5 have a focus on specific populations and needs, for which a collective focus on safeguarding adults and children is vital.

In order to strengthen our approach, through this cross-cutting theme we will:

- Strengthen the **strategic focus on all forms of homelessness in safeguarding** by working with partners through the Safeguarding Adults Boards and beyond, committing to new areas of development and practice,
- Bring together people working on safeguarding and homelessness to **develop knowledge, relationships and practice, strengthening collaboration and collective focus** on the population,
- Capture what's happening across the NEL system to see where **best practice** could be spread and improvements achieved.

Workforce development

As well as being a NEL ICS priority,[223] workforce development is one of the key principles for action in the national inclusion health framework.[5] This steers the importance of developing the workforce structure to deliver integrated health, care, and support differently, equipping people with the knowledge and skills to reduce health inequalities, focusing on staff wellbeing and retention and creating opportunities for employment and career development for local people.[132 224 225]

To address the complex needs of people experiencing homelessness, core services need to be more inclusive, accessible and person-centred and specialist services need to be funded, supported, grown and sustained. Evidence suggests that workforce development is required in many of these areas, reflecting the wider capacity and strategic issues facing public and VCFSE services, but also the need to raise addressing health inequalities and prevention on the agendas of systems and organisations.[6 48 226] Specialist services supporting people experiencing homelessness are often funded in short term, piecemeal ways, making attracting, retaining and developing staff extremely hard.[227 228] As described in our strategic opportunities, consistency in staff and service is a vital if services are to improve health, and social outcomes for people experiencing homelessness.[6 72]

Learning and development for staff around health inequalities, inclusion health groups and homelessness is vital and needs to be tailored to the type of service being provided, be it mainstream or specialist. This can include a focus on population profiles and needs, entitlements to care, safeguarding, a focus on the impact trauma and digital inclusion, as well as space to reflect and be supported by peers.[5 6 229 230 231] Working to support and improve the health and wellbeing of people who are the most socially excluded from society can be rewarding and fulfilling, but also impactful on people's wellbeing. This can be particularly true when a service is stretched, uncertain and people feel they are not able to make enough of a difference or indeed they have their own lived experience of homelessness or trauma or are at risk of homelessness. Evidence exists for the type of initiatives that can make a difference including peer support and psychological interventions.[227 232 233 234]

Creating opportunities for employment, skills and career development for people with lived experience of homelessness offers many advantages for organisations, systems and individuals. For organisations this includes gaining a deeper understanding of the people they serve, developing more informed solutions, building credibility through trust and inspiration and breaking down barriers and stigma through a more diverse and inclusive workforce. For individuals, routes into employment and skill development can support inclusion and stability through income, a sense of empowerment and growth, enable skills and abilities recognised, improve connections and aid career progression.[235 236 237]

Taking a holistic workforce approach we will enable workforce development across our homeless health pillars in the ways identified in and utilise our system workforce strategies and priorities, along with wider evidence and best practice to:

- Increase the **knowledge, understanding and system leadership of the value and impact of consistently funded, high quality, specialist services** to support people experiencing homelessness, making the case for strategic investment,
- Scope and establish a **learning and development programme** that will equip people in mainstream and specialist services with the knowledge and skills to reduce health inequalities and improve outcomes for people in inclusion health groups, building on what exists or is being established, such as learning around trauma informed care,
- Work with colleagues across NEL to **scope and implement interventions to support staff wellbeing**; based on evidence of what works and what people say would be impactful,
- Work with system partners to **create opportunities into employment and career development** for people with experience of or who are at risk of homelessness.

Data intelligence and evaluation

The NEL definition of homelessness is broad, including those who are roofless, houseless, living in insecure accommodation, and living in inadequate housing. This comprehensive definition aims to be inclusive of all groups experiencing homelessness, including vulnerable migrant populations, the Gypsy Roma and Traveller (GRT) communities, sex workers, and individuals in contact with the criminal justice system. However, data and intelligence around people experiencing homelessness and wider inclusion health groups, though available in some forms, is often limited, incomplete and doesn't articulate the full extent of the health needs within this population. A report from Pathway highlighted that these groups are often 'invisible' or under-represented in health data.[55]

Many factors influence the current state of inclusion health data in north-east London and beyond, which have been identified through the narrative of this strategy. As a system, we currently do not understand the demographics and needs of those experiencing homelessness due to the barriers experienced when trying to access health care. For example, research shows that around two-thirds of GPs refuse to register patients without an address, contrary to NHS guidelines on access to healthcare.[50] [238] Another study showed 65.5% of rough sleepers were registered with a GP, compared to 98% of the general population.[239] Additionally, many individuals face a lack of trust in the system and encounter stigma from frontline staff, hindering their ability to seek care.[50] Another key challenge is digital exclusion; as healthcare moves increasingly toward digital platforms, many in this population lack access to the necessary digital resources to engage with these services.[71] This digital divide can impede the interaction with health services, thereby hindering data collection.

Data fragmentation is also a critical issue. The transient nature of the homeless population, combined with the absence of integrated data systems across health and social care providers, leads to isolated and incomplete data. This makes it difficult to gain a full picture of people's healthcare needs even when they are interacting with services. Coupled with this is the lack of standardisation in data collection due to inconsistent classification, recording and coding of homelessness, inclusion health and wider information such as housing status. This issue is particularly prevalent for those experiencing hidden homelessness, insecure housing, or inadequate housing. Without standardisation, it is difficult to aggregate or compare data effectively across different settings.[55] People often report experiencing stigma, discrimination and a lack of trust in health and care services so, they may be reluctant to fully engage and declare their personal and demographic information.[240] More broadly, data that drives a focus on health inequalities is often analysed by accommodation postcodes or demographic information based on protected characteristics,[241] through which it is not easily possible to identify people in inclusion health groups facing extreme health inequalities. A proposed solution to this issue is a better system for recording housing status as proxy for identifying people in inclusion health groups.[242]

Importantly, understanding what matters to people and what works must be captured in a range of ways, beyond quantitative data. This requires collaborating with people who have lived experience of homelessness

(see 'our strategic opportunities') and using creative, broad evidence collection - employing qualitative research, varied evaluation approaches, and engaging tools to share insights effectively.[5] [11]

Good quality data, intelligence and evaluation is key to understanding the health needs of our population to prevent and address health inequalities. To effectively address the health and social needs of people experiencing homelessness, we must harness the power of data and intelligence by improving data collection, sharing and analysis, in alignment with our NEL ICS Joint Forward Plan,[62] to 'identify the most vulnerable people living locally including those not using services and those frequently using services to provide more targeted and proactive support which better meets their needs.'

Through this cross-cutting theme we will:

- Collaborate with partners to **develop an inclusion health needs assessment** that encompasses the broad definition of homelessness to build understanding of the health needs of the inclusion health population in NEL,
- Embed a **unified definition of inclusion health across NEL and implement standardised coding practices** in both primary and secondary care settings to enhance data capture, quality, and comparability,
- Improve **data sharing between sectors and organisations** to enable holistic, personalised and joined up care planning through the Universal Care Plan, a pan-London digital care plan that puts the patient at the centre of their care, ensuring their wishes and preferences are always considered by health professionals caring for them,
- Identify **key outcome measures** to determine which metrics are most relevant to understand and measure the impact of interventions, informing strategic action,
- Develop and support the **use of a range of research and evaluation methods** to evidence population needs and the impact of services.

Remaining meaningful and areas of developing focus

Over the next five years, the strategy will evolve in response to national and local developments, ensuring it remains meaningful, dynamic and aligned with changing priorities and community and population needs. In practice this means we will draw strongly on the cross-cutting theme of data, intelligence and evaluation; capturing and demonstrating impact, improvement and learning through action steered by the strategy and using this to inform what we focus on in the future.

Whilst the ambitions of this strategy are extensive and will necessitate significant focus, resource and joint working, there are emerging areas of risk and opportunity that as we look to the future will require consideration. These areas include the risks associated with climate change[243] and the impact that this will have on the most vulnerable populations; and the opportunities that taking a joint ICS and population health approach offers in addressing the underlying causes of homelessness and preventing people becoming homelessness.

Climate change

The Greater London Authority published the London climate resilience review in July 2024[244] recognising that climate change will impact Londoners disproportionately depending on socio-economic and demographic factors such as age and ethnicity. The CDP[245] has also established that the UK's most marginalised and vulnerable health groups are the most at risk from climate change as their specific health and social vulnerabilities heighten the risk of illness and death during severe weather.

Climate change means that people sleeping rough will be exposed not only to severe winter weather but also increasingly hotter summers, particularly in heavily urbanised areas such as London. The impact of increased temperatures can intensify risk factors in people sleeping rough and those in insecure housing, due to the presence of underlying physical and mental health conditions, drug and alcohol dependencies, reduced access to air-conditioned or shaded environments, drinking water, and increased social isolation. The result of which is that people experiencing homelessness are at an elevated risk of hospitalisation associated with even moderately high temperatures.[246] Considering this, areas that require further scoping include:

- Reviewing extreme weather protocols that set out the actions needed in extreme hot or storm conditions – taking learning from current protocols such as 'SWEP'.[247]
- Adaptation planning – understanding the risks to homeless populations and incorporating these into planning for climate change across the system, examples could include ensuring public spaces have dedicated shaded areas and drinking water facilities and testing the climate resilience of temporary accommodation
- Training staff in the homelessness and housing sector about the impacts of climate change and air pollution on those experiencing homelessness
- Understanding the impact of climate change in driving migration to the UK
- Continuing to embed the work on the NEL Green Plan to decarbonise the NHS and improve air quality

Housing, health and wider partnerships

ICSs are in a key position to take forward the work outlined in this strategy and to maximise the opportunities that greater joint working between the health and care system and housing, particularly with a focus on the most excluded populations.[248] [249] We are proud that the collaboration of housing and health is explicitly recognised in pillar four and more collaborative approaches are required to tackle some of the most systemic issues we face be it climate change or the supply of good quality affordable housing.

This has been recognised in the recent publication of ICS housing profiles by the GLA[250] resource that aims to support people working across the system to understand and work jointly to mitigate the key housing-related issues that drive poor health in London, with a focus on housing quality, security and affordability. As the ICS develops and as the ambitions of the strategy are met there should be a greater emphasis on how

we can drive integration between health and housing. As a starting point the collective understanding of what our NEL housing profile is telling us will enable a series of conversations with system partners to develop a new approach to tackling health inequalities in NEL. Furthermore, there are opportunities to consider the use of NHS estates and buildings to support vulnerable communities, including people experiencing homelessness.[251] Beyond the ICS, we will make opportunities to work with wider partners, including the police and criminal justice system, to align, integrate and address the needs of people experiencing homelessness together.

Population health approaches for prevention

Taking a preventative approach to health inequalities and homelessness is further supported by our population health approach in NEL. Work is being piloted in our some of our place-based partnerships, exploring what a population health preventative approach could look like for those most at risk of becoming homeless, addressing the risks of homelessness before the point of crisis. The London Borough of Barking and Dagenham and place health partners are piloting a tool that uses predicative analytics (bringing together disconnected datasets) to identify people at risk of becoming homeless, flagging warning signs like missed utility payments or health issues that could be linked to homelessness and triggering wrap around support to help prevent the situation tipping into crisis. To be rolled out in 2025/26, this pilot will be evaluated to assess whether it can be scaled up as an ICS wide approach to preventing homelessness.

Conclusion and next steps

Due to the cumulative impact of austerity, cost-of-living increases, and the national housing crisis, more people in NEL are facing the insecurity of becoming homeless. The impact of this on individuals and our wider system is profound and this strategy sets out how as the NHS, we are working strategically with our partners to achieve change to ensure people are supported at their most vulnerable time.

As this strategy is being published at a time of transition for Integrated Care Boards (ICBs), the role of strategic commissioning becomes more prominent and there is an increased emphasis on neighbourhood-level working. This presents valuable opportunities to implement the strategy at Place, while the ICB maintains a strategic role in measuring impact and ensuring that the call to action is heard and acted upon. The strategy will be approved, monitored, and periodically renewed by the ICB Board. A development plan will underpin its delivery and will be regularly refreshed to align with evolving policy and service-level changes. With many areas of focus in the strategy already underway and much best practice across NEL, we need to be bold as a system to achieve more together and we are excited to formalise this commitment through the NEL Homeless Health Strategy.

Contact us

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City of London Corporation Committee Report

Committee(s): Health and Wellbeing Board	**Dated:** 11/07/2025
Subject: Healthwatch City of London Progress Report	**Public report:** For Information
This proposal: Provides progress information.	
Does this proposal require extra revenue and/or capital spending?	No
If so, how much?	£N/A
What is the source of Funding?	N/A
Has this Funding Source been agreed with the Chamberlain's Department?	N/A
Report of:	Healthwatch City of London
Report author:	Gail Beer Chair, Healthwatch City of London

Summary

This report details the work of Healthwatch City of London for Q1 2025/26

Recommendation(s)

Members are asked to:

Note the report.

Main Report

Background

Healthwatch is a governmental statutory mechanism intended to strengthen the collective voice of users of health and social care services and members of the public, both nationally and locally. It came into being in April 2013 as part of the Health and Social Care Act of 2012.

The City of London Corporation has funded a Healthwatch service for the City of London since 2013. The first contract for Healthwatch came into being in September 2019 and was awarded to a new charity Healthwatch City of London (HWCoL).

HWCoL is registered on the on the Charities Commission register of charities as a Charitable Incorporated Organisation and is Licenced by Healthwatch England (HWE) to use the Healthwatch brand. The current contract for Healthwatch City of London was awarded in September 2024.

HWCoL's vision is for a Health and Social Care system truly responsive to the needs of the people who live, work and study in the City. HWCoL's mission is to be an independent and trusted body, known for its impartiality and integrity, which acts in the best interests of those who live and work in the City.

Current Position

The HWCoL team continue to operate from the Portsoken Community Centre and through hybrid working – both at the office and home working.

The communication platforms continue to provide residents with relevant information on Health and Social care services via the website, newsletters, bulletins, and social media.

The team are fully staffed and have a team of volunteers.

Public Board Meetings

1. Board Meeting in Public 6th June 2025

HWCoL held a Board meeting in public in June 2025. This meeting was held at the Golden Lane Community centre with 15 attendees. David Curran, Director of Nursing and Governance, St Bartholomew's Hospital was due to present on the Healthwatch Enter and View report to the cardiology department and their response to the recommendations, however unfortunately, David was unable to attend at the last minute. We are rescheduling this update for a later date.

The meeting gave us the opportunity to outline our key priorities for the year which are:

1) Deliver 10 patient panels to inform service users about Health and Social care topics that are important to them.
2) Hold a summer information event in June and our AGM in October, both events will give residents important information on local Health and Social Care services and on the work of Healthwatch City of London.
3) Undertake two research projects – Emergency pathways at Barts Health and UCLH and access to dentistry in the City.
4) Carry out an Enter and View at the Physiotherapy department at St Leonards Hospital. This will enable a review of access, provision and satisfaction of the

service and with a full report to include recommendations for improvements or changes.

5) Increase engagement with the Portsoken community – hold two engagement events and increase representation from the community.

6) Maintain, train and utilise a dedicated team of volunteers. To attend focus groups to give the City's perspective, research and write reports for projects, help with HWCoL events and carry out enter and view visits.

7) Scrutinise how the City of London Corporation awards and monitors its contracts for Social Care provision. Focus on the patient/resident feedback elements of the contracts. Review feedback from patients via the annual social care survey and analyse safeguarding statistics.

The meeting also covered our workplan for the year, a financial update and an overview of the meetings we attend to make sure the City voice is heard.

Projects

1. Digital Apps in Healthcare

In April HWCoL held the public launch of the digital apps report 'Digital Apps: A help or hindrance? Understanding and accessing digital healthcare apps' to members of the project focus groups and the digital lead at the Homerton, this followed on from the last quarters launch to service providers.

The public launch was very well attended and continued the lively discussion around the use of apps in healthcare. This is clearly a subject the draws strong views from residents and an area that HWCoL will continue to monitor and keep abreast of any changes from service providers in the City. We need to keep this conversation alive and will continue to raise this at Integrated Care Partnership Board.

The report was shared to the Health and Wellbeing Board at the last meeting.

Support to the City of London Corporation

1. Adult Social Care Advisory Group

HWCoL have agreed to set up and manage an Adult Social Care Advisory group following a request from the City of London Corporation. The initial meeting of the group was scheduled for 19th June, however due to some hesitancy from service users and despite several attempts at contacting users, the meeting was cancelled.

HWCoL have met with the Adult Social Care team and agreed a way forward to increase interest and engagement with users of social care.

The team will be organising three sessions each with a different aspect of social care to try and appeal to a wider set of users with the Head Occupational Therapist who will present on the Adult Social Care services offered in the City. These will take place at the Guildhall, Portsoken Community Centre and the Golden Lane Community Centre to reach as many residents as possible.

The Adult Social Care team also attended the Health in the City Day to increase awareness of the sessions and their service provision.

2. Family Design Lab

Advertising of the City of London Corporation's Family Design Lab in response to the change in delivery of services for children, young people and families in the City of London in response to national government reform.

Enter and View Programme

Healthwatch have a statutory function to carry out Enter & View visits to health and care services to review services at the point of delivery.

1. Neaman Practice Enter and View

HWCoL undertook an Enter and View visit to the Neaman Practice on 13th February 2025. The visit was carried out by the HWCoL staff team and a Board member. The report has been written and is with the Neaman Practice for response and comment. This was received on Friday 20th June and once reviewed will be shared with this Board in Q2. The full report will be launched at a Public Board meeting with the Practice Partners.

Communications and Engagement

HWCoL Events

1. Health in the City Day with the Neaman practice

On Saturday 21st June HWCoL held its annual Health in the City Day at the Golden Lane Community Centre with the Neaman Practice.

This year there were stalls for residents to visit from City Carers Community, IMAGO, Older Peoples Reference Group, Age UK City of London, Dragon Café in the City, Advocacy Project, Together Better, Shoreditch Park and City PCN, NHS NEL Cancer Alliance, Gloji (City and Hackney Smoke Free Service), HealthSpot and the Adult Social Care Team, City of London Corporation.

Also provided by the Richmond Road Medical Centre, there were blood pressure tests and blood sugar readings, and the Mental Fight Club ran a Japanese Embroidery workshop.

HWCoL advertised the event via a leaflet drop to all flats in the Barbican and Golden Estate, regular social media adverts, adverts in estate communication bulletins, and promotion via stall holders.

Over 50 residents attended the event and initial feedback from the stall holders and residents was very positive.

2.Carers Week event with IMAGO and City Carers Community

To mark Carers week (9th – 15th June) HWCoL held a tea party at the Guildhall at which we were joined by Dragon Café in the City and supported by Imago, the carers support service.

Dragon Café led an embossed foil card making workshop, where participants created some imaginative and unique cards. This was followed by a tea party.

Judith Finlay, Executive Director of Community and Children's Services and Hannah Dobbin, Strategy and Projects Officer joined us to express their appreciation and commitment of the unpaid carers community.

3. Patient Panels

Patient panels are designed as information sessions for residents to attend on topics of concern or interest to them. They also are for residents to give feedback on those services and share ideas for improvements. HWCoL's patient panel series attract new residents at every event. Reports from all Patients Panels are published on the HWCoL website. These are now a recognised and useful way of drawing providers and receivers of care together.

3.1 Patient Panel May Skin Cancer Awareness and Prevention.
Following a request from a residents, HWCoL ran a Patient Panel on Skin Cancer Awareness. It was our most popular Patient Panel to date with 20 people attending.

Dr Thomas McLeod, GP and clinical lead on North East London Cancer Alliance skin cancer risk reduction campaign led the session.

Dr McLeod told the audience about the two different groups of skin cancer, melanoma and non-melanoma, what to look out for on suntan lotion bottle labels, UVA, UVB and SPF, getting enough Vitamin D safely and what to look for when inspecting moles or dark spots. He promoted the NEL Cancer Alliance website LDN get sun set which gives advice on how to stay safe in the sun.

There is more work to do to promote the use of sun protection for City workers and tourists.

Upcoming panels

3.2 Cardiopulmonary resuscitation (CPR) training session with the London Ambulance Service

Due to popular demand, we have organised another CPR training session with the London Ambulance Service. This will be held on Thursday 17th July at the Artizan Library, 1 Artizan Street, London, E1 7AF from 10:30 – 12pm.

These CPR training sessions are always sold out. There is a real appetite for a more comprehensive schedule of both CPR and first aid training amongst City residents.

3.3 North East London Cancer Alliance – Ovarian and Womb Cancer

For residents to find out more about the symptoms, prevention and treatment of ovarian and womb cancer.

North East London Cancer Alliance and leading gynaecological cancer charity The Eve Appeal have launched a second phase of their 'You Need to Know' campaign,

to raise awareness of ovarian cancer symptoms and improve early diagnosis, as with all cancers the early diagnosis and treatment supports better outcomes.

The campaign encourages women in north east London to speak to their GPs if they experience persistent bloating or other unexplained changes in bowel movement or eating habits.

The session will be held on Wednesday 3rd September 12 – 1.30 at the Golden Lane Community Centre, EC1Y 0SA.

4. Neighbourhoods Engagement Involvement

4.1 City Action Group

HWCoL attended the third City Action Group meeting in June. The City Action Group is a separate group formed from the Shoreditch Park and City Neighbourhood forums which specifically focus on residents in the City.

At the meeting there were representatives from CoL and the City advice. It was agreed that the meeting for residents would be held on 8th July at the Golden Lane Community Centre.

The Forum is designed for residents to discuss the local priorities for the City, these will be decided from the three key priorities in the Health and Wellbeing Strategy:

- Financial Resilience
- Mental Health
- Making Social Connections

Service providers representing each area have been invited to attend and support the event with an information stall. There will be a main presentation on each area by a CoL officer followed by group discussions.

5. Falls Prevention Engagement

The engagement work carried out by Healthwatch City of London and Healthwatch Hackney has been fed back to the Falls Prevention pathway review, as reported previously. The initial outcomes from the review are due to be presented in Q2, which HWCoL will attend.

MRS Independent Living have been commissioned to continue to provide the Staying Steady Classes in the City which the outcome of the review and next steps are agreed by the system and City and Hackney Public Health Team.

6. Portsoken Community Engagement

Unfortunately, the meeting arranged with Portsoken Councillors in Q1 was postponed. HWCoL have now contacted the councillors to agree separate meetings to progress this work. This has already started with some helpful initial engagement.

A volunteer from the community has also agreed to work with HWCoL to promote engagement across the estate and community. The volunteer will help to produce leaflets in the correct languages, help encourage attendance at events and help interpret messages.

HWCoL has also had discussions with the Population Health Hub and NHS NEL who are both keen to improve engagement and promote health messages to the area. The Population Health Hub is looking at running some resident-led information sessions, where they will engage with the community to hear what areas they would like to have more information on. NHS NEL are looking at health literacy in the area.

7. Annual Survey

HWCoL has completed its annual survey. The results of this will be analysed in Q2 and reported on in the next report.

8. Pharmaceutical Needs Assessment

Gail Beer sits on the steering group who oversee the work of the City and Hackney Pharmaceutical Needs Assessment. The survey period for resident feedback has finished with the draft report now out for consultation. The final report will be presented at a Health and Wellbeing Board in the autumn.

HWCoL advised on the conclusions of the report and the easy read version.

9. Public Representative Programme

Last quarter HWCoL raised its concerns about the public representatives programme losing funding following the recent Government announcements on structures in the ICB. The programme was run by Healthwatch Hackney but supported representatives from both the City and Hackney. HWCoL are in discussions with Healthwatch Hackney on how to utilise the representatives going forward. It is also important to understand better the public's representation in this group and how they work amongst the wider population.

10. Sexual and reproductive health strategy and action plan

HWCoL have been participating fully in this piece of work, supporting Froeks from City and Hackney Public Health Team, to identify any gaps in the plan and suggest ways to address that.

Getting young people involved in this is core for the City, and HWCoL are already having discussions.

Issues raised on behalf of residents

1. Neaman Practice Booking system

As raised in the last report the Neaman Practice have introduced a new appointment booking system. HWCoL were contacted by several concerned residents that the system was confusing and more importantly that they had not been informed of the change. HWCoL had a discussion with the Practice who explained the new system, and why it had been implemented. HWCoL held a Patient Panel with Dr Hillier (who has overseen the roll out) for concerned residents. To support residents, HWCoL held a focus group to deep dive into the issues raised by residents which took place in Jan 2025.The team also held a focus group specifically for carers on 11th April.

Feedback from this engagement has now been reported back to the Practice, they have actioned the recommendations from the report which HWCoL will monitor.

Planned activities for Q2

- Continued monitoring of the Falls Prevention review
- Publish report of Neaman Practice Enter and View
- Report on engagement on Neaman Practice Booking System
- Report on Healthwatch City of London Annual survey
- Publish Healthwatch City of London Annual Report
- Continued work with CoL to set up the Adult Social Care Advisory Group
- Production of three year work plan
- Increased engagement with the Portsoken Community through Court of Common Councillors
- Develop draft plan for delivery of major projects

Conclusion

The team at Healthwatch City of London have had a busy Q1 delivering several well attended events, and continued engagement with residents of the City of London.

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Committee(s): Health and Wellbeing board	**Dated:** 11 July 2025
Subject: First Aid Interventions including AED, anti bleed out and trauma kits	**Public**
Which outcomes in the City Corporation's Corporate Plan does this proposal aim to impact directly?	Providing excellent services, vibrant thriving destination, flourishing public spaces
Report of: Sandra Husbands, Director of Public Health; Judith Finlay Executive Director, Community and Children's Services	**For Information**
Report author: Chris Lovitt	

Summary

Physical trauma and out of hospital cardiac arrest are two of the leading causes of death and disability in the UK. Reducing the time before first aid, including the application of cardiopulmonary resuscitation (CPR) and the use of an automated external defibrillator (AED) can significantly increase survival rates by up to 50-70%.

Increasing training, awareness and confidence to use first aid skills amongst staff, businesses and members of the public along with increasing access to and use of first aid kits, trauma kits and AEDs can help reduce death and disability. This would support the delivery the City of London's Corporate plan objectives and the duties of the Health and Wellbeing Board to improve health and wellbeing.

The board is invited to consider the role of HWB partners in maximising the benefits of first aid interventions and, if additional resources are required, potential sources of funding or staff time.

Recommendations

Members are asked to:

- Note the role that first aid interventions along with increasing awareness and confidence can have in reducing death and disability
- Consider how partners can maximise uptake of training and suitable provision of equipment for effective first aid interventions.

Main Report

Background

1. **Physical trauma:** is defined as serious injury to the body. Two main types of physical trauma are:
    a) Blunt force trauma—when an object or force strikes the body, often causing concussions, deep cuts, or broken bones.
    b) Penetrating trauma—when an object pierces the skin or body, usually creating an open wound.

2. Up to 59 per cent of deaths from injury may have been preventable if first aid was given before the emergency medical services arrived.

3. First aid was only attempted in around half of all cases (excluding where the person was found dead) despite someone being at the scene of the accident before the arrival of the emergency medical services 96 per cent of the time.

4. **Cardiac arrest:** is the abrupt loss of heart function, breathing and consciousness.

5. Fewer than 1 in 10 people will survive an out of hospital cardiac arrest. However, immediate initiation of cardiopulmonary resuscitation (CPR) can double or quadruple survival, and defibrillation within 3–5 minutes of collapse can produce survival rates up to 50–70%[1].

6. Automated external defibrillators (AED) are portable medical devices that can analyse the heart's rhythm and, if necessary, deliver an electrical shock, or defibrillation, to help the heart re-establish an effective rhythm. AEDs can be used by any member of the public without any prior training.

Current Position

7. The London Ambulance Service (LAS) has established London Lifesavers which aims to increase CPR training and give members of the public the confidence to use a Public Access Defib (PAD). They also have the London Lifesavers schools programme, which focuses on delivering free training to all schools across the capital aimed at year 8 pupils.

8. LAS have identified 21 London neighbourhoods where there is no access to an AED device and 129 with limited access. None of these neighbourhoods are situated in the City of London, however a large number are in North East London.[2]

9. There are a wide range of providers who organise training to promote first aid, trauma awareness and anti bleed training in the City of London ranging from private providers, the City of London Police, charities to NHS organisations.

[1] https://cks.nice.org.uk/topics/cardiac-arrest-out-of-hospital-care/
[2] https://www.londonambulancecharity.org.uk/london-neighbourhoods-in-need-of-public-access-defibrillators

However, there is currently no strategic approach to provision of first aid training available to members of the public, within schools or businesses or workplace.

10. The Health and Safety (First-Aid) Regulations 1981 require employers to provide adequate and appropriate equipment, facilities and personnel to ensure their employees receive immediate attention if they are injured or taken ill at work. However, these Regulations do not place a legal duty on employers to make first-aid provision for non-employees such as the public or children in schools.

11. The Health and Safety Executive strongly recommends that non-employees are included in an assessment of first-aid needs and that provision is made for them.

12. Although AEDs have become increasingly available within workplaces, businesses and community settings there is currently no legal requirement to provide these, maintain them or record their location on databases that can assist emergency call handlers directing people to their location.

13. Following the outcomes of the Lord Harris review on how to improve London's readiness for terror incidents and recommendations from Lord Kerslake review of the Manchester bombing the City of London Police has developed a specification for Emergency Trauma Packs (ETPs). ETPs provide both first responders and members of the public with significantly more additional equipment than a traditional first aid kit in order to be able to provide life saving interventions to treat major and catastrophic injuries.

14. ETPs have been specified in conjunction with the London Ambulance Services and over 100 ETPs are located in businesses and major attractions within the City of London. Premises that have an ETP are provided with a window sticker to promote their location to members of the public and also the emergency services. 15 ETPs have also been located within the City of London car parks.

15. The City of London Police have also undertaken pop up tents across the City of London where bleed prevention techniques have been demonstrated. Over 300 kits containing a tourniquet, bandages and adhesive chest seals have been deployed in pubs and bars.

16. The City of London Corporate Safety Team have developed HSG 44 First Aid Guidance[3] and HSG 51 Guidance on Defibrillators[4] which sets out the duties and responsibilities of all City of London staff and premises controller of Corporation properties. All CoL staff also receive a CitizenAid app which includes information on how to locate and use an AED.

Recommendations

[3] HSG 44 First Aid Guidance

[4] HSG 51 - Guidance on defibrillators

17. Partners of the Health and Wellbeing board consider how training, awareness and provision of suitable equipment can be promoted and funded across the City of London.

18. Explore the potential role of local planning guidance in relation to encouraging AEDs and other suitable first aid equipment to be provided as part of new developments.

19. Explore options to encourage organisations to register their AEDs and other first aid devices on the LAS and BHF directories.

Corporate & Strategic Implications –

Strategic implications – Increasing first aid training, awareness and provision of suitable equipment is in accordance with the Corporations Corporate Plan.

Financial and resource implications- provision of training, provision of first aid equipment and maintenance all require financial resources. CIL funding could be explored to assess if this could be a suitable source of funding to support provision. Many buildings and organisations have purchased AEDs however the extent to which these are regularly maintained is unknown. Publicly available AEDs are listed on LAS and BHF directories and promoting more organisations to list AEDs can assist with quality assurance of maintenance and access.

Legal implications- there are general legal duties to provide and protect the health and safety of employees and people accessing facilities. Private member bills which specifically seek to expand the legal duties to provide first aid facilities such as AEDs have been tabled in several Parliamentary sittings but not progressed part 2nd reading stage

Risk implications- failure to provide adequate first aid facilities present a legal, financial and reputational risk to organisations

Equalities implications – The Lifesavers work of mapping of neighbourhoods without AEDs or poorer access to AEDs concluded that poorer more deprived neighbourhoods, which often have higher rates of cardio vascular disease, violent injuries have lower access to suitable devices.

Climate implications- Although AEDs require regular maintenance, recharging etc there is little or no climate implications from their deployment.

Security implications- First Aid training and devices has the potential to improve security through ensuring more resilience of response to mass casualty and security incidents.

Conclusion

20. First aid training and provision of suitable publicly accessible equipment can reduce preventable death and disability. The Health and Wellbeing board should consider how to make best use of these opportunities and in doing so promote the health and wellbeing of residents and workers

Appendices

None

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