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Homelessness and Rough Sleeping Sub Committee

Date: **THURSDAY, 10 JULY 2025**

Time: 11.00 am

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

Members:

Mark Wheatley (Chairman)
Deborah Oliver, (Ex-Officio) (Deputy Chairman)
Deputy Helen Fentimen OBE JP
Dawn Frampton
Steve Goodman OBE
Shravan Joshi MBE
Helen Ladele
Sophia Mooney
David Williams
Robert Atkin, Safer City Partnership
James Breed, External Member
Patrick Fowler, External Member
Paul Kennedy, City Churches
Irmani Smallwood, External Member

Enquiries: **Blair Stringman**
blair.stringman@cityoflondon.gov.uk

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Ian Thomas CBE
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Agenda

1. **APOLOGIES**

2. **MEMBERS DECLARATIONS UNDER THE CODE OF CONDUCT**

3. **MINUTES**

To agree the public minutes and non-public summary of the meeting held on 14 May 2025.

For Decision
(Pages 5 - 10)

4. **MHCLG AND SUBREGIONAL PERSPECTIVE**

Presentation to be heard.

For Discussion

5. **CITY OF LONDON POLICE UPDATE**

The Commissioner of the City of London Police to be heard.

For Information

6. **INTRODUCTION TO HOMELESSNESS AND ROUGH SLEEPING SERVICES REPORT**

Report of the Executive Director, Community & Children's Services.

For Information
(Pages 11 - 46)

7. **HOMELESSNESS & ROUGH SLEEPING STRATEGY UPDATE REPORT**

Report of the Executive Director, Community & Children's Services.

Item to follow.

For Information

8. **CO-PRODUCTION PROJECT PROGRESS REPORT**

Report of the Executive Director, Community & Children's Services.

For Information
(Pages 47 - 56)

9. **STATUTORY HOMELESSNESS SERVICE DEVELOPMENT PLAN**

Report of the Executive Director, Community & Children's Services.

For Information
(Pages 57 - 72)

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

Report of the Executive Director, Community & Children's Services.

For Information
(Pages 73 - 118)

11. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE SUB-COMMITTEE**

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

13. **EXCLUSION OF THE PUBLIC**

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

For Decision

Part 2 - Non-Public Agenda

14. **CITY OF LONDON POLICE NON-PUBLIC UPDATE**

The Commissioner of the City of London Police to be heard.

For Information

15. **QUESTIONS RELATING TO THE WORK OF THE SUB-COMMITTEE WHILE THE PUBLIC ARE EXCLUDED**

16. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT WHILST THE PUBLIC ARE EXCLUDED**

HOMELESSNESS AND ROUGH SLEEPING SUB COMMITTEE

Wednesday, 14 May 2025

Minutes of the meeting of the Homelessness and Rough Sleeping Sub Committee held at the Guildhall EC2 at 4.00 pm

Present

Members:

Mark Wheatley (Chairman)	Sophia Mooney
Deputy Helen Fentimen OBE JP	James Breed
Dawn Frampton	Patrick Fowler
Helen Ladele	Deborah Oliver

Officers:

Chief Inspector Nikki Gander	- City of London Police
Kirsty Lowe	- Community & Children's Services Department
Will Norman	- Community & Children's Services Department
Chris Pelham	- Community & Children's Services Department
Blair Stringman	- Town Clerk's Department

1. **APOLOGIES**
   Apologies for absence were received from Steve Goodman OBE and Shravan Joshi MBE.

2. **MEMBERS DECLARATIONS UNDER THE CODE OF CONDUCT**
   There were no declarations of interest.

3. **ELECTION OF DEPUTY CHAIRMAN**
   RESOLVED – That, in accordance with Standing Order 26 (6), Deborah Oliver being the only Member indicating their willingness to serve, was elected Deputy Chairman for the ensuing year.

4. **MINUTES**
   RESOLVED – That, the public and non-public summary of the minutes of the meeting held on 3 February 2025 be agreed as a correct record.

5. **ROUGH SLEEPING PREVENTION AND RECOVERY GRANT 2025/26 SUMMARY**
   The Sub-Committee received a report of the Executive Director, Community & Children's Services concerning a draft summary of the interventions that will be delivered by the City of London, through the Rough Sleeping Prevention and Recovery Grant for the period of 1 April 2025 to 31 March 2026.

   Members were reminded that this grant replaces the former Rough Sleeping Initiative (RSI), which had been in place for seven years, with the last three years delivered as a single three-year settlement. The RSPRG for 2025/26 will

be issued as a single Section 31 ring-fenced payment, totalling £1,373,509 for the City of London—broadly in line with the previous year's RSI allocation Officers noted that the new funding structure provides greater flexibility in how the grant is deployed, with no co-production process required with the Department for Levelling Up, Housing and Communities.

The draft plan, included in the report, outlines proposed interventions across prevention, outreach, accommodation, and recovery services. Members were advised that the plan remains subject to change as further operational details are confirmed.

In response to Member questions, officers clarified the following:

- The City of London continues to experience a disproportionately high level of rough sleeping due to its central location and perceived safety. While earlier RSI allocations were formula-based, recent funding has been more reliant on the quality and impact of local proposals.
- There is a possibility that future funding streams may consolidate the RSPRG with the Homelessness Prevention Grant (HPG), which operates under a more complex formula.
- The proposed winter crash accommodation model aims to complement the Severe Weather Emergency Protocol (SWEP) by smoothing service delivery across the colder months. Officers confirmed that access to such services would remain tightly gatekept to verified rough sleepers, and there is no evidence to suggest that such provision increases inward migration.
- Members discussed the potential use of church spaces for winter accommodation. Officers noted the logistical challenges in securing suitable venues but confirmed ongoing engagement with faith partners.
- On the topic of soup kitchens, officers explained that while welfare services are valuable, the City prefers to signpost individuals to structured support services to avoid inadvertently sustaining rough sleeping.

The Committee noted the report and thanked officers for their work. Members were invited to submit further questions to officers by email.

RESOLVED – That, the report be noted.

6. **STATUTORY HOMELESSNESS AND ROUGH SLEEPING SERVICE – USE OF TEMPORARY ACCOMMODATION REPORT**

The Sub-Committee received a report of the Executive Director, Community & Children's Services concerning a summary of temporary accommodation (TA) usage under s.188 and s.193 of the Housing Act 1996 and on a discretionary basis as a measure for the relief of rough sleeping.

Officers noted the report outlined the use of temporary accommodation (TA) during the 2024/25 financial year, including legal frameworks, household compositions, and current operational status. A total of 164 households were placed in TA, all within Greater London. Notably, no children were

accommodated in bed and breakfast settings. Over half of the placements were made on a discretionary basis, with the remainder under statutory obligations. The total cost of providing TA amounted to £1,716,131—an increase of £686,175 compared to the previous year.

The following points were noted:

- **Early Intervention and Prevention**: A Member raised concerns about the need for alternative approaches to prevent homelessness, particularly for families with children, to avoid disruption to education and social networks. Officers responded that statutory duties include mediation and eviction prevention, while discretionary placements are used to ensure safety. TA is also employed to support rough sleeping relief, which is recognised as good practice by the Ministry of Housing, Communities and Local Government (MHCLG).
- **Housing Market Challenges**: Officers highlighted the challenges posed by high private rental costs and limited availability of social housing, which contribute to extended stays in TA. Collaborative efforts are underway with other authorities to improve access to private sector housing.
- **Social Housing Allocation**: In response to a question raised by a Member about alignment between social housing allocation and homelessness services, officers confirmed that ongoing reviews and collaboration with housing colleagues are in place, particularly to support vulnerable groups such as care leavers.
- **Prison Release Coordination**: A Member raised the issue of early prison releases and the importance of coordination with probation services to prevent homelessness. Officers noted that the last wave had minimal impact but agreed on the need to prepare for future releases and enhance referral processes.
- **Veteran Support**: A Member asked about tracking veterans among the homeless population. Officers confirmed that veteran status is recorded and used to access additional support services.
- **Financial Pressures and Forecasting**: A Member questioned the long-term financial implications of TA, particularly for those under main duty. Officers acknowledged the need for improved forecasting and highlighted ongoing efforts to expand partnerships with the private rented sector, despite limitations in scale.

RESOLVED – That, the report be noted.

7. **ANNUAL SEVERE WEATHER EMERGENCY PROTOCOL (SWEP) REPORT 2024**

The Sub-Committee received a report of the Executive Director, Community & Children's Services concerning narrative and analysis on the City of London's Severe Weather Emergency Protocol (SWEP) 2024/2025.

Officers noted that this year, there were six SWEP activations between September and April, covering a total of 27 days. During this period, 82 unique individuals accessed SWEP services, resulting in 94 placements—the highest

number recorded to date. Despite the increased outreach and activations (double that of the previous year), the uptake of services was lower. The ability to offer long-term accommodation solutions was also reduced due to limited capacity among City officers and commissioned services.

Members discussed the importance of signposting individuals to additional services, particularly during winter. Members also highlighted the role of community shelters such as Hackney Night Shelters and shared personal experiences of volunteering and supporting rough sleepers. Officers confirmed that early-stage planning is underway for winter shelter provision, potentially in partnership with local churches, drawing on successful models from neighbouring boroughs.

The Sub-Committee noted a continued rise in rough sleeping numbers, despite milder winters. Officers attributed this to broader systemic issues such as the cost-of-living crisis, housing shortages, and cuts to adult social care. Members raised concerns about individuals who are employed but still rough sleeping due to affordability and immigration-related ineligibility for housing support. The complexity of these cases was acknowledged, particularly for those with no recourse to public funds.

Members shared observations from street outreach, noting that many individuals refused shelter even during extreme cold. Questions were raised about the consistency of such refusals and the operational challenges of securing accommodation on short notice. Officers clarified that while adult social care funding is a national issue, the City of London has maintained a progressive approach, including deploying social workers alongside outreach teams to conduct Care Act assessments.

Members discussed the need for better coordination with hospitals, particularly A&E departments, to prevent discharges onto the streets. Officers confirmed that while there are no hospitals within the City, efforts are being made to include neighbouring hospitals like Homerton in SWEP notifications. Additionally, the City has implemented a “Hot SWEP” protocol to address risks during extreme heat, including providing water, sunscreen, and access to cool spaces such as libraries.

Concerns were raised about the timing of SWEP activations by the Greater London Authority (GLA), often occurring late in the week. Officers explained that while the GLA uses predictive weather data, local authorities retain the autonomy to activate SWEP independently, which the City has done when necessary. Members acknowledged the strain on outreach teams during peak periods and the need for additional capacity to maximise the impact of SWEP.

A Member raised a follow-up on a previous commitment by the Chair of Finance at a recent Court of Common Council meeting to allocate increased council tax revenue toward homelessness services. It was proposed and unanimously supported to seek clarification on a resolution and pursue this matter through the Community and Children’s Services Committee. Members agreed to draft a formal resolution to ensure this funding opportunity is not lost.

RESOLVED – That, the report be noted.

8. **HOMELESSNESS AND ROUGH SLEEPING STRATEGY 2023–2027 UPDATE REPORT**
The Sub-Committee received a report of the Executive Director, Community & Children's Services concerning a summary of progress against the aims set out in the Homelessness and Rough Sleeping Strategy 2023–2027.

RESOLVED – That, the report be noted.

9. **CITY OF LONDON POLICE UPDATE**
Members received an update of the Superintendent of the City of London Police and the following points were made:

The following points were noted:

- The Chief Inspector provided an update on Operation Luscombe, which addresses begging in the City through a traffic light escalation system. A review identified the need for more frequent welfare support, prompting a shift to a more flexible, daily model.
- The Luscombe tickets are being redesigned to improve accessibility and clarity, including multilingual support.
- A multi-agency working group has been established to address risks associated with encampments and rough sleeping. Monthly operations now remove hazardous materials while maintaining a welfare-first approach.
- The largest encampment is at Castle Baynard, and efforts are focused on removing unused tents and balancing support for rough sleepers with community safety.
- Members raised concerns about resident safety and antisocial behaviour. The Chief Inspector encouraged reporting via 101 and welcomed direct contact for broader concerns.
- A specific case at St John's Court was acknowledged as under active review.

RESOLVED - That, the update be noted.

10. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE SUB-COMMITTEE**
There were no questions.

11. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
There was no other business.

12. **EXCLUSION OF THE PUBLIC**
The public were not excluded.

13. **CITY OF LONDON POLICE NON-PUBLIC UPDATE**
There was no update.

14. **QUESTIONS RELATING TO THE WORK OF THE SUB-COMMITTEE WHILE THE PUBLIC ARE EXCLUDED**
There were no non-public questions.

15. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT WHILST THE PUBLIC ARE EXCLUDED**
There was no other business.

The meeting closed at 5.20 pm

Chairman

Contact Officer: Blair Stringman
blair.stringman@cityoflondon.gov.uk

City of London Corporation Committee Report

Committee: Homelessness and Rough Sleeping Sub-Committee	**Dated:** 10/07/2025
Subject: Introduction to Homelessness and Rough Sleeping Services Report	**Public report:** For Information
This proposal: • **delivers Corporate Plan 2024–2029 outcomes**	Links to Corporate Plan outcomes 1, 2, 3, 4,10
Does this proposal require extra revenue and/or capital spending?	No
If so, how much?	NA
What is the source of Funding?	NA
Has this Funding Source been agreed with the Chamberlain's Department?	NA
Report of:	Judith Finlay – Executive Director, Community and Children's Services
Report author:	Will Norman – Head of Homelessness Prevention and Rough Sleeping

Summary

This report provides new Members of the Homelessness and Rough Sleeping Sub-Committee with an overview of our Statutory Homelessness, Rough Sleeping (HRS) and Supported Accommodation Pathway teams and the work they undertake. The report explains where statutory duties are owed, the source of funding for staffing and service delivery, and the strategic context for the work.

The report is designed as a high-level summary for newer Members. Members will receive more focused reports relating to the work of specific teams at various points of the year.

This report references the following priorities from the Homelessness and Rough Sleeping Strategy 2023–2027:

- Priority 1 – Providing rapid, effective and tailored interventions

- Priority 2 – Securing access to suitable, affordable accommodation
- Priority 3 – Achieving our goals through better collaboration and partnership
- Priority 4 – Providing support beyond accommodation.

Recommendation

Members are asked to:

- Note the report

Main Report

Background

1. Homelessness and Rough Sleeping services are delivered by local authorities to meet the needs of homeless individuals and households. 'Homelessness' is a broad term that captures anyone who does not have access to a safe and secure home which is safe and appropriate for them to access. 'Homelessness' or 'statutory homelessness' are terms used in the sector to differentiate between homeless individuals or households who do not have a settled home, but they have not been recorded as rough sleeping.

2. 'Rough sleeping' is the most acute form of homelessness and refers to (usually) an individual who is roofless – i.e. they have been verified as sleeping on the streets or in a shelter not designed for permanent habitation.

3. As the phrase suggests, statutory homelessness is a regulated area, and local authorities have statutory duties under Part VII Housing Act 1996 (as amended). 2017 saw the introduction of the Homelessness Reduction Act which widened these duties and added new emphasis on prevention of homelessness. Other intersections with related legislation include (but are not limited to): Domestic Abuse Act 2021; Human Rights Act 1998; and Care Act 2014.

4. Verified rough sleepers fall under Part VII Housing Act duties. However, the complex and often chaotic nature of rough sleeping makes engagement with legislative frameworks challenging for some. There are countless reasons why individuals rough sleep and many local authorities have developed specific areas of practice focused on rough sleeping. Most London local authorities will have a Rough Sleeping Coordinator and access to an Outreach Team as a minimum. Many will commission their own services, and local authorities with the largest rough sleeping populations will have extensive and sophisticated partnership arrangements coordinated by a dedicated Rough Sleeping Team.

5. Regional and national homelessness and rough sleeping data is collected the Ministry of Housing, Communities & Local Government (MHCLG). Statutory work is overseen by the Homelessness Advice and Support Team (HAST) and rough sleeping work by the Rough Sleeping Initiative (RSI).

6. Statutory data is submitted automatically from our casework database via a bulk data return known as H-CLIC (Homelessness Case Level Collection). This is later published by MHCLG. For London-based local authorities, rough sleeping data is submitted through the Combined Homelessness and Information Network (CHAIN) which all London's outreach teams use. CHAIN is commissioned by the Greater London Authority (GLA).

7. The City of London participates in a number of forums hosted by MHCLG, London Councils and the GLA. Some of these are operational and others are more strategic.

8. There is a statutory requirement that all local authorities have a Homelessness and Rough Sleeping Strategy. The City's document for 2023–2027 can be found at Appendix 1. Members of the Homelessness and Rough Sleeping Sub-Committee hear a progress report at every meeting. Further oversight is provided by the Homelessness Prevention and Rough Sleeping Strategy Group which draws together partners and stakeholders who help us deliver our strategic objectives.

9. The total budget for 2025-26 is £5,800,000. This includes £1,553,000 of grant income (Homelessness Prevention Grant and Rough Sleeping Prevention and Recovery Grant) and £2,588,000 from Central Risk. Full budget information can be found at appendix 3.

10. The Homelessness and Rough Sleeping Service sits in People Division alongside Adult and Children's Social Care.

Current Position

11. For service area structure, please see the structure diagram at Appendix 2. There are currently 20 staff members in the service area.

<u>Statutory Homelessness</u>

12. The team consists of five officers: a Triage Officer handling general inquiries and providing the majority of our duty system; two Housing Officers who provide casework across a range of prevention, relief and main duty cases; a Senior Housing Officer who carries a caseload and provides day-to-day management support to the team; and a Team Support Officer to aid with administrative duties.

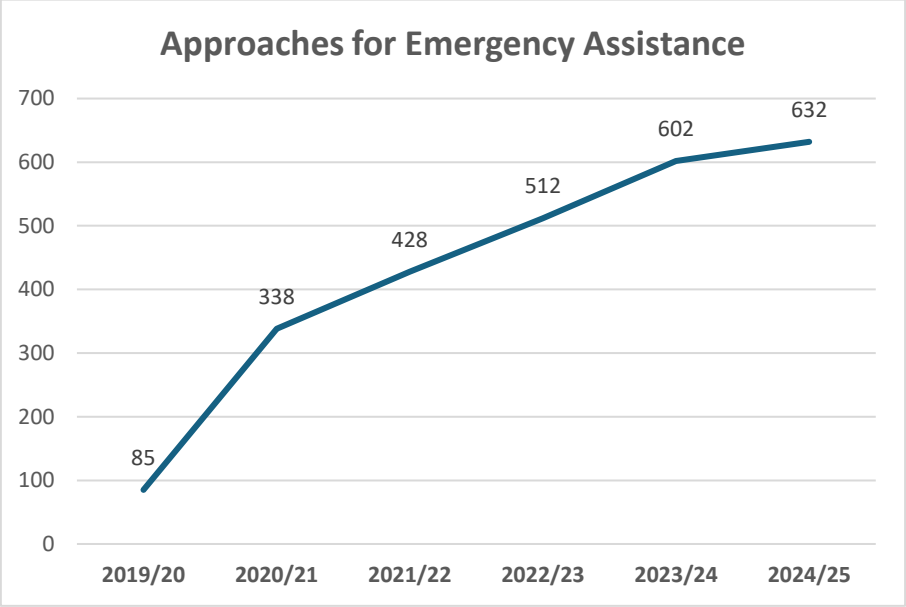
13. The primary function of the team is to ensure that the City of London is compliant with its duties as set out in the following legal frameworks:

    - Part VII Housing Act 1996
    - Homelessness Reduction Act 2017
    - Domestic Abuse Act 2021

14. Demand on the service has been steadily increasing over the last five years. Chart 1 illustrates the rate at which individuals and households approach the

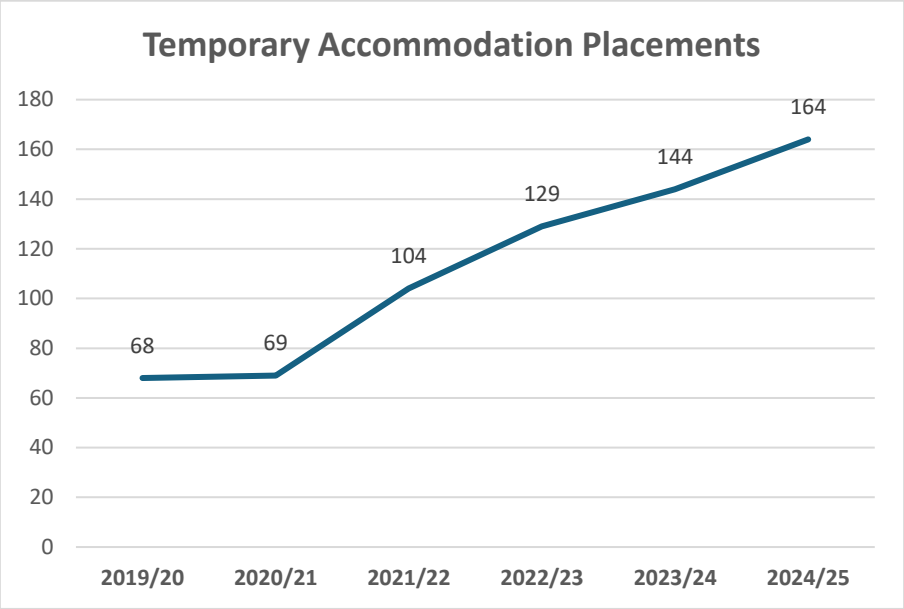
service for advice and guidance. These cases do not necessarily result in a homeless application being taken; however, the provision of advice is a duty covered by homelessness legislation. The rate at which approaches are made is a useful measure of developing pressures on wider homelessness and rough sleeping services.

Chart 1



15. Chart 2 tracks the rate at which individuals or families (described as households) are placed in Temporary Accommodation (TA). The number indicates placements per year. Placements in TA are made when the assessing officers have reason to believe the presenting household is homeless – i.e., they do not have access to somewhere safe and suitable to stay which it would be reasonable to expect them to occupy. More information about the City's use of TA can be found in previous Sub-Committee reports (please see background papers).

Chart 2



16. The Statutory Homelessness Service is funded from the core HRS budget and income from Housing Benefit claimable on TA.

Rough Sleeping

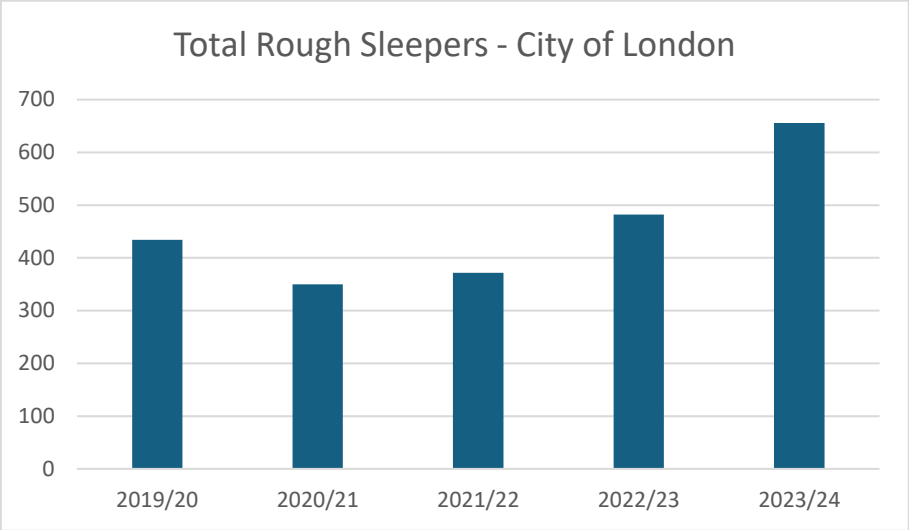
17. The team consists of five officers: a Rough Sleeping Service Manager who manages the budget, leads on commissioning and undertakes contract monitoring; two Rough Sleeping Coordinators who provide day-to-day direction and guidance for our commissioned services; a Pathway Liaison Officer to link rough sleeping services to our Statutory Homelessness and Pathway services; and a Team Support Officer.

18. Rough Sleeping services are coordinated by the City team but largely delivered through an array of commissioned services. This includes:

- City Outreach Team
- Snow Hill Court Assessment Centre
- Block booked TA
- Mobile Intervention Support Team (MIST)
- Navigator Service
- Severe Weather Emergency Protocol (SWEP)
- Dellow Centre City Caseworker
- Psychotherapy Service

19. Demand on the City's Rough Sleeping services has also been increasing in recent years. Chart 3 illustrates the rise in City rough sleepers between 2019/20 and 2023/24, the last year that annual data is currently available for.

Chart 3



20. An annual count of rough sleepers takes place in every local authority in England each autumn. In 2024, the City of London counted 86 individuals, a 41% rise on the same count the previous year. This is the third highest figure in England after Westminster and Camden (and followed by Somerset, Bristol and Brighton).

21. Rough sleeping is funded jointly by the core HRS budget and grant funding from MHCLG. Since 2018/19, the City of London has been awarded grant funding from the RSI, steadily increasing from £200,000 in 2018/19 to £1.3 million in 2024/25. In 2025/26, the RSI grant was replaced by the Rough Sleeping Prevention and Recovery Grant (RSPRG) and funding comparable to 2024/25 was awarded. We are currently awaiting a decision from MHCLG regarding a grant programme for 2026/27 onwards.

22. The City's Rough Sleeping services are currently being reviewed by Homeless Link, with a final report due later in July. Members will be briefed on the findings of this report at the October Homelessness and Rough Sleeping Sub-Committee.

23. More information on the RSPRG programme for 2025/26 can be found in the background paper listed at the end of this report.

<u>Supported Accommodation Pathway</u>

24. The Pathway Team consists of: a Pathway Coordinator who leads on contract monitoring, performance of our Pathway providers and the City's Tenancy Sustainment Team; a Pathway Liaison Officer who links in with outreach providers, suppliers and maintains sight of the moves in, within and out of the Pathway; and a Team Support Officer.

25. Additional to our residential services for former rough sleepers, the Pathway Team also includes the City's Tenancy Sustainment Team (TST) which

provides support to tenants vulnerable to tenancy loss across the City's portfolio of Greater London housing estates. The TST consists of one Senior TST Officer and three TST Officers. The service has a caseload of around 50 people.

26. The Pathway consist of the following services:

- **Grange Road** – high-support hostel offering 29 single occupancy rooms, including a cluster of self-contained units, located in Southwark.
- **Crimscott Street** – low-medium support hostel offering 21 self-contained units, located adjacent to Grange Rd in Southwark.
- **The Lodge** – jointly commissioned with Westminster and offering 40 single occupancy rooms. Prioritised for low or medium support residents with long rough sleeping histories or multiple unsuccessful stays in more typical hostels. Located in Camden.
- **City Lodge** – jointly commissioned with Westminster and operated along similar lines to the original Lodge. Offers 17 single occupancy rooms, and is located in Middle Street in the City of London.
- **City and Hackney Housing First** – currently proving 30 social and private rented sector tenancies in various London boroughs, 12 of which are occupied by City of London clients. Housing First provides wrap-around support to ensure that tenancies are sustained.
- **Discretionary TA** – flexible capacity depending on need. Dispersed offer in various London boroughs. Currently there are 35 individuals placed in TA.

27. Excluding discretionary TA, there are currently 94 beds at the disposal of the Pathways Team. The Snow Hill Court Assessment Centre is not included in the Pathway. Rough Sleeping services retain management responsibilities for this service as an 'off the street' offer to rough sleepers.

28. The Pathway is funded from the HRS core budget, complemented by some funding from the RSPRG.

29. The City's four residential schemes plus the Housing First project are being reviewed by City officers throughout 2025. The Rough Sleeping Assessment Centre falls under the responsibility of the Rough Sleeping Team and is not included in this process. Findings will be reported to Members of the Homelessness and Rough Sleeping Sub-Committee in early 2026.

Options

30. There are no options for Members to consider.

Proposals

31. There are no proposals for Members to consider.

Key Data

32. Summary data is included within the body of the report.

Corporate & Strategic Implications

33. Financial implications – none
34. Resource implications – none
35. Legal implications – none
36. Risk implications – none
37. Equalities implications – none
38. Climate implications – none
39. Security implications – none

Conclusion

40. The Homelessness and Rough Sleeping service area is made up of three teams: the Rough Sleeping Team; Statutory Homelessness Team; and Pathway Team. The latter also includes the City's Tenancy Sustainment Team. There are currently 20 full-time officers in the service area.

41. Demand on Statutory Homelessness and Rough Sleeping services have steadily increased over the last five years. Approaches for homelessness advice and guidance and placements in TA have roughly doubled over the last four years.

42. Five residential settings, a Housing First scheme plus numerous block-booked and ad-hoc TA placements are at the disposal of the Rough Sleeping and Pathway teams. The service has access to 94 rooms under commissioned arrangements.

43. The Homelessness and Rough Sleeping Service is funded through a combination of the core HRS budget, grant funding from the MHCLG and income from Housing Benefit placements.

Background papers

- Statutory Homelessness and Rough Sleeping – Use of Temporary Accommodation Report (HRS Sub-Committee,14 May 2025)
- Rough Sleeping Prevention and Recovery Grant 2025/26 Update Report (HRS Sub-Committee, 3 February 2025)

Appendices

- Appendix 1 – Homelessness and Rough Sleeping Strategy 2023–2027
- Appendix 2 – Structure diagram
- Appendix 3 – Homelessness & Rough Sleeping Budget Allocation 2025-26

Will Norman
Head of Homelessness Prevention and Rough Sleeping

T: 020 7332 1994
E: will.norman@cityoflondon.gov.uk

Homelessness and Rough Sleeping Strategy 2023-27

Foreword

from the Chairman of the Community and Children's Services Committee

I am pleased to introduce the City of London Corporation's Homelessness and Rough Sleeping Strategy 2023-27. This strategy aims to respond to homelessness that may be the result of a loss of a home or those who are at risk of losing their home, and those who sleep rough on our streets.

This strategy renews our commitment to provide the support to improve health, wellbeing, and accommodation outcomes for those experiencing homelessness or rough sleeping in the Square Mile. Developed collaboratively, the strategy commits to deliver tailored interventions, access to accommodation, and providing sustainable routes off the streets.

We are committed to proactively identifying those at risk of becoming homeless and ensuring useful information is readily accessible and easy to understand to prevent homelessness occurring in the first place and respond effectively where it occurs. We are committed to learn through our engagement with people who have experience of homelessness and rough sleeping as a priority.

This strategy represents our determination to tackle an issue which is complex and challenging. Through its delivery, the City Corporation will assist people who are some of the most vulnerable in our community or face the most challenging circumstances of their lives, whilst recognising the unique circumstances they may face.

Ruby Sayed (Barrister), Common Councillor
Chairman – Community and Children's Services Grand Committee

Foreword

from the Chairman of the Homelessness and Rough Sleeping Sub-Committee

Preventing and ending homelessness and rough sleeping requires collective action. Too many individuals still find themselves without a home or at risk of losing the roof over their heads. As the UK's financial hub with a vibrant nighttime economy and transitory population, the Square Mile sees a disproportionate level of visible homelessness.

By working together across sectors, we can achieve better outcomes for all Londoners affected by homelessness and rough sleeping. We have made meaningful progress by investing in key services alongside our partners. This includes delivering much-needed additional temporary accommodation, securing additional funding for our commissioned street outreach service, and opening a Rough Sleeping Assessment Centre within the Square Mile in Spring 2024.

We have also taken great strides to deliver better services to improve health outcomes for rough sleepers through our collaborative Homeless Health and Rough Sleeping Mental Health programmes, and we continue assisting vulnerable groups such as victims of domestic abuse through safe housing solutions.

We cannot tackle these systemic challenges alone. This strategy outlines our approach to partnership, builds on past successes, and signals to all City of London residents, workers, businesses, and service users that we are committed to tackling new challenges and emerging needs.

Eamonn Mullally, Common Councillor
Chairman – Homelessness and Rough Sleeping Sub-Committee

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1 Introduction

Homelessness is a crisis that can have a profound impact on the lives of those affected. Within the Square Mile, homelessness is most obviously seen on our streets, but it is an issue that is wider than rough sleeping – including those hidden from view who may sleep on a friend's sofa, or those housed in accommodation which is unsafe or severely overcrowded.

The groups most likely to experience homelessness are the most vulnerable in our society with related mental and physical health issues within single person households. However, anyone can experience homelessness and those who have been in care, experienced exclusion from school or college, experienced the criminal justice system, have a history of substance misuse, victims of domestic abuse and non-UK nationals are all over-represented within homelessness statistics.

As well as these referenced groups, this strategy relates to those homeless whether they are individuals, couples, households with children or without.

The City of London Corporation is committed to prevent or end the homelessness of those seeking our help. Whichever route brings people, families, or children into our services, we aim to act swiftly and effectively with compassion, fairness and respect.

We spend more than £4 million each year to deliver the services, support and accommodation to prevent or resolve homelessness. This strategy provides the priorities to focus our delivery and investment going forward, to shape our services and to guide our decision making in order to deliver our vision, that:

- homelessness is brief
- it does not reoccur
- its impact on the individual, families and children, and our communities is minimised
- and it is prevented where possible.

To secure this vision, we have identified four strategic priorities:

1. **Providing rapid, effective and tailored interventions** to minimise the duration of homelessness, prevent the loss of accommodation and prevent the crisis of street homeless leading to the harm of long-term rough sleeping.

2. **Securing access to suitable and affordable accommodation** by maximising access to a range of housing options, delivering more homes; providing supported specialist housing accommodation for those with support needs.

3. **Working collaboratively** with other agencies including the voluntary and Business Improvement Districts to reach across traditional boundaries and support those facing homelessness or rough sleeping, and deliver a consistency of service across service and local authority boundaries.

4. **Supporting beyond accommodation** to provide support alongside appropriate accommodation to secure better outcomes, enhance employability, support recovery and prevent repeat homelessness.

These priorities provide the framework for our strategy to deliver better outcomes for individuals, and more efficient and effective services. They will be underpinned by a Five-Year Service Development Plan that will be continously refreshed, so that it remains responsive to political, policy and economic change.

2 Strategic Context

This strategy is shaped and responds to the drivers of national and regional policy, and the interface with a range of City Corporation strategies and responsibilities.

National

The UK Government sets the legislative framework for preventing and addressing homelessness. Since 2017 the UK Government has acted to strengthen legislation, to shift the focus to prevention, and to reduce the barriers to help for specific groups such as those including children, who experience domestic violence and those who have served in the armed forces. Legislation gives local authorities the primary role in responding to homelessness. It is backed by significant funding in the form of a Homelessness Prevention Grant.

The Government is also committed to end rough sleeping in this parliament. To meet this commitment, the Government has published a cross-government strategy, *Ending Rough Sleeping for Good* which introduced several initiatives and funding so that local authorities, voluntary, faith and community sectors can intervene swiftly when someone is sleeping rough.

These commitments include funding to local authorities in the form of the Rough Sleeping Initiative Grant, and programmes to increase the supply of supported accommodation.

The Government has also expanded its Rough Sleeping Drug and Alcohol Treatment Grant Programme, with the scheme providing funding for substance misuse treatment services for people sleeping rough or at risk of sleeping rough.

Regional

The Mayor of London has set out his vision and priorities for tackling the shortage of affordable housing across London, and its links to homelessness in his London Housing Strategy. The strategy highlights the importance of prevention and the need to address the root causes of homelessness to drive forward effective prevention work.

He is committed to ending rough sleeping and has established the Life Off the Streets Executive Board – of which the City Corporation is a member – to work in partnership with organisations across London to monitor the effectiveness of interventions in tackling rough sleeping and identifying further interventions.

Local

The City of London Corporation is the governing body of the Square Mile, dedicated to vibrant and thriving City, supporting a diverse and sustainable London within a globally successful UK.

Its Corporate Plan 2018-2023 seeks a flourishing society in which:

- People are safe and feel safe
- People enjoy good health and wellbeing
- People have equal opportunities to enrich their lives and reach their full potential
- Communities are cohesive and have the facilities they need

This strategy supports the delivery of that plan, and both contributes to and is supported by the delivery of a range of strategies and plans including *the Joint Health and Wellbeing Strategy, the Local Plan, the Safer City Partnership Strategy, the Violence against Women and Girls Strategy and the Department of Community and Children's Services Business Plan.*

3 Background

Homelessness describes a range of situations that include those described by legislation, and situations we might recognise as homelessness such as sofa surfing or in its worst form, rough sleeping.

Government legislation describes a household as homelessness where:

- they have no accommodation they are legally entitled to occupy, either in the UK or overseas
- they have accommodation but cannot secure entry to it
- they have accommodation designed or adapted to be lived in that consists of a 'moveable structure' (such as a caravan, mobile home, or canal boat) but they have nowhere to put it
- they have accommodation but it is not reasonable or suitable to continue living there

Somebody is threatened with homelessness if:

- they are likely to become homeless within 28 days
- they have been giving a valid notice (known as a Section 21 notice) to leave a property, and that notice will expire within 56 days

Local authorities have a legal responsibility to support people and families who are threatened with homelessness or who are homeless. As well as the 1996 Housing Act, this strategy has also been informed by the following national legislation.

- Homelessness Reduction Act 2017
- Domestic Abuse Act 2021
- Armed Forces Act 2021
- Children Act 1989

These four Acts add to existing legislation and strengthen the response to tackling homelessness. They explicitly state that a person who is homeless as a result of being a victim of domestic abuse is classed as being in priority need, as well as those who previously served in the regular naval, military or air forces.

The picture of statutory homelessness in London highlights the challenges local authorities in London are facing, with rising demand and cost for housing, temporary accommodation and homelessness and rough sleeping services. The average cost of privately rented accommodation has risen by 5% in the 12 months to May 2023 up from an increase of 5% in the 12 months to April 2023. (Office for National Statistics, 2023).

The average private rent in London was £2039 per month which is beyond the means of many families. This is also true of properties for purchase within London, particularly with higher mortgage borrowing rates and the price of housing means that secure home ownership is out of reach for many individuals and families within London, and places more pressure on the rental market, which has increased rent prices. This has placed acute stress on the budgets of many households within London and has increased the number of individuals or families presenting to us for homelessness assistance or tenancy and social housing support.

Applications for homelessness in London have risen by 54% between 2013 and 2023 and UK Government statistics show that in 2022, 59% of people in temporary accommodation across England were in London.

The number of people seen sleeping rough in London is also increasing. In 2023, the GLA reported that the number of people sleeping rough in London has increased by 9% compared with 2022. The figures show that 3,272 individuals were sleeping rough in the capital from April to June 2023, compared to 2,998 individuals from April to June 2022. Of those 84% were male, and half were UK nationals.

The City

With London's smallest population, the City Corporation deals with the lowest number of approaches for homeless assistance – having a duty to assist 29 households in 2022/23 - and has the lowest number of households placed in temporary accommodation in London.

With over 500,000 jobs supported within the Square Mile, it is unsurprising that the majority of those seeking homelessness advice, information and assessment are connected to the City Corporation through work.

In 2022/23, 512 people approached the City Corporation for help because of the risk of experiencing homelessness – an increase of 16% on 20/22. In the same year, 129 households were placed into temporary accommodation over the course of the year – an increase of 20% on 2021/22.

In 2022/23 outreach services recorded 482 people sleeping on the streets of the Square Mile – the sixth highest level among London's local authorities. Half of those sleeping rough were new to the streets – having no record of street homelessness anywhere in London.

Among those homeless on the streets, 38% had long-term histories of rough sleeping and 17% had returned to street homelessness. The profile of those sleeping rough in the Square Mile has moved towards a younger, more complex cohort with higher support needs.

Our strengths

- A commitment to deliver comprehensive services that has been backed by a significant growth in funding by the City Corporation
- Quality services, co-located with social care, that deliver advice, guidance and assessment that is accessible through an inclusive range of channels
- Spot purchasing of interim accommodation allowing us to search in or as close as we can to the areas where a homelessness applicant last resided to help maintain links with support networks and services where possible
- Provision of specialist and enhanced services – such as a dedicated homelessness social work, enhanced tenancy sustainment and "Housing First" accommodation
- Integrated and tailored response to street homelessness that goes beyond accommodation to support those who sleep rough to sustain a life away from the streets
- The learning and success of our "everybody in" approach during the pandemic evolved into an "in for good" approach to prevent a return to the streets
- Successfully securing external funding and partnerships to strengthen our approach and expand services
- Committed partnerships with neighbouring local authorities, the City and Hackney Health and Care Board, City of London Police and the voluntary sector

Our challenges

- Housing insecurity and homelessness is increasing, and the wider economic context would suggest this will continue in the period ahead
- Increasing demand places pressure on our services and budgets, and is increasing London-wide competition for - and the cost of - temporary accommodation
- The diversity of need we respond to – including from those fleeing domestic violence, those from the LGBTQI+ community, those with uncertain migration status and youth homeless - is growing and more evident
- Secure, affordable housing options are severely limited and constrain the timely move-on from our hostel and interim accommodation provision
- Many of those homeless on our streets are very transient – moving across service boundaries and interrupting service interventions
- Housing solutions are predominantly beyond the boundaries of the Square Mile and the statutory remit of our wider services
- Access to primary care for those homeless on the streets is limited by location of provision
- Some of those homeless on our streets can be associated with anti-social behaviour or other criminality – as victim or perpetrator – causing concern to those who live, work in or visit the City
- Services that play a vital role in preventing homelessness and sustaining life away from the streets – including mental health services and voluntary sector services – are facing significant pressures

4 Strategy Progress

Since the last Homelessness and Rough Sleeping Strategy in 2019, the City Corporation has delivered new initiatives to tackle homelessness and rough sleeping. These include:

- a pilot for a safe and secure accommodation project for women fleeing domestic abuse to help address violence against women and girls (VAWG)
- a high support hostel to provide 29 additional beds, securing a more effective response to rough sleeping
- funding for a tri-borough "staging post" hostel for those street homeless to relieve pressure on assessment and emergency placements
- a Rough Sleeping Mental Health Programme (RaMHP) in partnership with East London Foundation Trust (ELFT)
- a Homeless Health Coordinator to deliver a dedicated work plan to improve the health of rough sleepers
- a new partnership with Guy's and St Thomas' to provide clinical in-reach to Grange Road hostel
- an extended substance misuse offer to those who have left street homelessness and been accommodated beyond the Square Mile
- improved Homelessness and Rough Sleeping web pages to provide enhanced information and advice

5 Developing this strategy

This strategy has been developed through consultation with key stakeholders, including those who have experienced homelessness and those who remain homeless in the City.

This process has identified the four key priorities, set out in the section below. For each priority, we set out what the implementation of this strategy will achieve in addressing that priority, and what will be done to secure those achievements.

6 Priorities

Priority one: Providing rapid, effective and tailored interventions

By focusing on the prevention of homelessness before it occurs, we recognise that early interventions are important to minimising the duration and preventing homelessness. We believe that for this to be the most effective, these early interventions should be personalised to provide the most appropriate response in conjunction with the City of London Housing division.

To deliver this priority, over the next four years we will focus on the following:

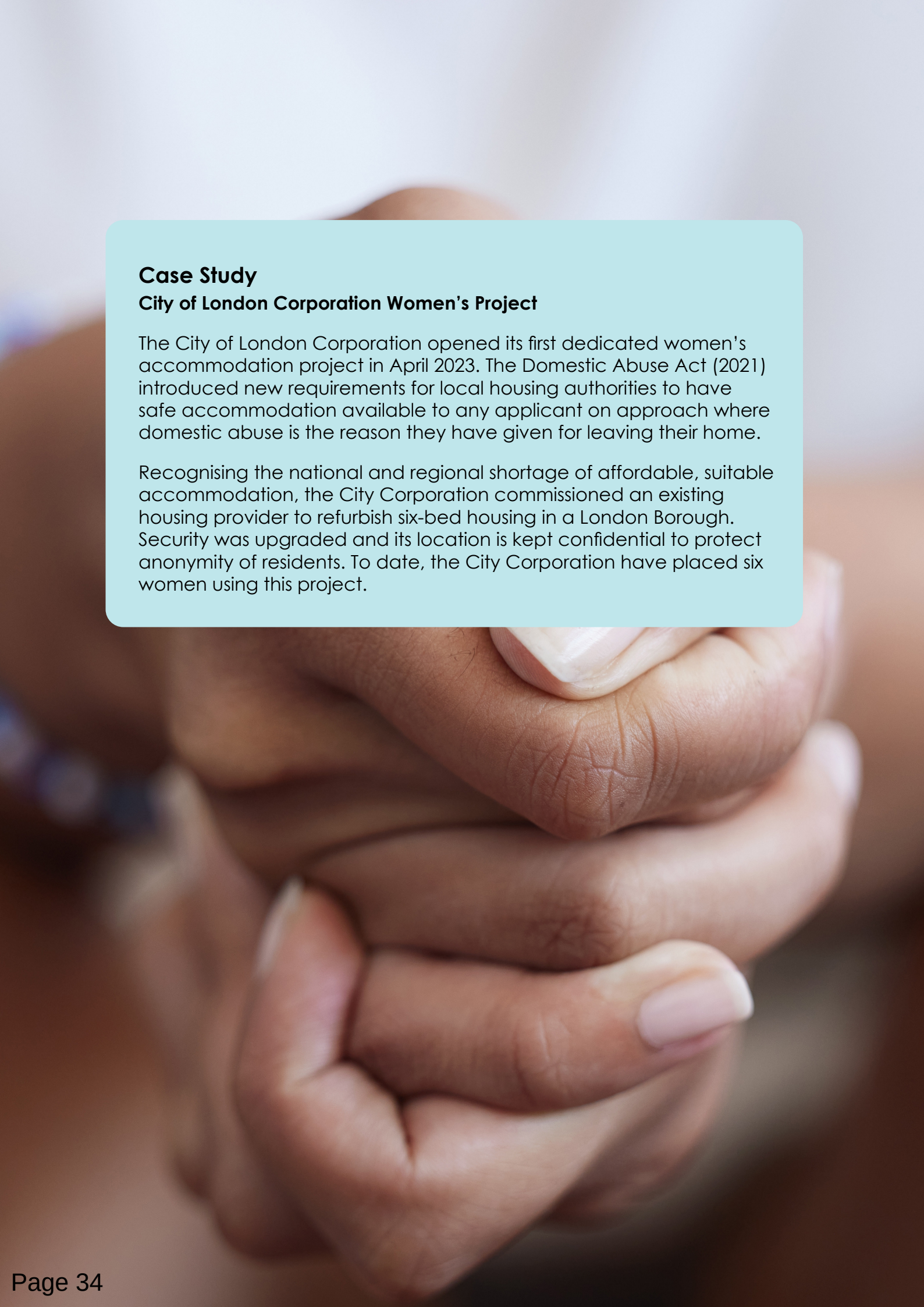
- Improve access to rapid 'off the street' options for rough sleepers to end rough sleeping events quickly
- Deliver a clear, consistent approach to protect those sleeping rough, our communities and our services from ASB and criminality ensuring our community feels safe for all
- Strengthen our communication methods to improve referral pathways to local providers and outreach services
- Embed co-production with people with lived experience of homelessness when designing or renewing services

Key actions to deliver these include:

- Open a new Rough Sleeping Assessment Centre in the Square Mile (under construction, due to complete in 2024)
- Review and recommission our frontline outreach services that consider inclusion of best practice examples and input from those with lived experience of homelessness and or rough sleeping
- Implement new Severe Weather Emergency Protocols (SWEP) so these interventions reach more people in an impactful way
- Re-commission the City Advice Service so that all groups of people including residents and young people have access to accurate information and support.

Some of our key measures of success on the delivery of these are:

- Increase in the rate of homelessness preventions
- Increase in referrals received under the Duty to Refer
- Reduction in the number of individuals entering temporary accommodation
- Reduction in the number of individuals sleeping rough during severe weather events
- Enhanced information and advice



Case Study

City of London Corporation Women's Project

The City of London Corporation opened its first dedicated women's accommodation project in April 2023. The Domestic Abuse Act (2021) introduced new requirements for local housing authorities to have safe accommodation available to any applicant on approach where domestic abuse is the reason they have given for leaving their home.

Recognising the national and regional shortage of affordable, suitable accommodation, the City Corporation commissioned an existing housing provider to refurbish six-bed housing in a London Borough. Security was upgraded and its location is kept confidential to protect anonymity of residents. To date, the City Corporation have placed six women using this project.

Priority two: Securing access to suitable and affordable accommodation

We recognise that access to suitable and affordable accommodation is central to promoting good health and wellbeing of our service users, as well as being a way off the streets for those rough sleeping. We believe that access to suitable and affordable accommodation needs to be appropriate to the level of need of the client and will help prevent homelessness occurring in the first place.

To deliver this priority, over the next four years we will focus on the following:

- Increase access to safe and suitable accommodation for those fleeing domestic abuse and violence against women and girls (VAWG)
- Work to keep families and children near local services and schools
- Minimise the use of inappropriate temporary accommodation
- Improve options within the private rented sector to support move on
- Reduce the number of rough sleepers returning to the streets

Key actions to deliver these include:

- Maximise our temporary accommodation offer by using targeted support, help with rent deposits and support to sustain long-term tenancies
- Create and implement a temporary accommodation framework for procurement of interim and emergency housing
- Deliver new accommodation solutions, such as increases in the number of available hostel beds and access to social housing in the City of London
- Expand the City of London's Housing First offer to maximise the number of tenancies available to rough sleepers

Some of our key measures of success on the delivery of these are:

- Reduction in the number of households placed in temporary accommodation
- Reduction in the length of stay in temporary accommodation
- Increase in the number of properties available to individuals facing homelessness or that are rough sleeping
- Number of commissioned and appropriate hostel beds increases

Case Study

High Support Hostel

The City of London Corporation and its commissioned partners conducted research to determine what additional projects could be introduced to have the highest impact in supporting those in our rough sleeping population who have the most complex needs. In November 2022, The City of London Corporation opened a 29-bed high support hostel.

This new service occupies a site that was redeveloped from the ground up and designed with psychologically informed principles in mind. The project removes barriers between staff and residents and creates mixed areas for residents and staff to share time and participate in activities.

Priority three: Working collaboratively

Homelessness and rough sleeping cannot be solved in silo. Working in partnership with multiple agencies that reach across traditional boundaries is key in supporting those facing homelessness or that are rough sleeping. By working in partnership with key services when developing or delivering the offer, services will be delivered consistently across service and local authority boundaries.

To deliver this priority, over the next four years we will focus on the following:

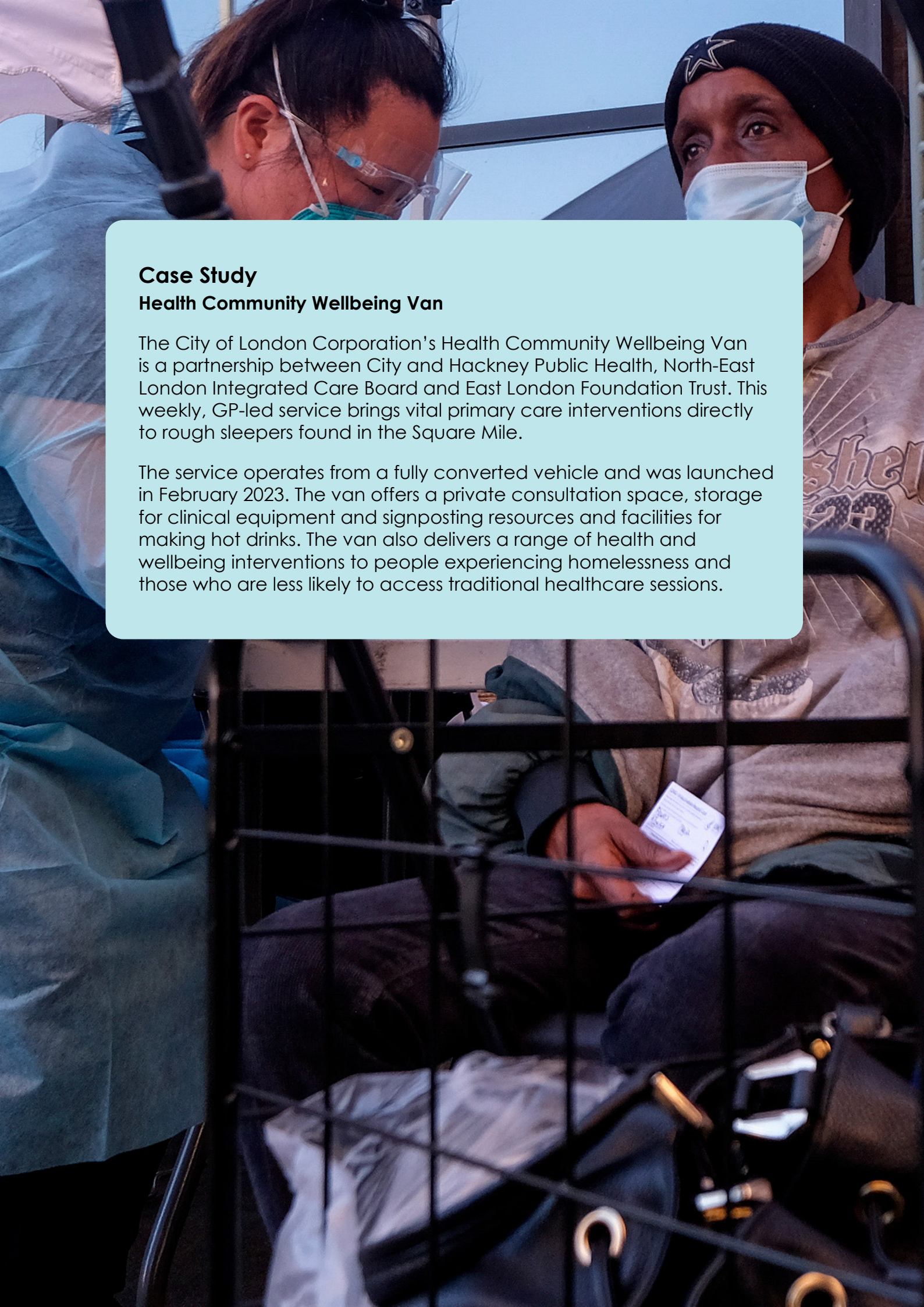
- Develop sub-regional and pan-borough solutions to homelessness
- Strengthen our engagement with health partners to improve interventions for the most vulnerable
- Maximise the use of commissioned drug and alcohol services, City Advice and psychological services to prevent homelessness
- Deliver an embedded multi-agency response to ASB and criminality to protect rough sleepers and our communities
- Collaborate with Business Improvement Districts within the City of London to build on relations with the business community and improve the sharing of information with employers to tackle persistent issues.

Key actions to deliver these include:

- Develop and implement a new Youth Homelessness Protocol to improve the holistic approach to supporting young people facing homelessness
- Implement an improved pathway for non-UK nationals who have no recourse to public funds
- Improve the safeguarding of vulnerable adults who are street homeless by developing solutions with the City and Hackney Safeguarding Adults Board
- Amplify key messages through shared communication with Business Improvement Districts within the City of London
- Maximise funding opportunities alongside Business Improvement Districts to increase the use of joint communication campaigns and related activity.

Some of our key measures of success on the delivery of these are:

- Increase in cross-sector buy-in to homelessness prevention within the Square Mile
- Reduction in anti-social behaviour reported
- Up take of commissioned services increases
- Improved pathways for those who have no recourse to public funds



Case Study

Health Community Wellbeing Van

The City of London Corporation's Health Community Wellbeing Van is a partnership between City and Hackney Public Health, North-East London Integrated Care Board and East London Foundation Trust. This weekly, GP-led service brings vital primary care interventions directly to rough sleepers found in the Square Mile.

The service operates from a fully converted vehicle and was launched in February 2023. The van offers a private consultation space, storage for clinical equipment and signposting resources and facilities for making hot drinks. The van also delivers a range of health and wellbeing interventions to people experiencing homelessness and those who are less likely to access traditional healthcare sessions.

Priority four: Support beyond accommodation

We recognise that it is important to provide wrap around support alongside appropriate accommodation for those who are rough sleeping or facing homelessness to enable them to remain in long term accommodation and prevent a return to the streets.

By providing wrap around support that is tailored to the needs of the individual, we aim to secure better outcomes, improve health and wellbeing, enhance employability and support recovery, all of which will reduce the likelihood of returning to the streets or homelessness occurring in the first place.

To deliver this priority, over the next four years we will focus on the following:

- Improve health and wellbeing outcomes among those facing homelessness or that are rough sleeping
- Improve tenancy sustainment in the private rented sector so clients on the path to recovery remain housed
- Improve the employability of former and current rough sleepers
- Support service users with complex substance misuse needs to remain in long term accommodation
- Strengthen feedback opportunities by giving service users a stronger voice to shape the services they use

Key actions to deliver these include:

- Reduce delays in hospital discharge by improving communication with hospital teams
- Expand the support offer available to those with complex substance misuse needs by maximising the involvement of commissioned Pan-London services
- Deliver a clinical space in the Square Mile to provide primary care for those sleeping rough
- Encourage local businesses to employ and train those who have or who are experiencing homelessness

Some of our key measures of success on the delivery of these include:

- Reduction in the number of people sleeping rough
- Reduction in the number of repeat rough sleepers
- Reduction in delayed transfers of care
- Increase in number of service users entering education, employment or training

Case Study

Employment and Progression Service – 'Streets to Work'

The first project of its kind in the City of London, 'Streets to Work' launched in February 2023. The project has a remit to work across all our cohorts – vulnerably housed social tenants, residents in supported accommodation and rough sleepers.

The service offers individuals the opportunity to build up their skills through education, training and employment opportunities as well as through volunteering. The service offers a mix of one-to-one and group sessions held in the community or at a client's accommodation. We expect to see the project work with a minimum of 40 people per year, with 15 of these gaining stable employment.

7 Implementation

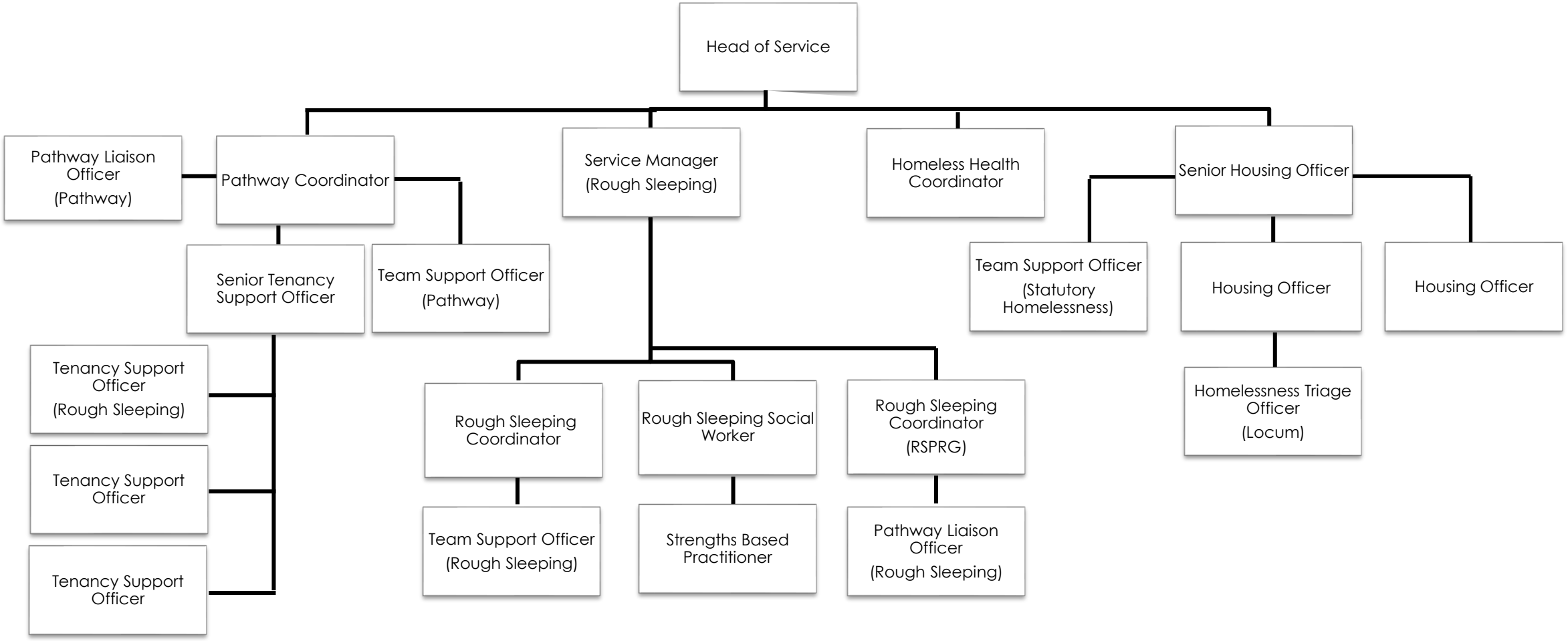
This strategy is delivered in the context of legislative change – particularly the Government's commitment to fully embed the Homelessness Reduction Act 2017 and its commitment to prevention, and the enactment of the Domestic Abuse Act 2021.

It aligns with the Government's strategy *Ending Rough Sleeping for Good* and with the City Corporation's participation in the Mayor of London's Life of the Streets Taskforce and its framework to address the wider determinants of rough sleeping with partners across the capital.

In its delivery it supports the City Corporation to meet the objectives of its Corporate Plan and is supported by the delivery of the Housing Strategy, Joint Health and Wellbeing Strategy and Safer City Partnership Strategy.

The Homelessness and Rough Sleeping Strategy is agreed, renewed, and monitored by the City Corporation's Homelessness and Rough Sleeping Sub-Committee. A detailed service development plan will support the delivery of this strategy and will be refreshed to reflect service demand and legislative change.

Homelessness Prevention and Rough Sleeping



June 2025

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Appendix 3

Homeless & Rough Sleeping Services Budget Allocation 2025/26	**Budget**
	2025/26
	£'000
Central Risk	
Employee expenses	**(962)**
Premises related expenses	**(55)**
Transport related expenses	**(3)**
Supplies and Services:	
• *High Support Hostel (HSH)*	*(700)*
• *Rough Sleeping Prevention and Relief (RSPR)*	*(1,374)*
• *Outreach Contract*	*(500)*
• *Other Commissioned Services*	*(49)*
• *Security - Parkguard*	*(35)*
• *Legal costs*	*(3)*
• *St Mungos - Crimscott*	*(140)*
• *The Lodge*	*(150)*
• *Rough Sleepers Assessment Centre (RSAC)*	*(500)*
• *Severe Weather Emergency Protocols (SWEP)*	*(50)*
• *Other Supplies and Services*	*(64)*
	(3,565)
Third Party Payments:	
• *Other Bodies*	*(55)*
• *Accommodation*	*(1,150)*
• *Client subsistence & travel*	*(10)*
	(1,215)
Total Expenditure	**(5,800)**

Appendix 3

Income **Government Grants:**	
• Homelessness Prevention Grant (HPG)	179
• Rough Sleeping Prevention and Relief Grant (RSPRG)	1,374
Rent Allowance	**825**
Transfer from Reserves	**834**
Total Income	**3,212**
Total Central Risk	**(2,588)**

City of London Corporation Committee Report

Committee: Homelessness and Rough Sleeping Sub-Committee	**Dated:** 10/07/2025
Subject: Co-production Project Progress Report	**Public report:** For Information
This proposal: • **delivers Corporate Plan 2024-29 outcomes**	Diverse Engagement Communities Proving Excellent Services
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?	Yes
Report of:	Judith Finlay, Executive Director of Community and Children's Services
Report author:	Kirsty Lowe, Rough Sleeping Services Manager

Summary

This progress report follows on from the previous co-production paper submitted to the Homelessness and Rough Sleeping Sub-Committee in December 2024. The report provides a summary of the achievements of the co-production service over the last financial year, April 2024–March 2025, and the workplan for the current delivery year.

Overall, the co-production service has achieved well against its aims, and the service has a clear 2025–2026 workplan to build on its current successes.

The Rough Sleeping Prevention and Recovery Grant (RSPRG) funds the co-production service until 31 March 2026. Once the Ministry of Housing, Communities & Local Government (MHCLG) notifies authorities of possible 2026–2027 grant funding, a decision will be made regarding future service delivery.

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

1. In 2019, the Healthier City and Hackney Fund funded Groundswell, a leading homelessness advocacy organisation, to provide health assistance to City residents. The service was not able to fully deliver the work as intended, which resulted in an opportunity to repurpose an underspend of the budget elsewhere.

2. In 2020–2021 the Rough Sleeping Team repurposed the underspend and worked with Groundswell and an independent researcher, Becky Rice, to carry out interviews with those who had slept rough in the City and who had recently been accommodated in the temporary City Assessment Service (CAS). CAS was commissioned in response to the Government's 'Everyone In' approach to protect and preserve life due to the COVID-19 pandemic. All people who were met rough sleeping in the City were offered accommodation, predominately at CAS, which was the first emergency off the streets, rough sleeping accommodation within the Square Mile. In 2024, the permanent rough sleeping assessment service, Snow Hill Court opened.

3. The aim of this piece of work was to hear from those with lived experience about why they had decided (many for the first time) to come in off the streets and engage with services such as CAS. Groundswell and Becky Rice produced the *City Voices* report, which sets out recommendations based on the wants and needs of the service user. The report went on to shape and guide decisions to commission the permanent assessment service, Snow Hill Court.

4. In 2021, the findings of *City Voices* was shared with senior City officers and Members from the Homelessness and Rough Sleeping Sub-Committee through a series of workshops facilitated by Groundswell. Members confirmed ongoing support of the Homelessness and Rough Sleeping Team's ambition to work and commission services in a more co-produced way.

5. Co-production is a way of working together to create positive change. Co-production seeks to maximise the involvement of people who have experienced a problem or challenge in identifying and solving that problem. This might include designing, commissioning, delivering, improving, or evaluating services.

6. 2022 marked the first year of the multi-year Rough Sleeping Initiative (RSI) grant funding. RSI funds enabled the City to commission a multi-year advocacy/co-production service. Groundswell was awarded phase 1 of the three-year plan in

2022. This involved consultation of a broader group of services users, including those currently sleeping rough and those across the accommodation pathway.

7. By 2023 the phase 1 consultation report was complete. It recommended that the City directly commission a co-production service. The contract was awarded to Mayday Trust and Groundswell. Mayday Trust later merged with Platfform who the lead commissioned provider of the City of London (CoL) Co-production Service are now.

8. The co-production service delivered by Mayday Trust and Groundswell began in November 2023. The focus for the first six months was to recruit the team. The team was initially made up of four staff, which later increased to five staff members who deliver on three main areas:

   a) **Advisory Group:** Members are made up of diverse individuals with lived experience of homelessness and/or rough sleeping. Members are working with, or have previously worked with, City rough sleeping/homelessness services.

   b) Champions: Each rough sleeping and accommodation support service has a nominated champion. Professionals meet every month to discuss the importance of co-production, the ways in which their services deliver co-production, and to highlight potential barriers to delivering co-production.

   c) Workshops/promotion: This group sets up and facilitates four co-production workshops attended by leaders and decision-makers from across the CoL and all homelessness commissioned organisations. The workshops are an opportunity to share good practice but also to agree next steps for how the City will commission and deliver co-produced homelessness services.

Current Position

9. The three-year RSI funding came to an end on 31 March 2025. CoL was notified by MHCLG of the one-year RSPRG in late December 2025 for this financial year (1 April 2025–31 March 2026). CoL confirmed continuation of funds for the co-production service for a further year.

10. The co-production service's quarter four (Q4) contract monitoring meeting took place in May 2025 where annual achievements were discussed:

    a) **<u>Advisory Panel Members</u>**
       (i) A key performance indicator (KPI) was to recruit and maintain between five and eight panel members each quarter. The project was able to achieve an average of six members across the year.

       The members have all received one-to-one co-production and participation training and ongoing support and guidance from the Engagement and Support Coordinator (ESC). The ESC works in a

very person-centred way, focusing on the members' individual needs and strengths. A recent example of this support is that one panel member is being supported by the Groundswell progression team to find employment opportunities.

The group is diverse, with women and those from LGBTQ+ communities represented more recently. The women who joined the group have already helped the panel update the group agreement to better reflect the group's diversity.

(ii) A KPI was to host one Advisory Panel meeting a month. The project was able to exceed this, hosting 15 meetings in total with an average attendance of three members at each meeting. It has been steady progress for the project and the group, seeing attendance numbers peak in Q4, where the average attendance was six.

In the later quarters the Advisory meetings focused on the Rough Sleeping Outreach Service as part of an Appreciative Inquiry approach. The group would get together to review progress made in the last Appreciative Inquiry and prepare for the next.

Appreciative Inquiry is a positive approach to organisational change that focuses on emphasising positive idea generation, encouraging discussion, focusing on strengths and untapped potential. Appreciative Inquiry approaches typically undergo four stages, which is known as the 4D cycle of Discover, Dream, Design and Deliver.

Further to this, the group is developing areas of interest and investigation of their own choice, including what 'move on' accommodation is available to clients after the supported accommodation pathway, and mapping street count and housing stock figures across the CoL. In March 2025, the group did a 'deep dive' into the process of contract tendering and planned service visits to help the group's understanding of services, monitor their efficiency and develop useful knowledge for future employment.

b) <u>Champions</u>

(i) A KPI was to host one Champions meeting a month. The project slightly underachieved, however, delivering 10 meetings over the year, with an average attendance of five champions each meeting.

Over the year, the Community Partner has worked hard to recruit champions through regular visits to services and team meetings. They have facilitated workshops attended by various presenters from across the partnership to present models of co-production, and to impart knowledge and skills in how best to deliver client participation, with varying success.

Future planning meetings are currently taking place with champions, managers and City officers, with the aim to structure future meetings in a way that enables particulate to fully engage and motivate champions to prioritise the work.

(ii) A KPI to deliver one Learning Group or Appreciative Inquiry session a month. The service delivered eight sessions in total in 2024–2025 and delivered a further two sessions this financial year to complete the Appreciative Inquiry. In this group, Advisory Panel members, City officers, champions and City Outreach workers came together as a wider working group to: share thoughts and ideas on what homeless provision worked well in the authority area; and set out what the future Rough Sleeping Outreach Team should look like for the second half of the year through the Appreciative Inquiry. All work from the Appreciative Inquiry will be written up in the coming months and will go on to shape the future tendering process for the new City Outreach Service.

Engagement with the City Outreach Team has been a particularly valuable aspect of the Appreciative Inquiry approach. The service has commented that the Outreach Team's contribution has deepened the co-production services' understanding of existing operational realities and constraints. Their involvement has helped provide evidence of the impact of co-production, and in turn has supported stronger relationships across the two services.

Feedback from the Advisory Panel:

'I really like seeing how our voices carry and are listened to, particularly meeting the decision-makers is impressive.'

'Despite feeling apprehensive and anxious about joining the group and navigating the space, I always come away feeling relaxed, included and heard.'

'I will take away an understanding of the dynamics and restraints behind commissioning services.'

'I enjoy speaking to people who have empathy and knowledge.'

'My highlight was hearing from the City officer who explained the commissioning cycle. In the future I want to go visit City officers and outreach in their place of work (Guildhall).'

c) <u>Workshops/promotions</u>

(i) A KPI to host and facilitate four leadership events, which the service delivered by the end of the financial year. All sessions were well attended by senior figures from service providers, public health, CoL officers, CoL members and representatives from London Borough of Tower Hamlets and London Borough of Hackney.

The workshops were a mix of presentations from Platfform, focusing on the theme of power-sharing, but also the sessions explored practical steps to putting co-production into action.

The service gathered feedback from participants, who reported how much attendees valued the opportunity to connect across roles and organisations, and particularly emphasised the importance of involving people with lived experience. The open discussions and range of perspectives were also appreciated, with many noting the strong commitment and engagement of those involved.

The workshops have been a meaningful and energising part of the wider co-production journey – helping to build shared understanding, strengthen relationships, and inspire collaborative action.

11. The table below sets out the outputs the co-production service will deliver this year.

Outputs	Learning that has led to this
Advisory Panel	
○ 10 Advisory Panel members ○ 12 monthly Advisory Panel meetings to gather and present feedback and insights, set priority areas, prepare for Appreciative Inquiries, and plan events ○ Training sessions and visits to services to develop knowledge and skills ○ Panel members receive one-to-one mentoring, progression support, reflective practice and attend extra participatory/team-building activities	Ongoing recruitment through gradual relationship-building is time-consuming but more effective than recruitment drives. The Advisory Panel is engaged and confident, and monthly meetings are working well. The Advisory Panel has strong relationships within the co-production project and desire to further develop skills and knowledge. We want to review how we can 'give back' and ensure that we are giving people opportunities to progress.
Champions programme	
○ Q1: Monthly meetings between champions, managers and City officers to understand barriers and challenges and explore remuneration, proposed solutions and agree on activities for Q2-4 ○ Q2–4: Monthly Champion Forums focused on practice-sharing and reflective learning ○ Agreed investment from CoL to support champion participation	Champions haven't yet had the chance to build relationships with City officers. We are proposing three joint meetings with champions, managers, and City officers to build trust and collaboration. It takes time for strong relationships to form between the project team, City officers, services, and the Advisory Panel. The service wants to create similar conditions for champions, recognising the time and care needed to build safety and shared understanding.
Learning Groups (until May 2025)	
○ Final Appreciative Inquiry Learning Groups in April and May ○ Co-produced set of recommendations for future commissioning of outreach service and a reflection	This space has been valuable and has helped build strong relationships, but now the service is to shift focus into rough sleeping services, for the reasons outlined above.

document evaluating the Appreciative Inquiry process in practice ○ Agreement on how to stay in touch in future, and on who will take forward actions	
Appreciative Inquiry in services	
○ Appreciative Inquiry delivered in one or two frontline services (topics selected collaboratively by champions, Advisory Panel, and people using the service, co-facilitated by champions and Advisory Panel members) ○ Training for champions on how to deliver Appreciative Inquiry in their service and sharing of system change resources ○ Facilitation training for champions and Advisory Panel members and project team ○ Write-up findings, key themes, and recommendations for next steps	Groundwork needs to happen before any session can take place – building relationships, helping people feel safe, building trust and confidence. This includes individual preparation and support for Advisory Panel members. The service has tested some small community listening approaches and worked with individual services, but intends to formalise how they reach people with lived experience outside of the Advisory Panel (who are currently rough sleeping and/or can't attend monthly meetings).
Co-production events	
○ Two events bringing together Advisory Panel, City officers, champions and local leaders – to be overseen by the Advisory Panel. Events to be held in September and February.	The service wants to create opportunities for everyone to come together. The Advisory Panel is keen to meet, influence and learn from more stakeholders.
Commissioner & Leader Working Groups	

○ Two to four Commissioner & Leader Working Groups focused on reflection, learning, and action planning to embed co-production more deeply into commissioning practices and service design. These sessions will build on previous learning, offering space to revisit reflections and potentially co-create a Team Agreement. Two of these sessions will be held in person, with a focus on practical action planning. In addition, we can offer up to two online sessions to explore themes such as power and relationships, reflective practice, and strengths-based leadership – depending on interest from the group. The two action-focused sessions to be held in June and November to alternate with the co-production events to maintain momentum. ○ A cross-borough co-production meeting to agree approach moving forward.	The service wants to build on the momentum from last year's workshops with a focus on practical action planning. Attendees in the cross-borough meeting have said it is useful to meet colleagues. The service intends to meet with City officers and other attendees to agree next steps for the group.

Corporate & Strategic Implications

12. Strategic implications – none
13. Financial implications – none
14. Resource implications – none
15. Legal implications – none
16. Risk implications – none
17. Equalities implications – none
18. Climate implications – none
19. Security implications – none

Conclusion

20. The co-production service has delivered well on most of its KPIs in 2025–2026 and has set out a clear vision of what is achievable for the service this year.

21. To date the project has: recruited and support an Advisory Group of people with lived experience; developed a Champions group of professionals working to deliver homelessness services; provided Learning Group and Appreciative Inquiry sessions for panel members, City officers, champions and outreach workers; facilitated four workshops, bringing together leaders in the City and the sector to commit to commission and deliver services in a more co-produced way.

22. The ambition of the Homelessness and Rough Sleeping Team is to continue to develop services in this area through continued commissioning of the current service.

Appendices

- None

Background Papers

- Homelessness Rough Sleeping Co-production Programme – Introduction Report 09/12/2024

Kirsty Lowe
Rough Sleeping Services Manager
Department of Community and Children's Services

T: 020 7332 3170
E: kirsty.lowe@cityoflondon.gov.uk

City of London Corporation Committee Report

Committee: Homelessness and Rough Sleeping Sub-Committee	**Dated:** 10/07/2025
Subject: Statutory Homelessness Service Development Plan	**Public report:** For Information
This proposal: • **delivers Corporate Plan 2024–2029 outcomes**	Links to Corporate Plan outcomes 1, 2, 3, 4,10
Does this proposal require extra revenue and/or capital spending?	No
If so, how much?	NA
What is the source of Funding?	NA
Has this Funding Source been agreed with the Chamberlain's Department?	NA
Report of:	Judith Finlay – Executive Director, Community and Children's Services
Report author:	Will Norman – Head of Homelessness Prevention and Rough Sleeping

Summary

This report provides Members with an overview of the new Statutory Homelessness Service Delivery Plan (SDP). The plan was created as a response to recommendations made by the Ministry of Housing, Communities & Local Government (MHCLG) following their diagnostic visit on 21 January 2025. This iteration of the SDP covers the period 1 June 2025 to 31 March 2026.

This report references the following priorities from the Homelessness and Rough Sleeping Strategy 2023–2027:

- Priority 1 – Providing rapid, effective and tailored interventions
- Priority 2 – Securing access to suitable, affordable accommodation
- Priority 3 – Achieving our goals through better collaboration and partnership

Recommendation

Members are asked to:

- Note the report

Main Report

Background

1. Local authority statutory homelessness functions are regulated activities; however, no mandatory inspection framework exists where periodic review takes place.

2. Approaches for homelessness advice and guidance have increased from 85 in 2019/20 to more than 600 in 2024/25. The number of households placed in Temporary Accommodation (TA) in a year has increased from 68 in 2019/20 to 164 in 2024/25. In the same period, the Statutory Homelessness Team has grown from two full-time Housing Officers, to three, plus a Triage Officer role.

3. The Homelessness and Rough Sleeping Service has adopted a commitment to continued learning. The Rough Sleeping Team, and how we commission the services we need to tackle rough sleeping, are currently under independent review for the second time in 10 years.

4. MHCLG's Homelessness Advice and Support Team (HAST) is the statutory equivalent to the Rough Sleeping Initiative (RSI), which works with local authorities to help them deliver local, regional and national rough sleeping strategies. HAST offers a diagnostic visit, which may be requested by HAST or a local authority. The City of London requested a diagnostic visit from Hast in December 2024. The visit took place on 21 January 2025 and feedback was provided via an additional visit on 13 March 2025.

Current Position

<u>HAST Diagnostic Visit</u>

5. Diagnostic visits do not form part of a mandatory inspection framework. The visit does not yield any overarching performance measure or standard rating. Diagnostic visits are either offered by HAST or requested by local authorities, which have no obligation to undertake them. Recommendations arising from the visits are advice only and there is no formal requirement to adopt recommendations.

6. HAST diagnostic visits use a 10-point framework:

i. **Homelessness and Rough Sleeping Strategy**
Aim: An up-to-date strategy and live delivery plan in place that reflects the local priorities identified through the homelessness review, developed and delivered with key partners, setting ambitious targets to reduce homelessness and end rough sleeping.

ii. **Funding, Leadership and Corporate Support**
Aim: Strong corporate leadership to reduce homelessness, and support delivery of excellent homelessness services, including through effective use of homelessness funding.

iii. **Use of Homelessness Prevention Grant (HPG)**
Aim: The HPG is used effectively to deliver on key priorities for funding: to embed the Homelessness Reduction Act **(**HRA), prevent single homelessness and rough sleeping, reduce family homelessness and use of TA, and eliminate use of B&Bs for families. Additional HPG funding is directed at vulnerable renters and preventing evictions from the private rented sector.

iv. **Embedding the HRA and Preventing Homelessness**
Aim: Fully embedded legislation, with a strong prevention culture across homelessness services and partnerships. Customer experience informs development of the service.

v. **Staffing Structure and Service Delivery**
Aim: Service structure and staff numbers are right for delivering an accessible service, with manageable caseloads, well-trained and supported teams. Face-to-face vs remote service delivery structured to meet need and provide the most positive customer experience.

vi. **Homelessness Case Level Collection (H-CLIC) and Performance Management**
Aim: H-CLIC data is accurately collected and reported to MHCLG, and is used locally to drive performance.

vii. **Access to Accommodation**
Aim: Access to all accommodation options are well managed according to customer need and availability of stock: through (HRA-compliant) Allocations Scheme, access to private rented sector and supported housing as appropriate; including for single people. Customers are well informed of their options and supported to access and sustain suitable accommodation.

viii. **Management of Temporary Accommodation (TA)**
Aim: Suitable and appropriate TA options provided with a strong focus on resettlement. Use of B&B is minimised, no unlawful use for families (six or more weeks). Households are not placed out of area where avoidable, and any out of area placements are in accordance with a published allocation policy.

ix. Preventing Single Homelessness and Ending Rough Sleeping
Aim: Strong understanding of rough sleeping in the area and a public commitment to prevent and end it, through multi-agency collaboration and offers of accommodation and support. Ensuring that rough sleepers access the relief duty, have needs fully assessed and a Personalised Housing Plan in place. Awareness of local causes of single homelessness and rough sleeping and working to actively prevent it.

x. Partnership Arrangements to Deliver
Aim: Having strong partnerships and ownership of plans to prevent homelessness, including through effective delivery of the duty to refer.

7. Three HAST officers attended the diagnostic visit on 21 January. MHCLG has access to extensive H-CLIC and Combined Homelessness and Information Network (CHAIN) data, meaning that a comprehensive data analysis had already been undertaken. During the day, the HAST Team met with the Statutory Homelessness Team, Judith Finlay (Executive Director, Community and Children's Services), Eamonn Mullally (Chair, Homelessness and Rough Sleeping Sub-Committee), Martin Goodwin (Housing/Social Housing Register), Ian Tweedie (Head of Adult Social Care) and Jacqui McKeating (Benefits Manager).

<u>HAST Feedback</u>

8. At the feedback visit on 13 March, HAST provided a comprehensive 37-slide feedback presentation. Feedback included detailed data analysis, (limited) near neighbour comparison[1] and a 'deep dive' into City-specific performance data. Five slides were dedicated to findings and recommendations. These can be found at Appendix 1.

9. The feedback recognised areas of strength, as well as areas where our service delivery is less developed or where future evolution may be required. Some examples taken from Appendix 1 include:

   In relation to corporate context and strategy:

   - *There is significant political oversight & support which has historically focussed on rough sleeping, but there has been more focus on statutory homelessness in the last few years as temporary accommodation placements have risen.*
   - *There is a clear commitment to support frontline homelessness services in regard to supporting the response to all types of homelessness. This includes offering a 'gold standard' service to care leavers.*
   - *A new Homelessness & Rough Sleeping Strategy 2023/27 confirms this commitment and provides a statutory framework on which to deliver*

[1] HAST uses a complex equation to help match the target local authority with two to four comparable local authorities. This exercise was hard to achieve for the City, with no viable matches.

services from. There is a very much a 'golden thread' that exists through the organisation.

In relation to service delivery:

- *Review [private rented sector] PRS options with specific regard to reviewing existing schemes nationally and across London. This could also mean working with individual boroughs.*
- *Consider team size when reviewing next steps in regard to increasing casework provision.*
- *Excellent knowledge of homelessness & associate legislation and a practical understanding of how it [is] used on [a] day-to-day basis (specifically to note the ability to offer accommodation under a power).*
- *Understanding of the current challenges specifically in regard to current temporary accommodation numbers and the need to be able to move homelessness prevention upstream and increase the use of the private rented accommodation for those applicants where this would provide a suitable & safe move on option.*
- *Clear commitment by external partners that the aspirations to support rough sleepers is a shared responsibility.*
- *Ensure enough time and commitment is given to strategic discussions with partners when reviewing the homelessness strategy actions and next steps.*

Service Development Plan

10. The 'potential next steps' section for each thematic area (oversight, operational management, the frontline, partnership, cross-corporation support) have been drafted into an SDP with an initial lifespan of 2025–2026. This will be reviewed at year end and extended into 2026–2027 as necessary. A copy of the 2025–2026 plan can be found at Appendix 2.

11. The SDP has 14 actions. The potential next steps, or recommendations, are not mandatory and an initial review identified 19 recommendations that have not been adopted. Reasons for this were varied, but were most commonly related to work already underway in the department which covers the recommendation, or knowledge of evidence that exists which may have been missed by the HAST Team, therefore rendering the recommendation not applicable.

12. Consideration was also given to capacity within the service to adopt each and every recommendation. Priority has been given to recommendations that are most likely to yield positive effects or strategic development required to match future demand.

13. A number of actions in the cross-corporation theme involved the Housing Team. Officers have met to review these actions separately. Four actions relating to the Housing Register, social housing allocations and Annual Lettings Plan have been carried over into the SDP.

14. Of the 14 actions on the SDP, eight are now underway and proceeding without issues. The remaining six are yet to commence.

Options

15. There are no options for Members to consider.

Proposals

16. There are no proposals for Members to consider.

Key Data

17. Summary data is included within the body of the report.

Corporate & Strategic Implications

18. Financial implications – none
19. Resource implications – none
20. Legal implications – none
21. Risk implications – none
22. Equalities implications – none
23. Climate implications – none
24. Security implications – none

Conclusion

25. Statutory Homelessness Services are not subject to any mandatory inspection framework. The City of London invited the MHCLG's HAST Team to undertake a diagnostic visit to gain a better understanding of the service's strengths, weaknesses and resilience in meeting future demand.

26. The visit took place on 21 January 2025, and feedback was provided on 13 March 2025. There are no mandatory actions to complete, and the visit did not result in an overall rating.

27. Feedback included a number of 'potential next steps', many of which have been carried over into an SDP to run until 31 March 2026. Any actions that cannot be complete in this time will be carried over into a supplementary plan for 2026/27.

28. The SDP has 14 actions, eight of which are already progressing. Four of the actions are shared with colleagues in Housing and will be addressed jointly.

Appendices

- Appendix 1 – HAST Feedback (abbreviated)
- Appendix 2 – Statutory Homelessness Service Development Plan 2025–2026

Will Norman
Head of Homelessness Prevention and Rough Sleeping

T: 020 7332 1994
E: will.norman@cityoflondon.gov.uk

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Ministry of Housing, Communities & Local Government

Corporate Context and Strategy

Oversight

- There is significant political oversight & support which has historically focussed on rough sleeping but there has been more focus on statutory homelessness in the last few years as temporary accommodation placements have risen.
- There is regular member scrutiny with performance reports on both rough sleeping and numbers in temporary accommodation
- There is a clear commitment to support frontline homelessness services in regard to supporting the response to all types of homelessness. This includes offering a 'gold standard' service to care leavers.
- A new Homelessness & Rough Sleeper Strategy 2023/27 (the Strategy) confirms these commitment and provides a statutory framework on which to deliver services from. There is a very much a 'golden thread' that exists from through the organisation.
- The Strategy confirms the response to 'all' types of homelessness including those at risk of losing their homes and those in vulnerable housing situations. It clearly links homelessness, health & wellbeing and understands that a tailored approach is required to deliver effective and life changing services.
- The Strategy confirms the commitment to learn through lived experience and the Corporation's role of leadership in a community where there is responsibility to help those who are more vulnerable than others.
- A Strategy Delivery Plan is in place and is monitored through a Sub-Committee that meets every 2/3 months and includes updates on the individual strategy workstreams.

Potential next steps	
• There is a real opportunity to share learning & best practice and by doing has the potential of promoting upstream homeless prevention across London & England.	• Evidence who your rough sleepers are, why they are rough sleeping and the geographical area that they have come from with the aim of sharing this information regionally to promote interventions that could reduce future rough sleepers by supporting them at an earlier stage (includes challenges from NRPF)
• Publish a yearly progress report that breakdowns whole numbers of homelessness demand and sets a clear picture of the pressures that the Corporation is facing.	• Evidence reasons for homelessness from those residents at risk of losing their home with the aim of reviewing how future targeted intervention work could support these residents at earlier stage going forward.
• Link health & wellbeing needs to demand and evidence the interventions/support that were needed to support this demand	• Evidence how service delivery or strategic thinking has changed because of lived experience learning

Ministry of Housing, Communities & Local Government

Service delivery

Operational Management

- A clear understanding of the link between strategic ambitions and frontline service delivery
- Excellent knowledge of homelessness & associate legislation and a practical understanding of how it used on day-to-day basis (specifically to note the ability to offer accommodation under a power)
- Understanding of the current challenges specifically in regard to current temporary accommodation numbers and the need to be able to move homelessness prevention upstream and increase the use of the private rented accommodation for those applicants where this would provide a suitable & safe move on option.
- Positive recognition that investment in officers (training, office culture, career progression) creates a knowledgeable workforce that seeks to offer a holistic service to residents and by doing so improves the outcomes for both the resident and the organisation as a whole.
- Positive understanding that a variety of different housing solutions are needed depending on the needs of the applicants. This includes access to social housing were appropriate and investment into PRS access.
- Clear picture given of how the service operates on a daily basis broken down into the customer journey and how the front door operates. Clear processes identified in how a customer is triaged and allocated to officers.
- Understanding of current caseloads per officer (currently running at 20/25 per officer) and linked temporary accommodation placements

Potential next steps	
• Review of Personal Housing Plans for all approved applicants in TA (21 out of 32 current placements) with a view of confirming the move-on option for each applicant. Potentially seek to make more social housing offers to reduce overall TA numbers.	• Review the very low numbers of rough sleepers going through the statutory homeless route (regardless of whether they go into temporary accommodation) to ensure that City is meeting all of its statutory obligations under homelessness legislation.
• Review the triage calls to ensure that all applicants that are meeting the threshold for an assessment of their circumstances & needs (the first HCLIC trigger) are having that assessment carried out.	• Review PRS options with specific regard to reviewing existing schemes nationally and across London. This could also mean working with individual boroughs.
• Consider formal management and officer training through accredited management courses and housing qualifications.	• Consider team size when reviewing next steps in regard to increasing casework provision.

Ministry of Housing, Communities & Local Government

Service delivery

The Front Line

- Clear link identified by officers to support the strategic ambitions of the Corporation and the understanding how it was being monitored and reported on.
- Officers are also responsible for project areas (rough sleeping, MARAC, MAPPA, DA etc…) which is in addition to casework duties (which is further broken down into specific workstream duties). This is positive as it enables a good understanding of how services deliver together (and the individual's role in that) but comes with a risk of being able to time manage effectively and be able to perform well in all areas.
- Good teamwork identified through case management meetings which provides an opportunity to discuss and work through solutions.
- Officers continue to 'own' cases until final discharge and this has ensured that PHP's continue to be updated throughout the applicant's journey through the service. Officers' therefore have a mixture of cases in each of the homelessness stages.
- Excellent understanding of homelessness & associate legislation and a practical understanding of how it used on day-to-day basis. Practical examples given on day of visit that shows confidence in legislation interpretation.
- Officer learning & development at present is led individually by officers.
- There is a good understanding of workload pressures and an open environment in which that can be talked about. This should be regularly reviewed

Potential next steps	
• Review the triage process to ensure that all applicants that are meeting the threshold for an assessment of their circumstances & needs (the first HCLIC trigger) are having that assessment carried out (for example there is no need for an applicant to provide documentation in order for an assessment to be carried out).	• Review cases currently going straight into a relief duty. If family/friends eviction or end of PRS (and PO has not already expired) then a prevention duty is likely owed in the first instance.
• Make sure that expired relief cases (where a main duty is owed) are completed shortly after 56 days unless a housing option is imminent	• Consider pulling housing allocations & HB into the bi-weekly casework meetings when necessary to discuss move-on or prevention options.
• Create personal development plans for all officers (including managers) to ensure relevant training & qualifications are identified	• Keep under review all project areas to ensure capacity within officer workloads and share best practice/swap projects to ensure multi-skilled officer base.

Ministry of Housing, Communities & Local Government

Service delivery

Partnership

- Meetings with internal partners - Housing Benefit, Social Services, Housing Allocations
- Meetings with external partners – Providence Row, St Mungos & Thames Reach
- Clear commitment by external partners that the aspirations to support rough sleepers is a shared responsibility
- Good understanding of the homelessness service identified across all partners including the current challenges and service aspirations.
- A number of examples of good practice including a social worker based in the housing options team, flexible use of DHP, care leaver offer
- Operational links between services clear and known to officer level
- Regular operational meetings have ensured that shared pressures are identified and joint solutions considered/acted upon.
- In regard to housing allocations more partnership work is recommended to review direct offers to households in temporary accommodation, void relet times and the priority given to other homeless households in order to prevent homelessness.

Potential next steps	
• Assure the Corporation that void relet times are solely due to major repairs and not difficulties with existing working practices.	• Consider introducing a yearly annual lettings plan which forecasts the lettings for the coming financial year and allocates them between competing housing demand groups
• Review the homelessness prevention work carried out by the allocations team to understand whether there is duplication with a view to a closer working relationship	• Evidence learning & changes in practice from lived experience with all partners
• Ensure enough time and commitment is given to strategic discussions with partners when reviewing the homelessness strategy actions and next steps.	• Ensure housing allocation policy meets current legal requirements especially in regard to the Homelessness Reduction Act 2017. • Support the allocations team to ensure their IT systems are fit for purpose which should then include auto-bidding and auto re-registration

Ministry of Housing, Communities & Local Government

Service delivery

Cross corporation support

Potential cross-Corporation actions
• Consider purchase / or repurposing of existing socially owned stock for both self contained and shared temporary accommodation. This includes reviewing existing sheltered accommodation.
• Combine housing register / housing needs service to remove duplication and make best use of existing resources.

• Ensure the best use of existing social housing
  • As part of stock survey work review & visit of all properties to determine housing need of current tenant
  • Active downsizer & under-occupation scheme
  • Be able to identify & work with overcrowded households at a much earlier stage to reduce future homeless approaches from family members.
  • Active reciprocal programme with other LA's (London & nationally) when a DA or gangs move is needed.

• Ensure strategic approach to development work both inside and outside of the Corporation boundaries   • Ensure homelessness data is included with housing register data when determining need

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Number	HAST Ref.	HAST Recommendation	Adopt	Action	Lead officer	When by	Evidence	RAG
1	1.2	Publish a yearly progress report that breakdowns whole numbers of homelessness demand and sets a clear picture of the pressures that the Corporation is facing.	Yes	Track on spreadsheet or through Jigsaw	WN	31/03/2026	Subcommittee report scheduled for Q1-Q2	Not started
2	1.4	Evidence who your rough sleepers are, why they are rough sleeping and the geographical area that they have come from with the aim of sharing this information regionally to promote interventions that could reduce future rough sleepers by supporting them at an earlier stage (includes challenges from NRPF)	Yes	Rough sleeping team to track	KL	31/12/2025	Include in annual data review Subcommittee report for Q2	Not started
3	1.5	Evidence reasons for homelessness from those residents at risk of losing their home with the aim of reviewing how future targeted intervention work could support these residents at earlier stage going forward.	Yes	Track on spreadsheet or through Jigsaw	SCol	31/07/2025	Data report in Jigsaw	Not started
4	1.6	Evidence how service delivery or strategic thinking has changed because of lived experience learning	Yes	Service user feedback loop	SCol	31/12/2025	Jigsaw report	Not started
5	2.2	Review the triage calls to ensure that all applicants that are meeting the threshold for an assessment of their circumstances & needs (the first HCLIC trigger) are having that assessment carried out.	Yes	Call notes recorded on Jigsaw need to be routinely checked	SCol	31/07/2025	Call notes/stored call recordings	Ongoing - no issues
6	2.3	Consider formal management and officer training through accredited management courses and housing qualifications.	Yes	Push through WFDB	WN/ZD	31/03/2026	Training logs and WFDB minutes	Ongoing - no issues
7	2.5	Review PRS options with specific regard to reviewing existing schemes nationally and across London. This could also mean working with individual boroughs.	Yes	Already started - LBTH etc	WN	31/03/2026	PRS scheme	Ongoing - no issues
8	2.6	Consider team size when reviewing next steps in regard to increasing casework provision.	Yes	Underway	WN	31/03/2026	Team size and structure	Ongoing - no issues
9	3.3	Create personal development plans for all officers (including managers) to ensure relevant training & qualifications are identified	Yes	Dedicated learning and training offer through WFDB	WN/SCol/ZD	31/03/2026	People training offer updated	Not started
10	3.4	Review cases currently going straight into a relief duty. If family/friends eviction or end of PRS (and PO has not already expired) then a prevention duty is likely owed in the first instance.	Yes	Minor evolution of practice	SCol	31/03/2026		
11	4.2	Review the homelessness prevention work carried out by the allocations team to understand whether there is duplication with a view to a closer working relationship	Yes	Explore possibility of regular meeting and data sharing	MG/WN	30/09/2025	TBC	Ongoing - no issues
12	4.4	Consider introducing a yearly annual lettings plan which forecasts the lettings for the coming financial year and allocates them between competing housing demand groups	Yes	WN to be included in annual lettings plan	LG/WN	31/03/2026	Annual lettings plan	Ongoing - no issues
13	5.1	Consider purchase / or repurposing of existing socially owned stock for both self contained and shared temporary accommodation. This includes reviewing existing sheltered accommodation.	Yes	Pick up through asset management strategy (Housing)	LG/WN	31/03/2026	Asset Management Strategy	Ongoing - no issues
14	5.9	Ensure homelessness data is included with housing register data when determining need	Yes	WN to be included in annual lettings plan	LG/WN	31/03/2025	Annual lettings plan	Ongoing - no issues

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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
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 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.

[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

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 London borough of City and Hackney. 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

Proposals

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

Andrew Trathen
Consultant in Public Health, City and Hackney Public Health
E: andrew.trathen@cityandhackneyph.hackney.gov.uk

Will Norman
Head of Homelessness, Prevention & Rough Sleeping
T: 0207 3321994
E: will.norman@cityoflondon.gov.uk

Nana Choak
Homeless Health Coordinator
T: 020 3834 7564
E: nana.choak@cityoflondon.gov.uk

Cindy Fischer
Senior Manager, Unplanned Care – NEL Health and Care Partnership
E: cindy.fischer@nhs.net

Dr Padma Wignesvaran
Clinical Director - Homeless and Inclusion Health, Greenhouse Practice
E: padma.wignesvaran@nhs.net

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

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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

To find out more about the NEL Homeless Health Strategy, contact the NEL Integrated Care Board, Health Inequalities Team:

- Ellie Hobart: ellie.hobart@nhs.net
- Nicola Weaver: n.weaver@nhs.net
- Melody Dhinda-Rees: melody.dhinda-rees@nhs.net

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