North East London Health & Care Partnership

NEL Homeless Health Strategy 2025 – 2030

Working together to improve health outcomes for people experiencing homelessness.

Contents

Introduction

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

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

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

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

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

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

Executive summary

Our purpose

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

Our ambition

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

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

Our approach

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

Our homeless health pillars

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

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

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

Our cross-cutting themes

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

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

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

Our key strategic opportunities

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

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

Transformation, system delivery and financial approach

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

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

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

Defining homelessness

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

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

Scope of the NEL Homeless Health Strategy

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

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

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

The case for change

Population summary and challenges

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

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

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

The cost of inaction

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

Data and intelligence show that:

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

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

Our opportunities

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

Key strategic opportunities

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

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

Working with local people and communities

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

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

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

Equitable access to core services and specialist support

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

Co-designing the strategy

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

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

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

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

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

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

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

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

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

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

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

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

* Hackney, Newham and Tower Hamlets

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr Lucy Langford, Newham GP [147]

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

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

Cross-cutting themes

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

Safeguarding

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

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

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

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

Workforce development

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

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

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

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

Data intelligence and evaluation

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

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

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

Through this cross-cutting theme we will:

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

Remaining meaningful and areas of developing focus

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

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

Conclusion and next steps

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

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

Contact us

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