North East London Health & Care Partnership

NEL Homeless Health Strategy – Case for Change

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

Contents

Introduction

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

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

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

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

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

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

Executive Summary

Our purpose

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

Our ambition

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

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

Our approach

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

Our homeless health pillars

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

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

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

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

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

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

Our cross-cutting themes

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

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

Our key strategic opportunities

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

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

Transformation, system delivery and financial approach

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

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

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

Defining homelessness

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

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

Scope of the NEL Homeless Health Strategy

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

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

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

The case for change

Summary of challenges

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

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

Population overview

Homelessness does not impact people equally

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

Rough sleeping

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

Temporary accommodation

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

Seeking refuge and asylum

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

Health needs

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

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

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

* Hackney, Newham and Tower Hamlets

Access to services and support

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

The system cost of inaction

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

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

Our opportunities

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

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

Key strategic opportunities

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

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

Working with local people and communities

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

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

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

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

Equitable access to core services and specialist support

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

Co-designing the strategy

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

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

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

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

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

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

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

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

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

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

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

† Hackney, Newham and Tower Hamlets

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Groundswell Peer steering the NEL Homeless Health Strategy, 2025

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

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

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

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

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

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

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

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

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

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

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

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

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

Through this pillar of the homeless health strategy we will:

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

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

Groundswell Peer steering the NEL Homeless Health Strategy, 2025

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

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

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

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

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

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

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

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

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

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

The experiences of families in TA in Westminster[182]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cross-cutting themes

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

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

Safeguarding

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

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

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

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

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

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

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

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

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

Workforce development

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

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

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

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

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

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

Data intelligence and evaluation

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

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

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

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

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

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

Through this cross-cutting theme we will:

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

Remaining meaningful and areas of developing focus

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

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

Climate change

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

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

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

Housing, health and wider partnerships

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

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

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

Population health approaches for prevention

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

Conclusion and next steps

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

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

Contact us

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