City of London Corporation Committee Report

Committee(s): Homelessness and Rough Sleeping Subcommittee Health and Wellbeing Board	**Dated:** 10/07/2025 11/07/2025
Subject: Meeting Health Needs for People Rough Sleeping in the City of London	**Public report:** For Information
This proposal: ● **delivers Corporate Plan 2024-29 outcomes** the strategic implications section]	Corporate Plan Outcomes: ● Diverse Engaged Communities ● Providing Excellent Services
Does this proposal require extra revenue and/or capital spending?	No
If so, how much?	N/A
What is the source of Funding?	N/A
Has this Funding Source been agreed with the Chamberlain's Department?	N/A
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Summary

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

Recommendation

Members are asked to:

- Note the report.

Main Report

Background

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

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

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

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

Current Situation

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

Community Wellbeing Team

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

The aims are to:

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

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

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

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

Challenges

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

Greenhouse and Other Health Partners

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

- Hep C Trust

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

ICB Perspective

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

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

Options

38. None

Proposal

39. None

Key Data

40. As per main report

Corporate & Strategic Implications

Financial implications

None

Resource implications

None

Legal implications

None

Risk implications

None

Equalities implications

None to consider at this stage

Climate implications

None

Security implications

None

Conclusion

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

Appendices

- Appendix 1 – NEL Homelessness and Rough Sleeping Strategy

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