Wandsworth Homelessness Health Needs Assessment 2023

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Public Health

THE BRIGHTER BOROUGH
Wandsworth

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Introduction

Current UK context

Homelessness is a complex problem throughout the UK and, in all its forms, has been increasing over a number of years nationally, notably from around 2010.

Between January and March 2022, 74,230 households in England became homeless or threatened with homelessness; around 1/3 of these households were families with children. These figures represent an 11% rise in 3 months and a 5% increase compared to the same period the previous year[i].

Rough sleeping in London is also increasing and London has the highest rates in England of both 'sofa surfers' and concealed homeless households, who are not sleeping rough or known to housing services[1].

Between 2010 and 2021/22, demands on local authorities in relation to homelessness have run at consistently higher levels compared to before 2010 leading to increased use of temporary accommodation across London, England and locally[2]. Many commentators have linked the rise in temporary accommodation to the negative impacts of various reforms to the welfare benefits system, as well as to wider economic factors.

By way of context, between 2004 and 2010, the Council achieved a 72 per cent reduction in its use of temporary accommodation for statutory homeless households, the largest percentage reduction amongst all London boroughs over that period.

Multiple current factors have exacerbated the ongoing issue of homelessness in the UK and remain a challenge including the COVID-19 pandemic, the current cost of living crisis, the war in Ukraine and Brexit. However, in the context of the COVID-19 pandemic, there are opportunities too, building on the Council's response to the national 'Everyone In' campaign.

How is homelessness defined?

A person does not need to be sleeping rough to be considered homeless. Whilst the 'Terminology' section defines legal and technical definitions of homelessness, the homeless charity Shelter puts it simply; *'the definition of homelessness means not having a home'*[3].

Being homeless includes:

- Individuals, partners, or families with no accommodation.
- Those in temporary or emergency accommodation.
- Those staying with family or friends.
- Those that are no longer able to remain or access their current accommodation due to issues such as domestic violence, conditions of the accommodation, appropriateness of accommodation, eviction, or other legal reasons.
- Those leaving institutions such as hospital or prison with no accommodation to go to.
- Those living in hostels, hotels, or Bed & Breakfasts.
- Those who are squatting.
- Those with no recourse to public funds.

1 Institute of Health Equity, Evidence review: Housing and Health inequalities in London https://www.instituteofhealthequity.org/resources-reports/evidence-review-housing-and-health-inequalities-in-london/full-report.pdf
[2] Wandsworth Housing resources and commitments for 2022/23 https://democracy.wandsworth.gov.uk/documents/s94990/22-161%20Wandsworth%20Annual%20Resources%20report.pdf
[3] Shelter: What is Homelessness? (2022) here

- Asylum seekers and refugees waiting to be accommodated.
- Those in mobile accommodation with no legal place to put it or live in it.
- Those in emergency shelter accommodation or people sleeping rough.

The population of homeless people is diverse and includes people of all ages and is constantly changing. The majority of children who are homeless in England are located in London, and people from Black and minority ethnic groups are overrepresented among families in temporary accommodation[4]. The health needs of each group differ.

This needs assessment will primarily focus on people who are known to housing services and defined as the council as at risk of homelessness or homeless, and rough sleepers. Where there are pockets of information about other groups, this too will be included, though the information available about these groups is limited.

Taking a public health approach to homelessness and homeless health

A preventative and public health approach to homelessness and homeless health involves addressing the 'causes of the cause' or social determinants of homelessness to prevent individuals becoming homeless initially. This should sit alongside a broad, robust response to homelessness when it does occur, including targeted interventions for those with complex needs. The human cost of homelessness is at its highest when it is continual or recurrent. Those who have repeated and long-term exposure to homelessness have the worst health outcomes and the highest financial impact[5,6].

Preventing homelessness initially is the best and most cost-effective way to tackle it and improve homeless health. Whilst lead responsibility for prevention of homelessness sits with the housing team in the Council, by the time a household presents, it is likely opportunities to resolve the issue have been missed. Actions required to prevent homelessness are most effective when delivered at the earliest opportunity and leaving prevention work until people are at immediate risk of homelessness may miss opportunities for less resource intensive interventions. Addressing structural factors that cause homelessness and identifying 'at risk' groups can support a preventative approach to homelessness in the longer term.

Understanding timely intervention points for the prevention of homelessness is also required. The most successful approaches start as early as possible to identify those at risk. Table 4 (adapted from Crisis[7]) outlines potential scenarios where homelessness may be prevented. In these scenarios, multiple services are in touch with individuals at critical time points on the person's journey and may provide an opportunity to intervene before the housing department is aware of the problem.

Table 4: Common areas where homelessness can be prevented: The plan to end homelessness, Crisis.

Scenario	**Agencies involved**
Person leaves prison with no accommodation	Prison, Community Rehabilitation Company
Person or household flees home to escape domestic abuse from known perpetrator	Police

[4] Institute of Health Equity, Evidence review: Housing and Health inequalities in London https://www.instituteofhealthequity.org/resources-reports/evidence-review-housing-and-health-inequalities-in-london/full-report.pdf
[5] Pleace, N. (2015) *At what cost? An estimation of the financial costs of single homelessness in the UK*. London: Crisis.
[6] Pleace, N. & Culhane, D.P. (2016) *Better than Cure? Testing the case for Enhancing Prevention of Single Homelessness in England*. London: Crisis.
[7] Crisis: The plan to end homelessness. Chapter 6: Preventing homelessness | The Plan To End Homelessness (crisis.org.uk)

Household leaves Home Office Asylum Support accommodation following an asylum claim decision	The Home Office
Young person leaves the care system	Children's services – local authority
Person is served an eviction notice from a registered social landlord	Housing association or social housing provider
Person is discharged from a psychiatric unit or other inpatient stay following treatment	NHS hospital, GP, adult social care (local authority)
Person is discharged from residential detox or a rehabilitation unit	Adult social care (local authority)

Source: Crisis: The plan to end homelessness.

For most people at risk of or experiencing homelessness and rough sleeping, there isn't a single intervention that can tackle this. Rather, action is required to support better integrated health and social care and help people to access and navigate the range of physical and mental health and substance misuse services they may require to maintain stable accommodation.

A public health approach to homelessness health requires collaborative working and sharing of experience and expertise across all services in contact with homeless residents to benefit those most in need and support individuals out of homelessness.

The Applying All Our Health model from Public Health England (2019)[8] suggests the following actions and roles that different sectors can play in improving the health of the homeless population:

Health and care professionals:

- Identify the risk of homelessness among people who have poor health and prevent this.
- Minimise the impact on health from homelessness among people who are already experiencing it.
- Enable improved health outcomes for people experiencing homelessness so that their poor health is not a barrier to moving on to a home of their own.

Partnership working:

Meanwhile, there should be clear local action and partnership working (across the local authority, Integrated Care Board, Integrated Care System, and other local organisations) to understand and align commissioning decisions to prevent and respond to homelessness across the lifecourse. This can include:

- Reducing the risk of homelessness to children and young people to strengthen their life chances.
- Enabling working-age adults to enjoy social, economic, and cultural participation in society.
- Breaking the cycle of homelessness or unstable housing by addressing mental health problems, drug and alcohol use, or experience of the criminal justice system.

[8] Public Health England: Guidance Homelessness: applying All Our Health (2019) https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health

The 'Multiple Exclusion Homeless research programme[9]' also considers preventative policy recommendations, including increased recognition of the impact of adverse childhood experiences and targeted work focussing on children experiencing issues known to increase the risk of homelessness later in life.

This requires strong local leadership and prioritisation to identify unmet need, funding, and actions to address gaps in provision. St. Mungo's Broadway and Homeless Link carried out an audit in 2014 of Joint Strategic Needs Assessments, Health and Wellbeing Strategies and Clinical Commissioning Groups' commissioning plans in 50 upper tier local authorities. They found that whilst there are some good examples, more needed to be done to ensure that homelessness is consistently addressed through local authority and (at the time) clinical commissioning group planning[10].

Recent NICE guidelines (2022) provide recommendations for integrated health and social care for people experiencing homelessness with aims to improve access to and engagement with health and social care, and ensure care is co-ordinated across different services and includes recommendations on:

- General principles, planning, and commissioning.
- Multidisciplinary service provision including homelessness multidisciplinary teams, homelessness leads and intermediate care.
- Improving access to and engagement with services, including outreach, the role of peers and long-term support.
- Assessing individual needs.
- Transition between settings and providing housing with health and social care support.
- Safeguarding.
- Staff support and development.

Terminology

There are many different definitions of homelessness and different terms relevant to homelessness that will be used in the needs assessment.

The terms 'homeless' and 'threatened homeless' are given here in context of homeless applications to a local authority in England. Other terms below are from the European typology of homelessness and housing exclusion.

Term	**Definition**
Homeless	Legally, the Housing Act 1996[11] defines a person as homeless if they either: - have no accommodation available to occupy in the UK or abroad. - are at risk of violence or domestic abuse. - have accommodation but it is not reasonable for them to continue to occupy it. - have accommodation but cannot secure entry to it. - have no legal right to occupy their accommodation.

[9] Fitzpatrick, S, et al (2011) Multiple Exclusion Homelessness Across the UK: A Quantitative Survey ESRC End of Award Report, RES-188-25-0023-A. Swindon: ESRC
[10] Public Health England: Guidance Homelessness: applying All Our Health (2019) https://www.gov.uk/government/publications/homelessness-applying-all-our-health/homelessness-applying-all-our-health
[11] Housing Act 1996. s.175(4)- (5)

	- live in a mobile home or houseboat but have no place to put it or live in it[12] e.g. this can include caravan sites where rules do not allow individuals to live there. Importantly accommodation must be available for the homeless occupant and those who would normally reside with them as a family member or other reasonable relationship.
Statutory homelessness	Individuals deemed to fall under the local authority's legal obligation or duty to house following being found to be homeless following assessment via application to the local authority as homeless.
Non-statutory homelessness	These individuals may be homeless but have not formally applied to the local authority as homeless or found not to be deemed as being 'owed a duty' by the local authority. Such individuals could for example be non-statutory but vulnerable (in temporary accommodation or supported accommodation by the council); rough sleepers prior to applying to the council for assistance; sofa-surfers or squatters; or individuals with no recourse to public funds.
Intentionally homeless	A person becomes homeless intentionally if all the three following apply: - they deliberately do or fail to do anything in consequence of which they cease to occupy accommodation; and, - the accommodation is available for their occupation; and, - it would have been reasonable for them to continue to occupy the accommodation. However, for this purpose, an act or omission made in good faith by someone who was unaware of any relevant fact must not be treated as deliberate.
Threatened with homelessness	A person is threatened with homelessness if either: - it is likely they will become homeless in the next 56 days. - they have been given a valid section 21 notice* in respect of their only accommodation[13]. *the first step a landlord has to take to end assured shorthold tenancy
Rough Sleeping ''Roofless''	Describes those who sleep or live on the street, in public places (known as 'bedded down') often thought to be the most 'visible' form of homelessness. This includes individuals who are sleeping in emergency accommodation such as night shelters.
Houseless	In temporary accommodation including transitional accommodation such as: women's shelters; refuges; emergency hostels; accommodation for immigrants; those in institutions (hospitals, prisons etc) due for discharge without housing options; staying with friends or family, sofa surfing; staying in a hostel, hotel or bed and breakfast.
Street homeless	A much wider term than rough sleeping, considering street lifestyles of some people who may not actually sleep on the street, but routinely spend time on the streets during the day. Some will end up sleeping outside, or in a derelict or other building not designed for human habitation, perhaps for long periods.

[12] Homelessness code of guidance for local authorities: Chapter 6 (22 Feb 2018) Department for Levelling Up, Housing and Communities available at: here
[13] Housing Act 1996. s.175(4)- (5)

	Others will sleep at a friend's house for a very short time, stay in a hostel, night-shelter or squat, or spend nights in prison or hospital[14].
Insecure housing	People living with the threat of eviction or being in temporary housing and needing to move multiple times therefore being unable to create a home.
Inadequate housing	People living in non-conventional structures or in unfit housing. Housing may be unaffordable, overcrowded, unsafe or poor condition.
Squatters	People sheltering in accommodation not intended for habitation, it may be unsafe and requires trespassing. Often difficult to visualise given the nature of sleeping space.
Sofa surfing	People staying with friends or relatives and may not be known to services.
Hidden homeless	People who become homeless but do not show up in official figures. Includes people without access to suitable housing, who may be staying with friends or family or living in squats, hostels and may not be known to services. Often a temporary solution[15].
Prevention duty	Places a duty on housing authorities to work with people who are threatened with homelessness within 56 days to help prevent them from becoming homelessness. Under the Homeless Reduction Act 2017.
Relief duty	Requires an authority to 'take reasonable steps to help the applicant to secure suitable accommodation that becomes available for the applicant's occupation' for at least six months. Under the Homeless Reduction Act 2017.
Priority need	Priority need for accommodation applies to certain individuals all the time, and others if they are 'vulnerable'. Always priority need: - at risk of domestic abuse. - pregnant or living with dependent children. - homeless because of fire, flood or other disaster. - a care leaver aged 18-20. - aged 16 or 17 possibly. Possibly priority need if vulnerable: - mental health problems or learning disability. - physical disabilities or serious health condition. - time spent in care, prison, or the armed forces. - fleeing violence from someone who is not a partner or relative. - old age. other special circumstances
Severe and multiple disadvantage	Those in the homelessness, substance misuse and criminal justice systems in England with 'poverty an almost universal, and mental ill health a common, complicating factor'.
Multiple exclusion homelessness (MEH)	People have experienced MEH if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other domains of 'deep social exclusion': 'institutional care' (prison, local authority care, mental health hospitals or wards); 'substance misuse' (drug, alcohol, solvent or gas misuse);

[14] Street Homelessness Factsheet. This factsheet was produced by Shelter. Rita Diaz 2006. https://assets.ctfassets.net/6sxvmndnpn0s/1sVouRBXVzym6oVsggXnqt/80036471dc9a38a416c52c752b9f3833/Factsheet_Street_Homelessness_Aug_2006.pdf

[15] http://www.homeless.org.uk/facts/homelessness-in-numbers/hidden-homelessness

	or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).
Co-occurring	Term used to describe individuals with a mental illness and co-occurring substance misuse issue.

Aims

Understanding the needs of the homeless population is a fundamental step towards addressing health inequalities faced by people experiencing homelessness locally.

A health needs assessment (HNA) is a tool used to build a picture of the health problems and needs of different populations with the aim to inform service provision to address needs identified and maximise the health gain in the population of focus.

The main aims of the homelessness health needs assessment are to understand:

- The scale of homelessness in Wandsworth.
- The health inequalities experienced by people who are homeless.
- The implications for the provision of services as well as identify the unmet needs.

The needs assessment faces a set of challenges relating to the inconsistencies around definitions of, visibility of and reporting of homelessness, meaning that the data used is often incomplete.

This needs assessment will primarily focus on those who are:

- 'Homeless' or 'threatened with homelessness' as defined by the Council.
- Rough sleepers.

Where there are pockets of data in other groups, this will be included, though it is likely this will be limited.

Policy context

The following section outlines the legislation, policies and strategies at a global, national, regional and local level that relate to homelessness health and wellbeing. These inform the delivery of local homeless services. Within each section they are ordered chronologically to provide the historical context:

Policy / Strategy (year)	Outline	Relevance to homelessness
Global		
Sustainable development goals (2015)	The 17 sustainable development goals are an urgent call for action by all countries for peace and prosperity for people and the planet now and in the future.	Those relating to homelessness are: no poverty, zero hunger, good health and wellbeing, quality education, gender equality, clean water and sanitation, affordable and clean energy, decent work, sustainable cities and communities and reduced inequalities[16].
The World Health Organisation: Housing and Health guidelines (2018)	Highlighted the inextricable link between housing and health, recognising that improved housing can save lives, reduce diseases, increase quality of life, help mitigate climate change and therefore contribute to a number of Sustainable Development Goals.	Provided evidence-based recommendations on conditions and interventions that promote healthy housing and facilitate leadership in enabling health and safety conditions to underpin housing regulations[17].
National		
Mental Health Act (1983)	Section 136 of the Mental Health Act (MHA) 1983 allows police officers to move someone to a place of safety if they believe them to be suffering from a mental health disorder and removing the individual is	People experiencing homelessness are at an increased risk of poor mental health[19]. For someone who is homeless, their place of residence is often not an option for assessment, (e.g. if the person is experiencing domestic abuse or if there is no fixed abode). This has

[16] Sustainable Development Goals https://sdgs.un.org/goals
[17] WHO: Housing and Health guidelines https://www.who.int/publications/i/item/9789241550376
[19] K. Amore and PL Howden-Chapman (2012) Mental health and Homelessness. Elsevier. Mental Health and Homelessness (researchgate.net)

	in theirs or the public's best interests[18]. A place of safety can include a person's place of residence if it is agreed it is suitable and: - the person who appears to be mentally disordered is living there and they agree to it being used as a place of safety. - if someone else is living there, at least one of the occupiers agrees as well as the person themselves.	implications for service use, often individuals are taken to a hospital (e.g. to A&E) whilst awaiting assessment. Police stations can be used but should only be used in an emergency. This alters a person's experience during a mental health crisis and their sense of safety despite being in a 'place of safety'.
Immigration and Asylum Act (1999)	Section 115 of the Immigration and Asylum Act 1999 states that a person will have 'no recourse to public funds' if they are 'subject to immigration control'.	This means that an individual subject to immigration control will have no entitlement to the majority of welfare benefits, including income support, housing benefit and a range of allowances and tax credits.
The Care Act (2014)	The Care Act outlines when local authorities have a duty to support adults with care and support needs. It seeks to place people in need of support at the centre of decisions about their care.	The Care Act has the potential to identify those with 'priority need' for housing, can establish whether accommodation is reasonable for needs and can prevent homelessness through the provision of services, establishing priority on allocation schemes, defend possession claims and identify needs for supported housing or a care home. Under The Care Act 2014, local authorities may assist individuals with no recourse to public funds (i.e. those who are subject to immigration control and have no entitlement to public housing or certain welfare benefits but access to NHS GP and adult social care may continue) if they have care and support issues not arising solely from destitution. Failed asylum seekers and those unlawfully present in the UK are excluded from support under the Care Act 2014

[18] Mental Health Crisis Care for Londoners. London's section 136 pathway and Health Based Placed of Safety specification. Health London Partnerships. December 2017

		unless necessary to prevent a breach of their human rights[20].
Public Health England: Improving health through the home (2016)[21]	'Improving health through the home' demonstrates the link between physical and mental health and wellbeing and the home, describing the impact of poor living conditions (e.g. cold, damp, hazardous, overcrowding, inaccessibility, instability). This work highlighted that the right home environment can both protect and improve health and wellbeing and was essential to delivering the NHS England Five Year Forward view, local authority plans for social care and supporting ambitions for the economy[22].	This led to 30 organisations at a national level representing housing, homelessness, health and care sector professionals signing *'Improving health through the home: a memorandum of understanding'* which outlined the shared commitment to joint action and collective ambition of partnership working across government, health, social care and housing sectors to improve health through the home.
Homeless Reduction Act, (HRA), (2017)[23]:	The HRA places duty on local authorities to intervene at earlier stages to prevent homelessness in their areas and requires housing authorities to provide homelessness services to those all affected not just those with 'priority need' including: - an enhanced **prevention duty** extending the period a household is threatened with homelessness from 28 days to 56 days, meaning that housing authorities are required to work with people to prevent homelessness at an earlier stage; and - a new **relief duty** for those who are already homeless so that housing authorities will support households for 56 days to relieve their	Implemented in 2018, the Homeless Reduction Act (HRA) changed the way that local authorities support homeless people. It addresses homelessness through earlier intervention, prevention, appropriate assessment of needs and developing individualised plans and gave local authorities new prevention responsibilities towards more people than previously. Since the HRA was introduced, there have been more households receiving statutory homelessness services. The HRA also introduced the 'duty to refer' for specific public facing authorities, meaning all those who they think might be homeless or at risk of homelessness must be referred to the local authority homeless or housing options team[24].

[20] Adults Safeguarding and homelessness. A briefing on positive practice. Local Government Association. March 2020.
[21] https://www.gov.uk/government/publications/joint-action-on-improving-health-through-the-home-memorandum-of-understanding
[22] https://www.gov.uk/government/publications/improving-health-through-the-home/improving-health-through-the-home#working-together
[23] Homelessness Reduction Act 2017 (legislation.gov.uk)
[24] A guide to the duty to refer - GOV.UK (www.gov.uk)

	homelessness by helping them to secure accommodation. Local authorities therefore must carry out an assessment and develop a personalised housing plan for those who are homeless or are at risk of homelessness, whether they have 'priority needs' or not. The term of being 'owed a duty' under the HRA can refer to either a prevention or relief duty.	
NHS England: Improving access for all: reducing inequalities in access to general practice services (2017)[25]	Resources were developed for general practice providers and commissioners to improve access to GP services and reduce inequalities in access to primary care services.	Homeless populations were identified as an 'at risk' group in relation to poor access to primary care, mainly due to: - Difficulty understanding health systems. - Lacking social support affecting the decision to seek help. - Disadvantages relating to digital exclusion affecting their ability to actively seek help. - Experience of discrimination and social exclusion when accessing care. The Doctors of the World 'Safe surgeries' initiative was launched in support of this in 2019 and encourages surgeries to sign up and declare that lack of ID, proof of address, immigration status or language are not barriers to patient registration.
National Rough Sleeping Strategy, 2018[26]	The government's rough sleeping strategy and delivery plan outlined the government's commitment to halving rough sleeping by 2022 and ending rough sleeping by 2027. The strategy outlined a range of cross-government initiatives to prevent rough	*The Rough Sleeping Initiative* announced ahead of the rough sleeping strategy was built around three core pillars**:** Prevent, Intervention and Recovery. This included providing timely support to tackle mental health issues, helping people leaving prison to find sustainable accommodation; providing people at high risk of rough

[25] Improving access for all: reducing inequalities in access to general practice services (2017) NHS England available at : https://www.england.nhs.uk/publication/improving-access-for-all-reducing-inequalities-in-access-to-general-practice-services/ Last Accessed [8/11/2022]
[26] Rough Sleeping Strategy (2018) Ministry of Housing, Communities & Local Government : Rough Sleeping Strategy August 2018 (publishing.service.gov.uk)

	sleeping and help those already sleeping on the streets.	sleeping with the right support to find work and live independently; and funding to local authorities for implementation.
NHS Long Term Plan, 2019[27]	The NHS Long Term Plan highlights the need for more work on prevention and reducing health inequalities to both improve health and wellbeing of the population and to reduce the pressure on health services.	Given the high level of need and experience of health inequalities in homeless populations, this population has been identified under 'inclusion health' initiatives with increased focus on homelessness in the health space.
Everyone In, 2020 [I]	In March 2020, due to the COVID-19 pandemic, the Ministry of Housing, Communities and Local Government (MHCLG) instructed local authorities to accommodate everyone who was sleeping rough, living in night shelters or in hostels where they were unable to self-isolate appropriately.	As a result of 'Everyone In', local authorities housed approximately 15,000 individuals in self-contained emergency accommodation. NHS England and NHS Improvement publicly stated that GP practices should agree on how to effectively connect and support local sites where homeless people were being housed.
Brexit, 2020	Since the UK left the EU on 31st December 2020, individuals living in the UK from the EU, Switzerland, Norway, Iceland or Lichtenstein have been required to apply to the EU settlement scheme for 'settled' or 'pre-settled' status. Individuals given 'settled' or 'pre-settled' maintain their rights to work in the UK, free access to the NHS, enrol in education or study in the UK, access public funds such as benefits and pensions where eligible and in and out of the UK.	Failure to apply to the EU Settlement Scheme prior to the 31st of December 2020 has implications for the receipt of benefits, access to public funds and their immigration status; and subsequently their ability to access housing and cases of homelessness as result can arise. [28]
Domestic Abuse Act, 2021[29]	The Domestic Abuse Act, 2021 changed homelessness legislation to give automatic priority for homelessness assistance to survivors of domestic abuse. The new statutory definition of	Domestic abuse is one is one of the leading causes of homelessness for women and families. However, being homeless or the fear of homelessness is also one of the main reasons women stay in households where they are at risk of or experiencing domestic abuse. Housing instability

[27] The NHS Long Term Plan. [ebook] NHS. Available at: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf> [Accessed 29 October 2022].
[28] No recourse to public funds network : https://www.nrpfnetwork.org.uk/information-and-resources/rights-and-entitlements/benefits-and-housing-public-funds/benefits/eea-nationals-and-family-members
[29] Domestic Abuse Bill: factshets (2020) Home Office available at: https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets

	'domestic abuse' also replaces the term 'domestic violence'.	and lack of affordable housing options also heighten the risk for women experiencing domestic violence.
Levelling Up, 2022[30]	The Department for Levelling Up, Housing and Communities published the Levelling Up White Paper in February 2022 which sets out how the government plans to spread opportunity more equally across the UK and highlights disparities in health and housing as priority areas[31].	Of the 12 core missions within this paper, one relates to housing with plans that by 2030, renters will have a secure path to ownership, with the number of first-time buyers increasing in all areas. The government's ambition is for the number of non-decent rented homes to have fallen by 50%, with the biggest improvements being seen in the lowest performing areas.
Ending Rough Sleeping for Good (2022)[32]	This cross-government three-year strategy intensifies efforts to tackle homelessness and rough sleeping, with a committed £2 billion of funding to do so, with the goal for rough sleeping to be prevented wherever possible and when it does occur to be rare, brief and non-recurrent.	The strategy takes a whole systems approach to tackling rough sleeping and includes the flagship Rough Sleeping initiative funding, which champions partnership working with local councils and the voluntary sector, alongside health services and other agencies to ensure no one falls through the cracks. It also sets out a plan for the 'Single Homelessness Accommodation Programme' in which accommodation is in place to help people, particularly young people, at risk of homelessness access accommodation and help individuals rebuild their lives.
Regional		
No Second Night Out, (2011)[33]	Launched in 2011, as part of the London Mayor's Task Force, in collaboration with St Mungo's to reduce rough sleeping and ensure that a rough sleeper did not experience a second night on the streets.	No Second Night Out is London's rapid response service to rough sleepers. Its purpose is to ensure that, wherever possible, rough sleepers' first night on the streets is also the last. In the long-term it aims to reduce the number of people sleeping rough

[30] Levelling Up the United Kingdom: Executive Summary (2022) Department for Levelling Up, Housing and Communities available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1095544/Executive_Summary.pdf Last accessed [08/11/2022]
[31] Levelling Up the United Kingdom: Executive Summary (2022) Department for Levelling Up, Housing and Communities available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1095544/Executive_Summary.pdf Last accessed [08/11/2022]
[32] Ending Rough Sleeping for Good (2022) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1102408/20220903_Ending_rough_sleeping_for_good.pdf
[33] No Second Night Out : Vision to end rough sleeping (2011) HM Government: Department for Communities and Local Government: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/6261/1939099.pdf

Mayor of London Rough Sleeping Plan of Action, (2018)[34]	The London Rough Sleeping Plan of Action was written to ensure a sustainable route off the streets for all rough sleepers.	It describes actions for the government, mayor and others to end rough sleeping. This London-wide plan focusses on: • Preventing rough sleeping. • Providing an immediate route off the streets. • Sustainable accommodation and solutions. • Supporting rough sleepers to rebuild their lives.
Healthy London Partnerships - Healthcare and people who are homeless: Commissioning Guidance for London (2019)[35]	This guidance outlines 10 commitments for improving health outcomes for homeless people in London which can be used to guide commissioning work to improve services. Over 100 NHS and non-NHS organisations across London, including those with lived experience contributed to the commitments.	The commitments are: 1) People experiencing homelessness receive high quality healthcare. 2) People with lived experience of homelessness are proactively included in patient and public engagement activities and supported to join the future healthcare workforce. 3) Healthcare 'reaches out' to people experiencing homelessness through inclusive and flexible service delivery models. 4) Data recording and sharing is improved to enhance the safety of people experiencing homelessness, enhance best practice and facilitate outcome-based commissioning. 5) Multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness. 6) People experiencing homelessness are supported to access primary care. 7) Mental health care pathways offer timely assessment, treatment and continuity of care for people experiencing homelessness.

[34] Rough Sleeping Plan of Action (2018) Mayor of London : Greater London Authority available at: https://www.london.gov.uk/programmes-strategies/housing-and-land/homelessness/rough-sleeping-plan-action#:~:text=About%20the%20plan,his%20current%20powers%20and%20resources

[35] Healthy London Partnership April-2019-Revised-Commissioning-Guidance.pdf (healthylondon.org)

		8) People experiencing homelessness are discharged from hospital to suitable accommodation. 9) Homeless health advice and signposting is available within urgent and emergency care pathways and settings. 10) People experiencing homelessness receive high quality, timely and co-ordinated end of life care
South West London Health and Care Partnership: South West London Homeless Health Programme (2021)	The Homeless Health Programme's core objective is for homeless people in South West London (SWL) to experience a significant reduction in health inequalities as a result of increased engagement with services and partnership working between agencies.	Three priority workstreams for the Homeless Health Programme include: (a) Improving primary care access via GP registration (b) Mental health offer (c) Mobilisation of two Pathway Teams pilots at Croydon and St George's hospitals

Table 7: Policies and strategies that relate to homeless health and wellbeing

What causes homelessness?

Risk factors for homelessness

The causes of homelessness are complex and multifactorial. Traditionally, causes of homelessness are broken down into two main components: structural factors and individual factors[36] as highlighted in Figure 1.

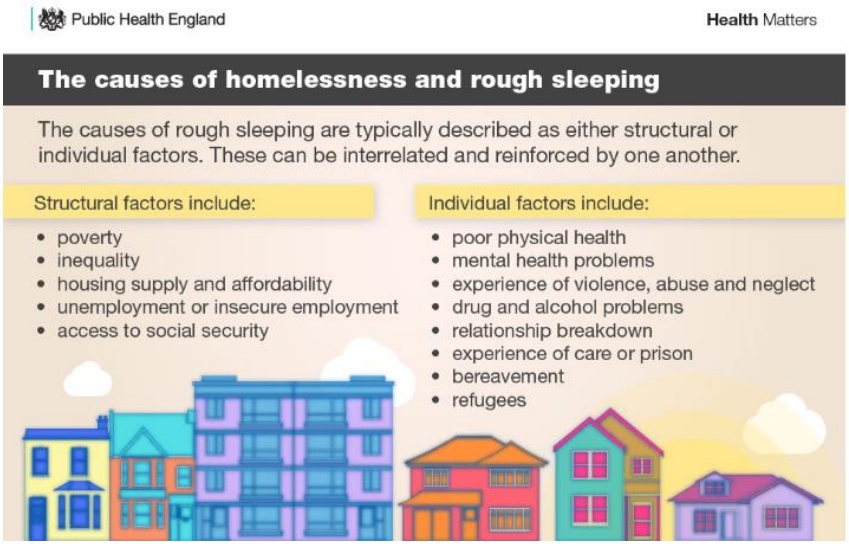


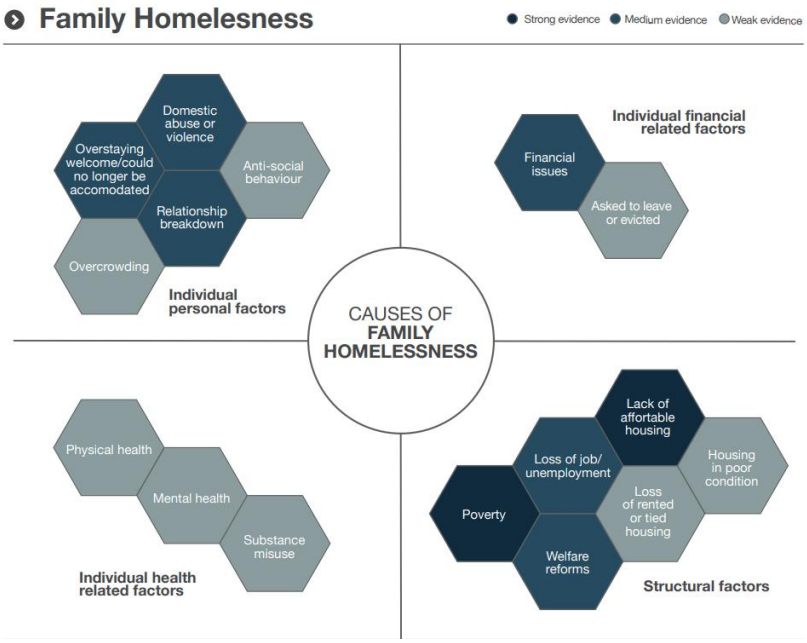
Figure 1: The causes of Homelessness and Rough Sleeping, Public Health England

These factors overlap and interact with one another. More recently, a rapid evidence assessment of causes of homelessness and rough sleeping in the UK from March 2019[37], broke the causes of homelessness down further into:

1) Individual personal factors
2) Individual financial related factors
3) Individual health related factors
4) Structural factors

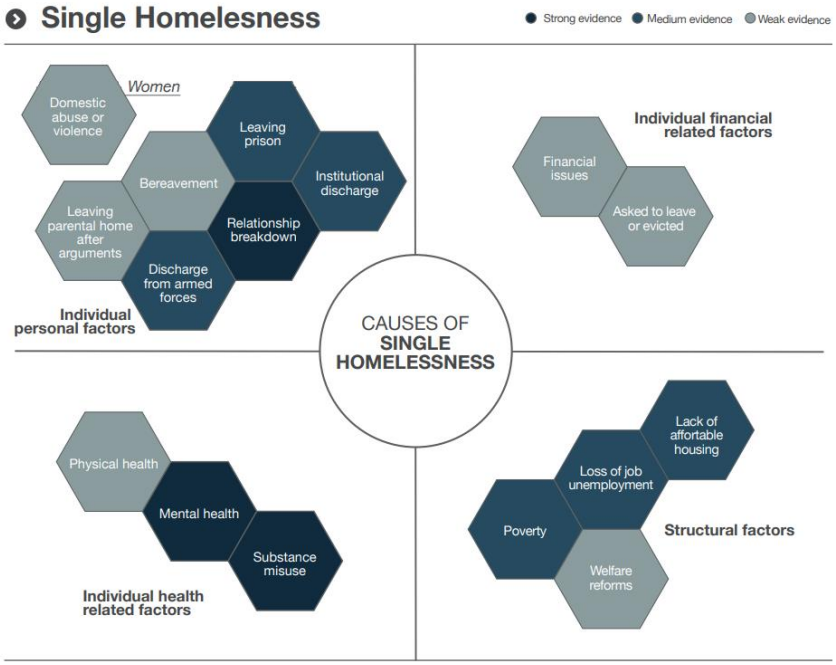
One review highlighted the different causes of homelessness in different populations including families (Figure 2), single people (Figure 3) and rough sleepers (Figure 4). The figures below illustrate the causes of homelessness in each group and are colour co-ordinated depending on the strength of evidence available for them. These are helpful to enable targeted approaches to addressing homelessness in each group.

[36] Bramley and Fitzpatrick, 2017; Busch-Geertsema et al., 2010; Fitzpatrick, 2005; Neale, 1997
[37] Homelessness: Rapid Evidence Assessment (publishing.service.gov.uk)



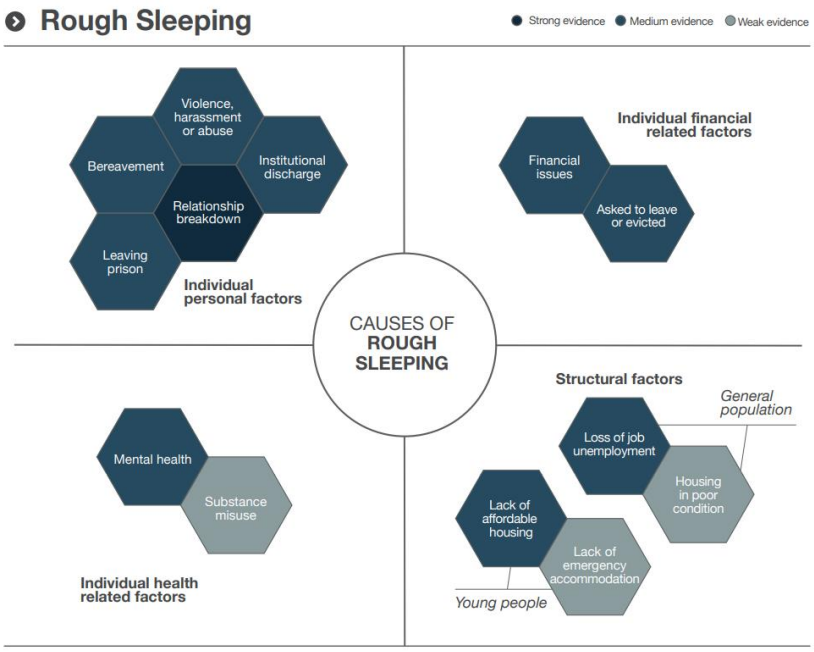
The causes of homelessness for families in the UK with the strongest evidence are **lack of affordable housing** and **poverty**, both of which are structural factors. There is medium evidence for domestic violence or abuse, relationship breakdown or overstaying welcome/could no longer be accommodated, financial issues, poverty, and lack of affordable housing as a cause of homelessness in this group.

Figure 2: Causes of family homelessness, UK. March 2019.



The causes of single homelessness with the strongest evidence are **relationship breakdown, mental health**. and **substance misuse**. There is medium evidence for poverty, loss of job/unemployment, lack of affordable housing, leaving prison, institutional discharge, and discharge from the armed forces as a cause of homelessness in single homeless people.

Figure 3: The causes of single homelessness, UK, March 2019



For the causes of homelessness in rough sleepers, there was the strongest evidence for **relationship breakdown**, with medium evidence for leaving prison, bereavement, violence, harassment or abuse, institutional discharge, financial issues, being asked to leave or evicted, loss of job/employment and mental health.
Lack of affordable housing has specifically been identified a cause of rough sleeping in young people (aged 16-25) with medium evidence supporting this.

Figure 4: The causes of rough sleeping, UK, March 2019

Individual health related factors were apparent as causes of homelessness in **all** groups, with the strongest evidence for **mental health** and **substance misuse** as a cause of single homelessness, moderate evidence for mental health as a cause of homelessness in rough sleepers and weak evidence for physical, mental health and substance misuse as causes of family homelessness. There was also weak evidence for substance misuse as a cause of homelessness in rough sleepers.

Causes of homelessness tend to cluster together in certain populations, creating multiple compounding risk factors for becoming homeless increasing risk of homelessness in certain groups and communities.

Causes of homelessness in Wandsworth

Data for this section is largely derived from the Department for Levelling Up, Housing & Communities[38] therefore, this only represents those individuals who present to the Council for assistance. The limitation of this is that those who do not present are not included in the data, though may still be experiencing homelessness. Therefore, while this data offers rough estimates relating to homelessness, it is likely this is an under-representation of the number of people experiencing all forms of homelessness in Wandsworth.

This statutory homeless population of people represents the number of households deemed to fall under Wandsworth Council's legal obligation or duty to house after being found to be homeless following an assessment. This means there are also people awaiting assessment who are not captured in this data.

It's important to note that, following an assessment, if found to be threatened with homelessness within 56 days people are owed the Prevention Duty. If found to already be

[38] Live tables on homelessness 2022 Department for Levelling Up, Housing and Communities https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

homeless individuals are owed the Relief Duty under the Homelessness Reduction Act 2017.

- Prevention duty: places a duty on housing authorities to work with people who are threatened with homelessness within 56 days to help prevent them from becoming homeless.
- Relief duty: requires an authority to 'take reasonable steps to help the applicant to secure suitable accommodation that becomes available for the applicant's occupation' for at least six months.

Homelessness often results from individuals or families losing their ability to stay in their current accommodation or settled home. Looking at data for 'reasons for loss of last settled home', the top 3 reasons for losing last settled home for both people that were assessed to be homeless or threatened with homelessness in Wandsworth were:

1) Family or friends no longer willing to accommodate (30% of those owed relief, 24% of those owed a prevention duty).
2) End of private rented tenancy (5% of those owed relief, 29% of those owed a prevention duty).
3) Domestic abuse (24% of those owed relief, 6% of those owed a prevention duty).

Table 3: Reason for loss of settled home, percentage of total applicants owed a duty under Homelessness reduction act (2017), Wandsworth 2021-2022

Reason	% of homeless population owed relief duty	% of threatened homeless population owed prevention duty
Friends of family no longer willing to accommodate	30%	24%
End of private rented tenancy	5%	29%
Domestic abuse	24%	6%

Domestic abuse was the reason for loss of last settled home in almost a quarter (24%) of residents in Wandsworth assessed to be homeless and owed a relief duty.

In stakeholder engagement interviews undertaken during this health needs assessment, housing colleagues highlighted that during and since the pandemic, the Council are often able to mediate around family eviction and have policies in place that are used to support continued accommodation prior to rehousing. However, it was noted by colleagues that since the pandemic, a higher proportion of individuals and families have been made homeless out of the family or parental home due to crisis, such as violence, gang activity and domestic abuse. Therefore, work related to preventing homelessness locally should shift and adapt in response to local need.

Also of note, 3% of people who were homeless and owed a relief duty had left an institution with no accommodation available. This however may be an under-representation if, for example, an individual is released from prison and has short term accommodation with family or friends that comes to an end. This may show as 'family or friends no longer willing to accommodate', masking the actual reason for homelessness.

Housing, homelessness and health

Housing and health

Housing and home life are important determinants of health. As shown in figure 5, housing sits amongst a broad combination of social and economic circumstances that influence an individual's overall health and wellbeing.

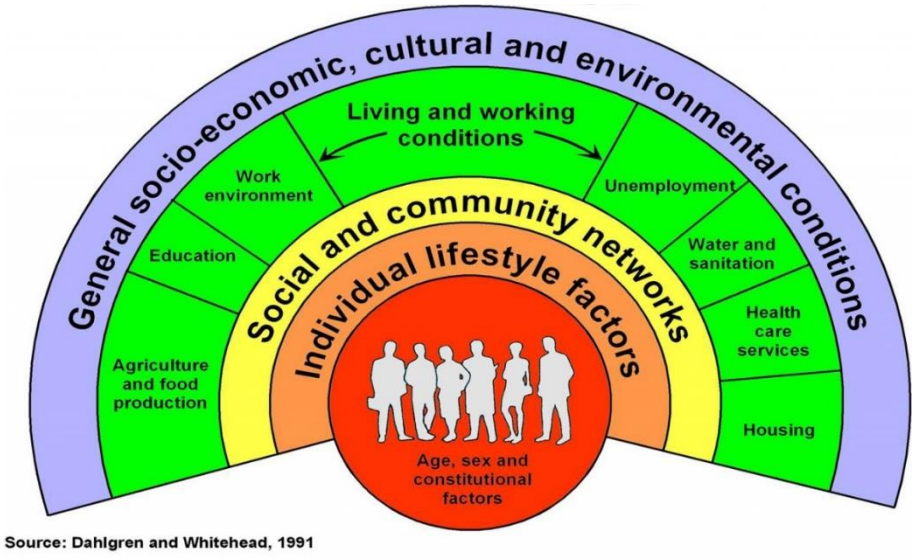


Figure 5: The Social Determinants of Health.: Dahlgren and Whitehead, 1991

The quality of housing plays a critical role in creating, maintaining and supporting good health; and housing that is inadequate, unsuitable or poor-quality housing has a negative impact on both physical and mental health. Housing can enable people to manage their own health and care needs; live independently; engage with treatment or recovery from ill-health or substance misuse; move on successfully after homelessness or trauma; the ability to access and sustain education, training and employment; and participate in society.

The right housing is also able to delay or reduce the need for primary, secondary and social care. It can enable timely discharge from hospitals, helps to prevent readmission and supports recovery from ill-health or planned admissions.

Housing can be thought to impact health through 3 main pathways which are highlighted in the recent report from the Institute of Health Inequalities: Housing and Health inequalities in London[39]. These are all particularly relevant to Londoners.

1) Housing quality
    - Meeting Decent Homes Standards.
    - Cold homes.
    - Overheating in homes.
    - Overcrowding.
    - Homes for an ageing population and people living with disabilities.
    - Homes for people with complex needs.

[39] Alice Munro, Jessica Allen, Michael Marmot (2022) Evidence Review: Housing and health inequalities in London available at: https://www.instituteofhealthequity.org/resources-reports/evidence-review-housing-and-health-inequalities-in-london

2) Housing security.
    - Housing security in the private rented sector in London
    - Homelessness
3) Affordability of homes.

There are increased risks to both physical and mental health associated with living in:

- A cold, damp, or otherwise hazardous house.
- An unsuitable home that doesn't meet a household's needs due to risks such as being overcrowded or inaccessible to a disabled or older person.
- An unstable home that does not provide a sense of safety and security including precarious living circumstances and/or homelessness[40].

People who are particularly vulnerable to the detrimental health impact of poor housing include children, older people, people with long-term conditions or disabilities. Housing can exacerbate health inequalities too; people from minority ethnic backgrounds on average experience worse housing, greater housing insecurity and greater housing need than White Londoners[41]. Similarly, those who are at risk of homelessness or recently out of homelessness are likely to live in homes that are not supportive of good health.

Homelessness and health

Health and homelessness are inextricably linked. Poor health can cause homelessness and being homeless has serious health consequences. People experiencing homelessness have worse health outcomes than those who do not with a disproportionate experience of both poor mental and physical health[42,43,44,45,46].

The reasons behind poor health outcomes in people experiencing homelessness can be generalised into the following broad categories[47]:

1) Direct impact of homelessness on health e.g. exposure to physical elements during rough sleeping.
2) Barriers to accessing healthcare.
3) Existing health inequalities in those at risk of or experiencing homelessness.

The above reasons overlap and are compounded by socio-economic factors that influence a person's health throughout their life course.

Mortality

Homelessness leads to very premature mortality and increased mortality rates. The average age of death of someone experiencing homelessness is around 30 years lower than that of the general population[48]. The Homelessness Kills[49] study by University College London (2012) found that most deaths in homeless people were preventable. The study included in the homeless population those sleeping rough, in hostels or in other hidden homeless situations.

40 Improving health through the home (2017) Public Health England https://www.gov.uk/government/publications/improving-health-through-the-home/improving-health-through-the-home
41 Gleeson, James. Housing and race equality in London: An analysis of secondary data [Internet]. Greater London Authority; 2022 Mar. (Housing Research Note). Available from: https://data.london.gov.uk/housing/research-notes/
42 Homeless Link (2010). The health and wellbeing of people who are homeless: evidence from a national audit. London: Homeless Link.
43 Queen's Nursing Institute (2008) Guidance resource: clinical assessment guidelines for single homeless adults. London: Queen's Nursing Institute.
44 Wright, N., Tompkins, C. (2006) How can health services effectively meet the health needs of homeless people?. British Journal of General Practice 56(525): 286-293.
45 Three Boroughs Homeless Team (2008) Homeless Health care: commissioning services for single homeless adults in Lambeth, Southwark and Lewisham.
46 Brodie, C., Perera, G., Rabee, S., et al. (2013). Rough sleepers: health and healthcare. A review of the health needs and healthcare costs of rough sleepers in the London boroughs of Hammersmith and Fulham, Kensington and Chelsea, and Westminster. NHS North West London.
47 The impact of homelessness on health: A guide for local authorities (n.d.) Local Government Association available at: https://www.local.gov.uk/sites/default/files/documents/22.7%20HEALTH%20AND%20HOMELESSNESS_v08_WEB_0.PDF
48 ONS, (2020), Deaths of homeless people in England and Wales: 2019 registrations. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations
49 Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England. The University of Sheffield & Crisis (2012). here

Key findings were:

- Homeless people aged 16-24 years old have twice the chance of dying as the general population This is four times great in those aged 25-34; five times greater in those aged 35-44; three times greater in those aged 45-54; and one and a half times greater aged 55-64.

- Around a third of deaths of people who were homeless were caused by drugs or alcohol. The chances of homeless people dying from alcohol-related causes were seven times higher than for the general population. The chance of homeless people dying from drug-related deaths was 20 times higher than the general population. Deaths due to drugs accounted for an eighth of all homeless deaths in London compared to a fifth nationally.

- Homeless people are three and a half times more likely to die by suicide than the general population. The average age of homeless people dying by suicide was 37 compared with the national average of 46.

- Homeless people have a nearly seven times higher chance of dying from HIV and hepatitis than the general population.

- Homeless people have a three times higher chance of dying from chronic lower respiratory diseases than their housed contemporaries and the average age of death was 56 compared to 76.

- Homeless people are twice as likely as the general population to die from heart attacks and chronic heart disease at an average age of 59 compared to 75 in the general population. In London, a quarter of homeless deaths were due to cardiovascular diseases compared to a fifth nationally.

- Homeless people have seven times the chance of dying from falls compared to the general population with an average age of death from falls of 45 compared to 77.

- The average age of death was found to be around 47 years for men and 43 years for women[50] which compared to an average age of death in England of 77 at the time. It is important to note that this was not life expectancy but age of death. Around a third of deaths were caused by medical conditions thought to have been due to causes that would have been amenable to timely medical treatment.

In 2020, across England and Wales, a total of 688 deaths of homeless people (mainly including people sleeping rough or using emergency accommodation such as homeless shelters and direct access hostels at or around the time of death) were registered across England and Wales. This represents a 12% decrease since 2019. Whilst not statistically significant, this is the first fall in the number of deaths since 2014.

These figures were affected by the Everyone In scheme which aimed to bring all those sleeping rough into accommodation during the pandemic. It is thought that by housing people and reducing the number of people experiencing homelessness, the scheme reduced the number of homeless deaths. However, it is known that the scheme may have led to difficulty identifying deaths of those housed under the scheme, meaning that the number of deaths may have been underestimated[51].

50 Ministry of Housing, Communities and Local Government. Homelessness: Causes of Homelessness and Rough Sleeping. Rapid Evidence Review. March 2019. Accessed:https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793471/ - check
51 Everyone In: Where are they now? The need for a roadmap out of street homelessness in England (2021) Shelter Available at: https://england.shelter.org.uk/professional_resources/policy_and_research/policy_library/everyone_in_where_are_they_now

The most common causes of death were:

1) Drug poisoning (~ 40% of deaths).
2) Alcohol-specific causes (12% of deaths).
3) Death by suicide (accounting for 11% of deaths).

One fifth of all the deaths registered across England and Wales were in London[52].

However, these mortality figures do not reveal the detail about the 'root cause' of mortality. Being homeless precludes a healthy lifestyle, with poor sleep, inadequate diet, difficulty maintaining personal hygiene, poor access to and experience of healthcare and difficulty maintaining a treatment contributing to poor health. Drug and/or alcohol use or mental health problems, often co-occurring, can lead to neglect of and exacerbate many physical health issues, which lead to premature death[53].

Health outcomes in homeless populations

It is well known that people experiencing homelessness face significant health inequalities and have poorer health outcomes than the general population. Diagnoses of physical and mental health conditions are higher than the general population and many of those experiencing homelessness experience early onset frailty[54].

Data from an extensive homeless health audit[55] by Homeless Link, represents the views of 3,555 people* experiencing homelessness between 2018-2021 across the UK. Of the 3,555 people responding: 71% male and 29% female. 93% were UK residents, and 89% identified as white. Most respondents were between 18 and 45 years old.

This research found that in the respondents:

Physical health

- 63% had a long-term illness, disability or infirmary, compared with 22% of the general population. 78% had a diagnosed physical health condition. Most people (80%) that reported physical health problems stated they were managing multiple conditions.
- The top 10 most common health conditions were: joint aches or problems with bones and muscles (37%), dental/teeth problems (36%), asthma (24%), difficulty seeing /eye problems (22%), stomach problems including ulcers (20%), foot problems (18%), fainting/blackouts (18%), skin/wound infection or problems (18%), chronic breathing problems (13%) and heart problems (13%) as can be seen in table 5. Dental issues, chest pain, breathing and eye problems and skin and wound conditions were all higher than in the general public.
- 36% of respondents reported having a disability. This compared to 18% rate in the UK working-age population.

52 Deaths of Homeless people in England and Wales (2021) ONS Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)
53 Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England. The University of Sheffield & Crisis (2012). here
54 The Unhealthy State of Homelessness 2022: Findings from the Homeless Health Needs Audit. Debra Hertzber and Sophie Boobis (October 2022) available at: Unhealthy_State_of_Homelessness_2022.pdf (kxcdn.com)
55 Unhealthy State of Homelessness, 2014 https://homelesslink-1b54.kxcdn.com/media/documents/Unhealthy_State_of_Homelessness_2022.pdf

Health condition (N=522)	Count	%
Joint aches/problems with bones and muscles	194	37%
Dental/teeth problems	187	36%
Asthma	125	24%
Difficulty seeing/eye problems	114	22%
Stomach problems, including ulcers	104	20%
Problems with feet	95	18%
Fainting/blackouts	93	18%
Skin/wound infection or problems	92	18%
Chronic breathing problems	70	13%
Heart problems	68	13%

Table 5: Ten most common health conditions reported by most recent wave of data collection from Homeless Link Health Needs Audit 2022

Mental health

- 86% reported a mental health diagnosis compared to a national population average of 12% (as reported via the GP survey 2021[56]) with 81% of this cohort reporting multiple mental health conditions. The most commonly reported mental health conditions were: depression (72%), anxiety disorder or phobia (60%) and a co-occurring drug or alcohol problem (25%).
- 45% were self-medicating with drugs or alcohol to help them cope with their mental health.

People experiencing homelessness are at an increased risk of poor mental health[57]. Factors contributing to mental ill health in homeless people include adverse childhood experiences, experience of violence, family conflict, relationship breakdown, poor physical health, learning difficulties, domestic abuse, drug and alcohol dependence, housing instability, poverty, debt and the trauma of experiencing homelessness itself.

Alcohol and drug use

- 54% reported using drugs in the last 12 months: 41% reported using cannabis/weed, 24% had used crack, 21% had used cocaine, 20% had used heroin, 8% had used amphetamines/speed and 27% reported use of other substances.
- 38% reported that they have or are recovering from a drug problem and 40% of them did not feel they were receiving support at the level they needed.
- 20% stated that they regularly drink alcohol over the Chief Medical Officer's low-risk guidelines, lower than the general population (24%). However, 29% of respondents identified as having or recovering from an alcohol problem.

[56] NHS, (2022), GP Patient Survey, National Report: 2022 survey. Available at: https://gp-patient.co.uk/downloads/2022/GPPS_2022_National_report_ PUBLIC.pdf
[57] K. Amore and PL Howden-Chapman (2012) Mental health and Homelessness. Elsevier. Mental Health and Homelessness (researchgate.net)

Wellbeing and preventative healthcare

In the audit these referred to smoking, nutrition and access to medication; and actions that homeless people can proactively take to support their health.

- 76% smoked cigarettes, cigars or a pipe (compared to 14% of adults in the general population). 50% reported wanting to give up but 46% of respondents stated they had not been offered smoking cessation advice.
- 71% were taking some form of prescription medication compared to 48% of adults in the general population[58].
- A third of respondents reported on average that they eat only one meal a day and 66% ate one or fewer portions of fruit or vegetables per day.
- Only 6% were fully vaccinated against Hepatitis B.
- Women experiencing homelessness were found to be much less likely to access cervical or breast screening programmes than the general population. Of those women eligible only 37% had had breast cancer screening in the last three years compared to 62% in the general population. 54% had received cervical screening compared to 70% in the general population.
- 24% had had a sexual health check in the year prior to the audit.

Poor health can be both a cause and consequence of homelessness. The trauma associated with homelessness leads to worsening mental health along with poor availability of good quality food, barriers to sleep, difficulty maintaining meaningful relationships and intense physical conditions for those who sleep rough. These factors contribute to poor health and wellbeing outcomes and subsequently increase the risk of self-medicating.[59,60]

Healthcare service use

Those experiencing homelessness have an increased need for statutory and voluntary sector health and social care services. Of those responding to the Homeless Link audit:

- There were high levels of GP registration among the homeless population responding to the audit (97%). Despite this, 6% reported they had been refused registration in the 12 months before the survey.
- Around 40% of people experiencing homelessness that responded to the Homeless Link audit had been admitted to hospital in the 12 months before the survey. The most common reasons for admission were related to a physical health condition (37%), a mental health condition and self-harm or a suicide attempt (28%)[61]. Of those admitted to hospital, a quarter (24%) were discharged onto the streets and a further 21% were discharged to accommodation that did not meet their needs.
- On average, people experiencing homelessness in the audit attended A&E 0.9 times a year, compared to 0.3 times a year among the general population[62].

Looking at the count of finished admission episodes across England NHS hospitals and English NHS commissioned activity in the independent sector (2019-2020), of those who had homelessness as a secondary diagnosis in hospital the most common diagnoses were respiratory disease, hepatitis C, diabetes, liver disease and pneumonia. This data relies on hospital coding, which is imperfect, but it provides an understanding of the breakdown of primary and secondary diagnosis in the population that were coded as homeless during their hospital stay.

58 NHS Digital, (2017) Health Survey for England, 2016. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2016
59 Groundswell, (2020), Women, Homelessness and Health: A Peer Research Project. Available at: https://groundswell.org.uk/wp-content/ uploads/2020/02/Womens-Health-Research-Report.pdf
60 Groundswell, (2018), Out of Pain. Available at: https://groundswell.org.uk/wp-content/uploads/2018/10/Groundswell-Out-of-Pain-Full-Report.pdf
61 Unhealthy State of Homelessness 2022, Homeless link: https://homeless.org.uk/knowledge-hub/unhealthy-state-of-homelessness-2022-findings-from-the-homeless-health-needs-audit/
62 NHS Digital, (2022), Hospital Accident & Emergency Activity 2021-22. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2021-22

Table 6: Count of finished admission episodes with a secondary diagnosis of homelessness and a primary or secondary diagnosis of one of the specified conditions, 2019-20. England.

Diagnosis	2019-2020
Respiratory disease	**4,469**
Hepatitis C	**1,905**
Diabetes	**1,478**
Liver disease	**1,255**
Pneumonia	**958**
Anaemia	920
Kidney failure	774
Alcoholic liver disease	667
Pancreatitis	365
Heart Failure	340
Sickle cell disorders	118
Lung cancer	83
Tuberculosis	72
Leukaemia	42
Non-Hodgkin's lymphoma	35
Prostate cancer	21
Bowel cancer	14
Breast cancer	13
Kidney cancer	12
Skin cancer	11
Brain tumours	6
Pancreatic cancer	6
Ovarian cancer	4
Thyroid cancer	2

Barriers to accessing needed support for physical and mental health means that people experiencing homelessness are over-reliant on emergency health services. People experiencing homelessness are three times more likely to have used A&E services in the last year than the general population. Rough sleepers are also more likely to be admitted as emergencies, rather than elective admissions, and stay in hospital for twice as long as the general population. The inpatient cost of a single homeless person has been estimated at between five to eight times the cost of the non-homeless population. [63]

63 Department of Health Office of the Chief Analyst (2010). Healthcare for Single Homeless People. London: Department of Health.

Evidence and the experience of those working with homeless people highlight that poor health is exacerbated by limited access to appropriate health services and limited integration between services. Additionally, the poor experiences of care homeless people often are subject to from the health service mean that health conditions are not always identified or treated effectively and can in turn lead to worse conditions developing despite many health outcomes described in earlier sections being preventable with timely intervention. Given that around a third of all deaths among people experiencing homelessness were amenable to timely and effective treatment[64], this highlights the importance of improving access to and experience of health and social care services for homeless people.

[64] Idridge RW, Menezes D, Lewer D et al. Causes of death among homeless people: a populationbased cross-sectional study of linked hospitalisation and mortality data in England. [version 1; peer review: 2 approved]. Wellcome Open Res 2019, 4:49

Groups at increased risk of homelessness and its health harms

Some groups within the population are at greater risk of becoming homeless and of the health harms associated with being homeless. And whilst technically anyone is at risk of becoming homeless, there is much higher risk in groups impacted by certain risk factors. Homelessness in London disproportionately affects families with children and people from Black and minority ethnic groups[65]. The majority of children who are homeless in England are located in London, and people from Black and minority ethnic groups are overrepresented among families in temporary accommodation[66].

Table 1 outlines inequalities experienced by each group relating to homelessness and the health harms experienced by this group. Oftentimes throughout the lifecourse, these risk factors overlap in certain individuals who are exposed to 'multiple exclusion homelessness'. At all ages homeless populations have poorer health compared to non-homeless populations.

Table 1: Groups at risk of homelessness, inequalities faced, and health harms experienced from homelessness.

Group	Inequalities	Health harms experienced from homelessness
Children and families	• Black and minority ethnic groups are overrepresented among families in temporary accommodation. • Children in lower income families have a high risk of becoming homeless.	**Children** • Children in temporary accommodation may have difficulty accessing universal healthcare e.g. immunisations. • Temporary accommodation is associated with greater rates of infections and accidents. • Homeless children are more likely to experience stress, anxiety and experience depression and exhibit behavioural issues (arguably a behavioural response) • Impact of homelessness on health and development extends beyond the period of homelessness. • Impact on educational attainment or access to school • Absenteeism more likely. • Increased likelihood of bullying and isolation in schools with difficulty creating meaningful relationships in schools and loneliness. • Moving home multiple times in early life affects a child's behaviour and mental health. • Early experiences of unstable housing associated with later drug use in young people. • Needs risk being overlooked by parents.

[65] Institute of Health Equity, Evidence review: Housing and Health inequalities in London https://www.instituteofhealthequity.org/resources-reports/evidence-review-housing-and-health-inequalities-in-london/full-report.pdf
[66] Institute of Health Equity, Evidence review: Housing and Health inequalities in London https://www.instituteofhealthequity.org/resources-reports/evidence-review-housing-and-health-inequalities-in-london/full-report.pdf

		Parents • Experience increased stress, depression, and isolation • More likely to go without food. • Increased stress in relation to child's health and education.
Young people	Young people experiencing homelessness are an extremely vulnerable group within homeless populations. They are more likely to have experienced trauma, abuse, and other adverse experiences prior to homelessness. There is an increased risk of homelessness in young people leaving care, young people who have run away from home, young people from Black and other ethnic minority groups, young LGBT people, those with experience of the criminal justice system, refugees, asylum seekers and those from rural areas.	• High levels of self-reported mental health problems, self-harm, drug, and alcohol use. • Increased risk of exploitation, abuse, trafficking, and involvement in gang and/or criminal activity. • Increased risk of sexually transmitted infections.
People with experiences of early childhood trauma	In homeless adults, significantly more people have been subject to adverse childhood experiences than the general population and it is a strong risk factor for homelessness. In homeless adults, 79% had experienced at least one form of childhood trauma and 53% had experienced 3 or more traumas. This compares to 47% of UK adults experiencing one adverse childhood experience (ACE)[67], and 10% of the general population experiencing four or more.	Early trauma and adverse childhood experiences result in increased likelihood of becoming homeless in the future. Trauma / adverse childhood experiences include: • Physical abuse • Neglect • Not being enough food at home to eat • Homelessness in childhood • Domestic abuse in the household • Parental substance misuse • Parental mental health issues • Poor family functioning • Socio-economic disadvantage/poverty • Separation from parents or caregivers • Parents in incarceration
People experiencing mental ill health	Poor mental health can be a cause and consequence of homelessness.	• Increased likelihood to self-medicate with drugs or alcohol. • Common mental health problems are over twice as high in the homeless population compared to the general population.

[67] Mark A. Bellis, Helen Lowey, Nicola Leckenby, Karen Hughes, Dominic Harrison, Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population, *Journal of Public Health*, Volume 36, Issue 1, March 2014, Pages 81–91, https://doi.org/10.1093/pubmed/fdt038

	Poor mental health is higher in groups at risk of housing insecurity, housing subject to overcrowding and those living in poor housing conditions.	• Psychosis is up to 15x higher in homeless people compared to the general population. • Homeless people are over 9 times more likely to die by suicide than the general population. • Difficulty accessing services to support mental health.
People experiencing threatening behaviour, abuse or violence	Higher levels of reported domestic violence amongst people who have experienced homelessness compared to general population. More often domestic violence is inflicted on women by men. Those at increased risk of domestic abuse also more likely to become homeless. Groups most at risk include: – Women aged 16-24. – Men aged 16-19. – Women who are separated with increased risk around time of separation. – Women who are pregnant or who have recently given birth. – Gay or bisexual men. – Transgender people.	• Poorer mental and physical health than the general population. • Increased risk of death by suicide. • Increased risk of death by homicide. • Increased risk of staying in abusive environment if at risk of homelessness.
People with substance misuse problems	Homelessness can be caused by or exacerbated by substance misuse. Rates of drug use are four times higher in homeless people than in the general population and a co-occurring diagnosis of substance use and mental health issues can be a barrier to accessing services[68].	• Homelessness can be a route into addiction for people who are rough sleepers, or in accommodation where others are using drugs or alcohol. • Homelessness affects the decision to first use or continue to use. • Difficulty accessing and engaging with treatment for substance misuse. • Increased hospital use. • Increased risk of withdrawal and relapse. • Increased risk of excess mortality among substance misusers who are also homeless, particularly if 'persistent homeless' or injecting drugs.
People with experience of the	15% of the prison population report having been homeless before custody compared to 3.5% of general population.	• More likely to reoffend on release from prison if not in accommodation. • Increased likelihood of non-completion of treatment received in prison or non-continuation if no accommodation on release from prison.

[68] The unhealthy state of homelessness, 2014 https://homelesslink-1b54.kxcdn.com/media/documents/The_unhealthy_state_of_homelessness_FINAL_1.pdf

criminal justice system		
People with severe and multiple disadvantages	Increased likelihood in populations experiencing poverty and mental ill-health of becoming homeless.	• Multiple disadvantages can make it hard to achieve positive health outcomes in this group for example, engaging with certain services may not be available whilst using substances such as drugs or alcohol.
People who experience rough sleeping	This group of homeless people have particularly poor health and wellbeing outcomes	• Average age of death is 47 years in men and 43 in women. • Death by unnatural causes is 4 times more common than in the general population. • Rough sleepers are 9 times more likely to die by suicide than the average person. • High level of drug and alcohol problems. • Significantly increased prevalence of infectious disease (TB, HIV, Hepatitis B & C) compared to general population. • More likely to be a victim of violent crime. • Increased risk of abuse and harassment from the general public. • 3 out of 10 female rough sleepers experience sexual violence whilst homeless. • Likely to experience exclusion from health services.

The following populations also frequently experience homelessness but are currently outside of the scope of this needs assessment to look into in detail due to the lack of available data and short time frame of the project: Gypsy, Roma and traveller communities, sex workers, migrant workers, refugees, and asylum seekers. These groups may be included in the data but not identified as separate groups.

The scale of homelessness locally

Statutory homeless population in Wandsworth

Data for this section is largely derived from the Department for Levelling Up, Housing & Communities[69]. This data set contains demographic information on the homeless population (including nationality, ethnicity, age and sexual identity). The data only represents those individuals who present to the Council for assistance, meaning that those who do not present are not included in the data, though may still be experiencing homelessness. Therefore, this data is likely to be an under-representation of the number of people experiencing statutory homelessness in Wandsworth.

The statutory homeless population represents the number of households deemed to fall under Wandsworth Council's legal obligation to offer a prevention or relief duty after being found to be homeless following an assessment. Consequently, those awaiting assessment are not captured in this data.

Homelessness assessments

Between April 2021 and March 2022, 2,888 households made a homeless application to the Council, an increase of 15% from the previous year.

Of those applications, Wandsworth Council assessed 1,469 households and found that 99% (1,455) of households assessed were owed a duty.

- 87% were homeless at the time of assessment and owed a relief duty.
- 12% were threatened with homelessness and owed a prevention duty.

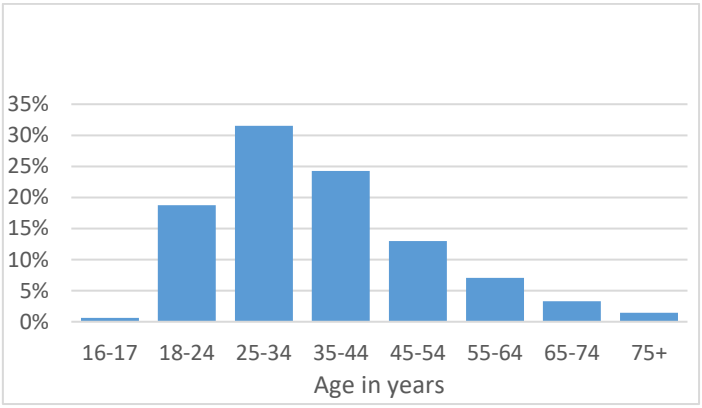
Between April and June 2022, a further 321 households were assessed as being owed a duty, with 81% homeless and 17% threatened with homelessness, therefore the trend continued. It is unclear from the data, whether homelessness may have been prevented with earlier assessment and intervention. However, the vast majority (99%) of those assessed were owed a duty under the HRA and most of the Council's work with the statutory homeless population is reactive rather than preventative, in that 87% of those owed a duty were owed a relief duty.

Demographics of the statutory homeless population

Age

The majority of people applying were aged between 18-44 years old.

Graph 1: Age of main applicants owed a prevention or relief duty, April 2021-March 2022, Wandsworth



69 Live tables for homelessness https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

Comparing this to the demographic data from the Census 2020 in Wandsworth, there is a bigger proportion of young adults aged 16-44 years assessed by to the Council as homeless. The majority of applicants (75%) were aged 16-44 years compared to older groups after considering the age distribution of the population.

Table 8: Age bracket, percentage of total homeless applicants, percentage of population based on Census data and comparative proportion as a decimal, Wandsworth.

Age bracket	Percentage of homeless applications	Percentage of Wandsworth population Census, 2021[70]	Proportion
16-24*	19%	23%	0.82
25-34	32%	40%	0.80
35-44	24%	33%	0.73
45-54	13%	24%	0.54
55-64	7%	17%	0.41
65-74	5%	9%	0.55

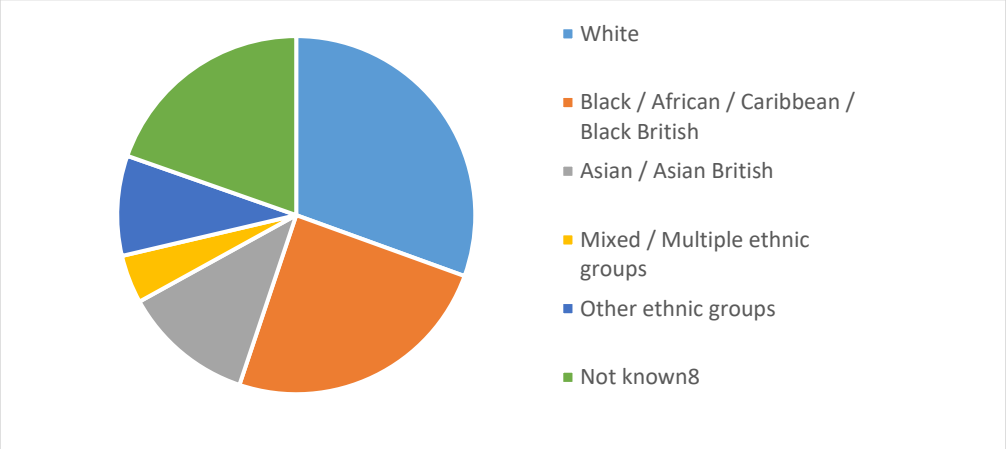
*NB: ONS census data includes those aged 15 in the youngest bracket therefore may not be directly comparable.

Ethnicity

Among those who were assessed as homeless or threatened homeless by the Council:

- 27% were Black/African/Caribbean/Black British.
- 26% of main applicants were White.
- 10% were Asian/Asian British.
- 6% were Mixed/Multiple ethnic groups/

Graph 2: Ethnicity of main applicant to Wandsworth Council owed a duty under the homelessness reduction act (HRA) April 2021-March 2022



Whilst ethnicity groups are not directly comparable, looking at GLA data[71] from 2019, around 70% of the Wandsworth population are thought to be White and 30% Black, Asian or other minority ethnic groups, with the estimated breakdown:

70 Population estimates by 5-year age group. https://www.datawand.info/population/#/view-report/63aeddf1d7fc44b8b4dffcd868e84eac/___iaFirstFeature/G3

71 GLA Housing-led ethnic group projections https://data.london.gov.uk/dataset/ethnic-group-population-projections

- 11% Black
- 10% Asian
- 6% Mixed or Multiple ethnic groups

Therefore, of the population applying to the Council as homeless and found to be owed a duty, there is an over-representation of Black, Asian and other minority ethnic residents and an under-representation of White residents, compared to the local demographics, with the biggest disparity seen in Black residents. Almost one third (27%) of applicants owed a duty under the HRA were Black, compared to an estimated 11% of Wandsworth's general population.

Nationality

Nationality data for the statutory homeless population in Wandsworth is relatively incomplete. The majority of applicants were UK nationals (68%) followed by non-EEA citizens who accounted for 21%.

Employment

A higher percentage (35%) of applicants to Wandsworth Council were registered as unemployed compared to the London unemployment rate of 6% for those aged 16 years and over. 13% of the population who were unemployed and assessed to be homeless or threatened homeless were not working due to long-term illness/disability[72].

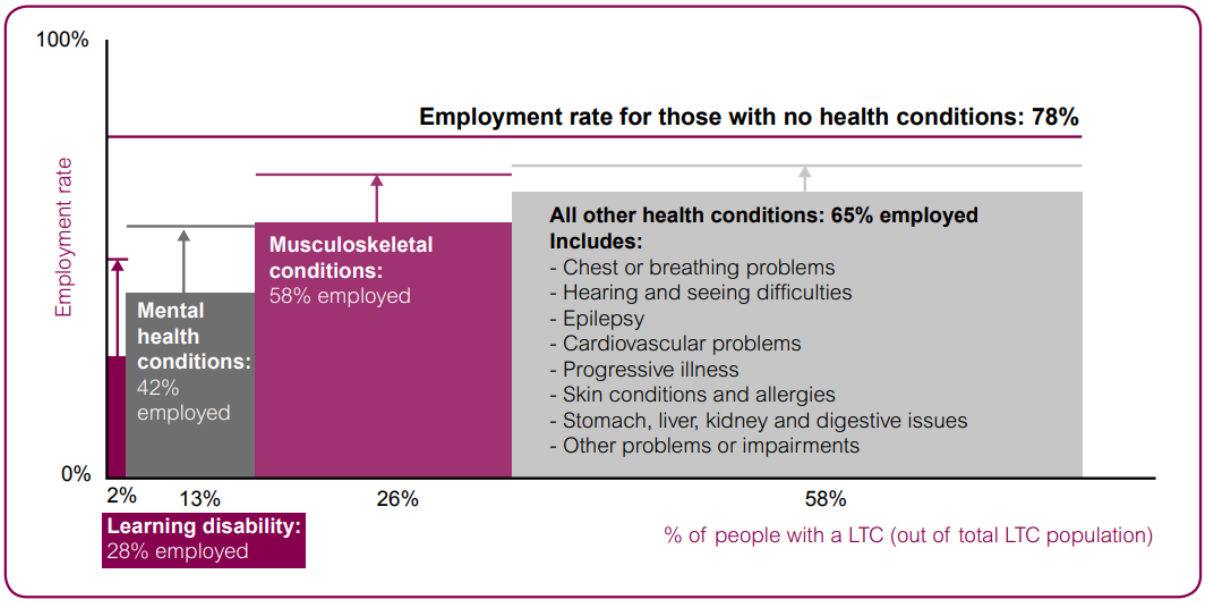
This highlights the complex interaction between poor health, employment and homelessness and inequalities in employment rates among those with health conditions. Employment rates is higher for those with no health conditions (as seen in graph 3). This is problematic given there are clear benefits to being in work for people with long-term conditions, including improved health and social outcomes. These inequalities in employment rate in the general population depend on the type of long-term health condition, and it is likely this is reflected in the local population too. Evidence suggests:

- Unemployment is associated with an increased risk of mortality and morbidity including cardiovascular disease, poor mental health, suicide, and health-damaging behaviours[73]
- Individuals unemployed for more than six months have lower wellbeing than those unemployed for less time[74]
- Varying employment rates of those with certain health conditions in particular, people with a history of substance misuse[75] and those affected by poor mental health[76] face barriers to securing and sustaining employment.

72 Labour market in the regions of the UK: October 2021
https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/regionallabourmarket/october2021

73 M.Marmot, J.Allen J, P.Goldblatt , T.Boyce, D.McNeish, M.Grady, et al. Fair society, healthy lives: strategic review of health inequalities in England post 2010. London: The Marmot Review; 2010.
74 3 J. Chanfreau, C.Lloyd, C. Byron, C.Roberts, R.Craig, D.De Feo, S. McManus , available at: http://www.natcen.ac.uk/media/205352/predictorsof-wellbeing.pdf
75 https://www.gov.uk/government/uploads/system/
76Mental health and work, Royal College of Psychiatrists https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212266/hwwb-mental-health-and-work.pdf

Graph 3 Employment rate for people with long term conditions and people with no health conditions, Labour force survey, 2014



Source: DWP Health and Work Core Statistics July 2014, Labour Force Survey Q2 2014

Work by Shelter[77] found that almost half of the 194 families with dependent children surveyed in their research were not in work or training. The research found that:

- A quarter of these families specified that physical health and/or mobility problems prevented them from working.
- A further quarter of families not in work or training were unable to work due to mental health problems.

Other significant reasons for not being able to work included:

- Lack of childcare.
- High rent making work unaffordable.
- Instability of family accommodation and not knowing how long they would be living in that address for.

Given that employment is a primary determinant of health, impacting both directly and indirectly on the individual, their family and community as well as the likelihood of becoming homeless, focussing on addressing health conditions in the homeless population that impact on employment is important and would likely have long-term health and wellbeing benefits. Similarly, improvements in the employment rate in homeless populations would likely improve health and wellbeing outcomes in this population.

Household type

Threatened homelessness.

Over half (52%) of those applying, found to be threatened with homelessness and owed a prevention duty had dependent children. Of those with dependent children, the most

77 Shelter: Sick and tired – The impact of temporary accommodation on the health of homeless families' (2004) https://assets.ctfassets.net/6sxvmndnpn0s/2v7vmNIMnPDfqQXRLkfUtq/b0e83dd39d63cae76aacfe4db8d03d49/Research_report_Sick_and_Tired_Dec_2004.pdf

common group were single parent females with dependent children, followed by a couple with children, three or more adults with children and single male parents.

Table 9: Households with dependent children threatened with homelessness, owed a Prevention Duty. April 2021-March 2022, Wandsworth

Household type	Percentage
Single parent (female)	32%
Single parent (male)	2%
Couple with dependent children	18%
Three or more adults with dependent children	5%

The rest of the population threatened with homelessness and applying to the council were either single adults, a couple or three or more adults without dependent children.

- 42% were single adults (19% male, 23% female)
- 5% were a couple or two adults without dependent children.
- 2% were three or more adults without dependent children.
-

Homeless

Of those who were homeless at the time of assessment and owed a relief duty, 36% had dependent children, whilst the majority (64%) did not. There was a higher proportion of single males who were homeless without dependent children compared to any other group.

- 60% were single adults (37% male, 23% female).
- 4% were a couple without dependent children.
- 0.2% had 3 or more adults without dependent children.

Of those with dependent children who were homeless and owed a relief duty the majority (27%) were single parent females[78].

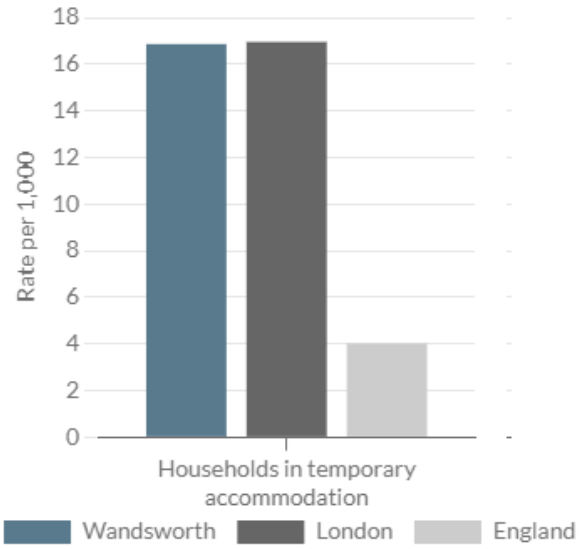
Table 10: Households with dependent children who are homeless and owed relief duty, April 2021-March 2022, Wandsworth

Household type	Percentage
Single parent (female)	27%
Single parent (male)	2%
Couple with dependent children	7%
Three or more adults with dependent children	1%

As of 2020/21 in Wandsworth, 16.9 per 1000 households (n=2,289) were in temporary accommodation, similar to the London average (17 per 1000 households, n=60,408) but more than four times higher than the England rate (4 per 1000 households)[79].

78 Live tables for homelessness https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
[79] Data Wand, Homelessness Housing - UTLA | Wandsworth | Report Builder for ArcGIS (datawand.info)

Graph 4: Households in temporary accommodation, Rate per 1000, 2020-21, Wandsworth, London, and England. Source: MHCLG



In Wandsworth in 2021/22, 1,240 households were provided with temporary accommodation, an increase of 53% (from 809) the previous year. The increase in temporary accommodation admissions locally is thought to have been driven by two main factors:

1) Changes made to the legislation via the Domestic Abuse Act, 2020.
2) The ending of previous moratoria on court sanctioned evictions from September 2021 as part of a national response to the COVID-19 pandemic.

A large proportion of Wandsworth residents who are threatened with homelessness or homeless are children. These children are at risk of poor health and wellbeing outcomes in the short and long term as well as severe poverty. Homelessness in childhood is also an adverse childhood experience.

A 2004 report from Shelter [80], in which almost 200 families with dependent children were surveyed, found that:

- Almost all families (90%) felt that their children's health had suffered as a result of living in temporary accommodation and 1 in 10 families stated their children found it difficult to make friends.
- Parents experienced considerable anxiety as they were unable to plan for their children's future, specifically around their education. This was compounded when families were moved multiple times.
- Over half of the families said that their health or the health of their family had suffered as a result of living in temporary accommodation.
- Among those suffering from depression, 63% said that it had worsened.
- 60% of people with asthma or other chest or breathing conditions stated their condition had deteriorated.
- Other health problems highlighted included skin problems/eczema, other mental health problems, colds and flu, disability, feeling isolated and lonely, feeling unsettled and experiencing anxiety and stress.

[80]Shelter: Sick and tired – The impact of temporary accommodation on the health of homeless families' (2004) https://assets.ctfassets.net/6sxvmndnpn0s/2v7vmNIMnPDfqQXRLkfUtq/b0e83dd39d63cae76aacfe4db8d03d49/Research_report_Sick_and_Tired_Dec_2004.pdf

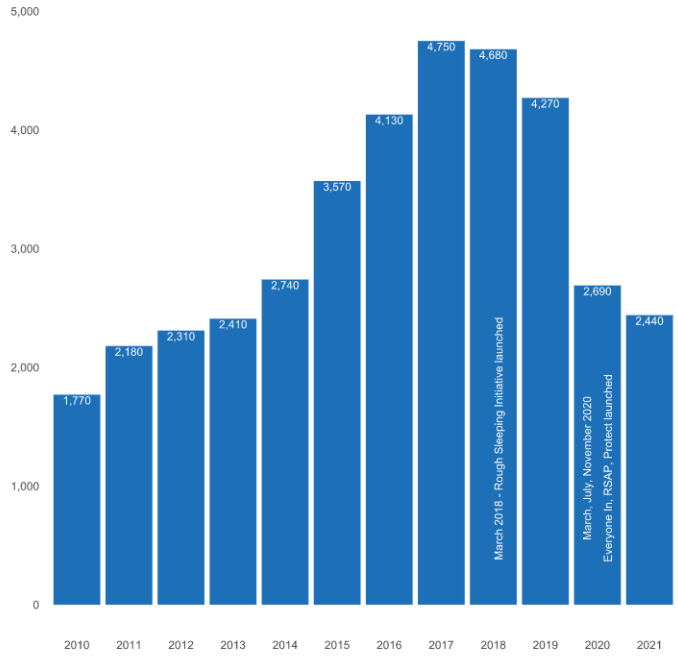
Table 11: Health impact of temporary accommodation of 194 UK families with dependent children in temporary accommodation in UK, 2003 answering: Since you have been housed in temporary accommodation, how does your health compare to how it was before?

	Total number answering	better	same	worse
Asthma	48	4	20	24
Other chest/breathing problems	38	2	8	28
Skin problems/eczema	56	11	16	29
Depression	104	11	27	66
Other mental health problems	24	5	3	16

In the same Shelter report[81], it was found that the longer families lived in temporary accommodation, the more likely they were to attribute their worsening health to their housing situation. As of July 2022, the average time spent in temporary accommodation of all forms in Wandsworth was 43 months which was higher than in 2021/22 (35 months).

Rough sleeper population in Wandsworth

The number of rough sleepers across England is difficult to estimate. However, the widely accepted method for doing so is via a count over a single night in autumn, which gives a snapshot into the numbers of rough sleepers. The count is collated by outreach workers, local charities and community groups and verified by Homeless Link. As of 31st March 2022, the number of people estimated to be sleeping rough on a single night in autumn across England appears to have fallen for the fourth year in a row since 2017[82].



Graph 5: Estimated number of people sleeping rough on a single night in autumn in England since 2010

[81] Shelter: Sick and tired – The impact of temporary accommodation on the health of homeless families' (2004) https://assets.ctfassets.net/6sxvmndnpn0s/2v7vmNIMnPDfqQXRLkfUtq/b0e83dd39d63cae76aacfe4db8d03d49/Research_report_Sick_and_Tired_Dec_2004.pdf
[82] CHAIN Rough sleeping snapshot in England: autumn 2021 - GOV.UK (www.gov.uk)

Nearly half (45%) of all people sleeping rough at the latest count were in London and the Southeast. In London, the highest numbers were seen in central London boroughs.

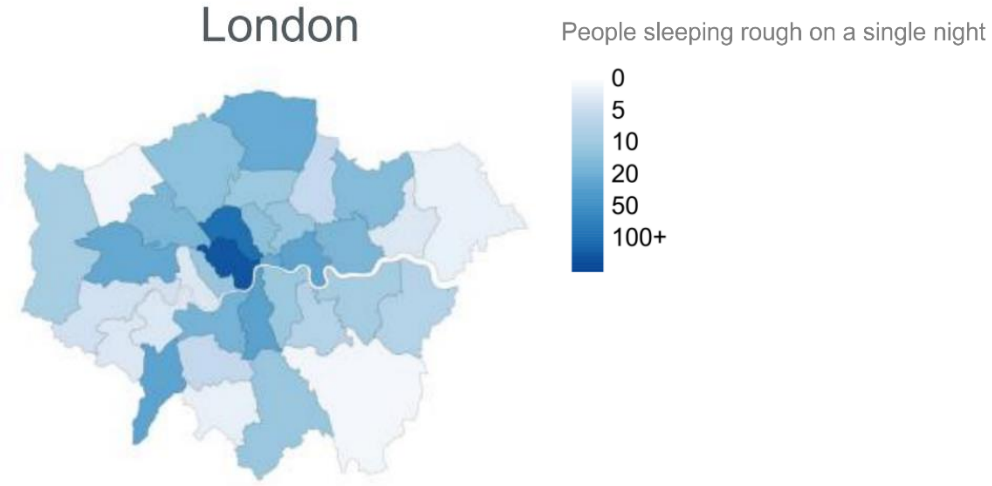


Figure 6: Map of number of people rough sleeping snapshot, Autumn 2021, London.

Locally, CHAIN data[83] provides a more accurate estimate of rough sleeper populations. The 'flow, stock, returner model' categorises rough sleeping in the year according to whether they have also been seen rough sleeping in previous periods.

Table 12: Descriptor of categories of rough sleeper populations as per CHAIN database, 2022

Category	Description
Flow	People who had never been seen rough sleeping prior to 2021/22 (i.e. new rough sleepers). Those within this category are further subdivided as follows: Unidentified - those new rough sleepers recorded without a name, and with only one contact. Identified - those new rough sleepers recorded with a name, and/or with more than one contact.
Stock	People who were also seen rough sleeping in 2020/21 (i.e. those seen across a minimum of two consecutive years).
Returner	People who were first seen rough sleeping prior to 2020/21 , but were not seen during 2020/21 (i.e. those who have had a gap in their rough sleeping histories).

Between April 2021 and March 2022, 3158 people were seen to be rough sleeping across outer London boroughs in 2021/2022. Of that, 67% of people seen sleeping rough were new rough sleepers (flow), 20% in the 'stock' category and 13% returners.

This compares to 264 people seen to be sleeping rough in Wandsworth. Almost half (48%) were new rough sleepers, 35% were 'stock' and 15% were returners. In this time period, Wandsworth was one of the boroughs with the highest number of rough sleepers along with Croydon, Lewisham, Redbridge, Heathrow, and Hackney. Most recent data from quarter one 2022/23 has seen a further 49 rough sleepers in Wandsworth. However, conversations with those working with rough sleepers locally suggest that this is an underestimate.

[83] CHAIN Rough sleeping snapshot in England: autumn 2021 - GOV.UK (www.gov.uk)

Borough	Flow	Stock	Returner	Total
Barking & Dagenham	95	26	10	131
Barnet	112	45	16	173
Bexley	75	13	5	93
Bromley	48	4	5	57
Croydon	176	52	43	271
Enfield	120	42	21	183
Greenwich	86	32	17	135
Hackney	152	47	30	229
Harrow	45	7	6	58
Havering	50	13	6	69
Heathrow	176	28	29	233
Hillingdon	95	28	17	140
Hounslow	97	25	22	144
Kingston upon Thames	53	23	23	99
Lewisham	187	38	39	264
Merton	28	11	6	45
Redbridge	152	60	35	247
Richmond	32	20	9	61
Sutton	20	4	5	29
Waltham Forest	106	30	17	153
Wandsworth	129	94	41	264
Bus route	95	22	25	142
Tube line	9	6	3	18

Table 13: CHAIN data: London outer boroughs numbers of rough sleepers: flow, stock, returner, and total figures. 2021/22

As of November 2022, in Wandsworth, 275 people who were majority rough sleepers were provided with emergency accommodation as a result of the COVID-19 'Everyone In' campaign. Of that 91 people were still in accommodation awaiting a more permanent arrangement, but as many as 264 (96%) had been 'closed'. This demonstrates that the Everyone In initiative successfully housed people who were otherwise rough sleeping in a relatively short time frame.

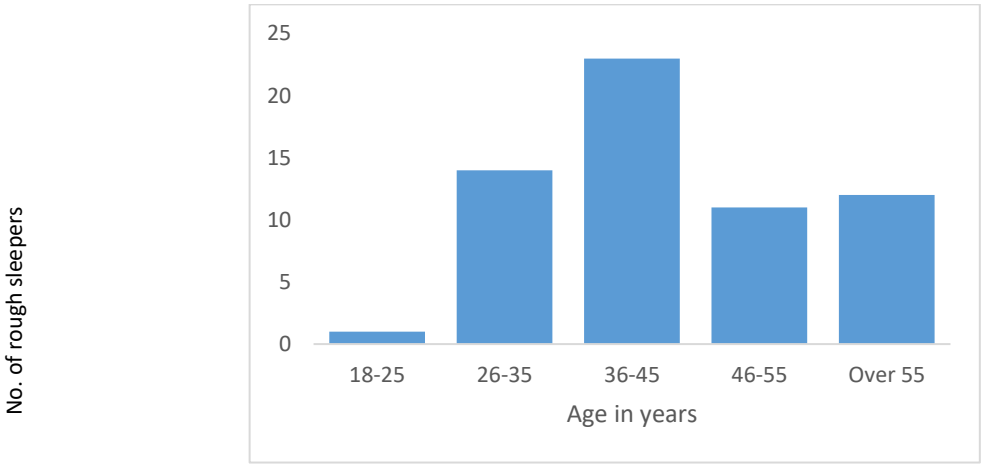
Demographics of Wandsworth's rough sleeping population

Age

The age distribution of rough sleepers in Wandsworth was broadly comparable to that of the age distribution across all outer London boroughs.

- 12% were aged 18-25 years compared to 10% in all outer London boroughs combined.
- 22% were aged 26-35 years compared to 27% in all outer London boroughs combined.
- 33% were aged 36-45 years compared to 29% in all outer London boroughs combined.
- 19% were aged 46-55 years compared to 22% in all outer London boroughs combined.
- 15% were aged over 55 years compared to 12% in all outer London boroughs combined.

Graph 6: CHAIN Count and age distribution of rough sleepers in Wandsworth, 2021-2022



Gender

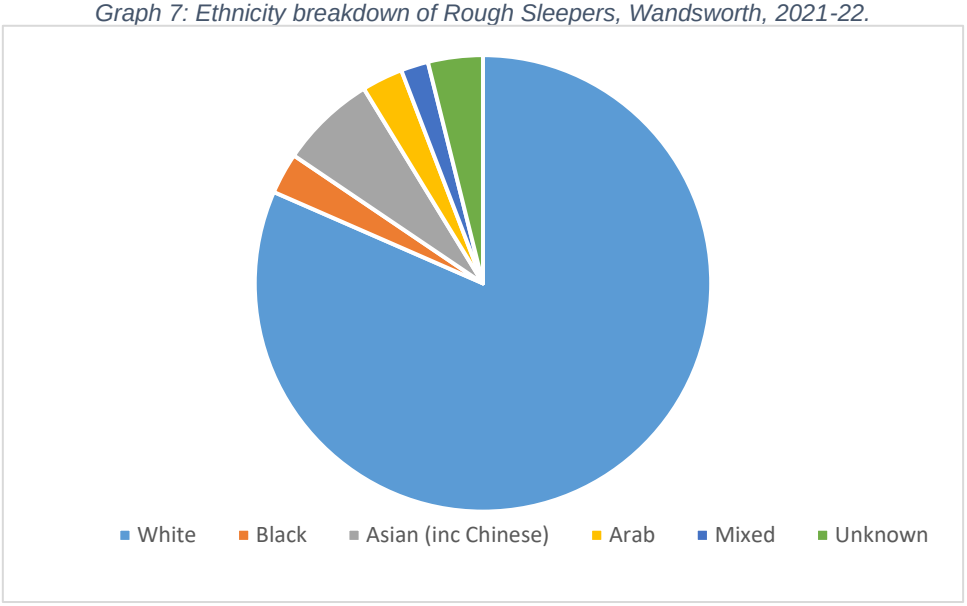
In Wandsworth (2021/22), 80% of rough sleepers were male and 20% female, with none identifying as non-binary. This is in keeping with the proportions seen in outer London boroughs.

Ethnicity

Of rough sleepers in Wandsworth (2021/22), 70% were White which is in line with borough demographics. 16% were Black which is an over-representation given that data from the 2021 Census shows that around 10% of the population is Black[84].

3% were Asian, 5% Arab, 3% Mixed ethnicity and 10% unknown. This compares with an Asian/Asian British or Asian Welsh population of 11.7%, Mixed or Multiple ethnic groups of 6.3% and 4.1% from Other ethnic groups in Wandsworth.

Graph 7: Ethnicity breakdown of Rough Sleepers, Wandsworth, 2021-22.



84 Population Report for Wandsworth https://www.datawand.info/population/#/view-report/63aeddf1d7fc44b8b4dffcd868e84eac/___iaFirstFeature/G3

Nationality

Half of rough sleepers identified between 2021/22 were UK nationals. 30% were from Central and Eastern Europe, 6% Other Europe, 6% African, 3% Asian and the remainder rest of the world or not known.

Experience of institutional settings

Locally, based on CHAIN data from 2020/21 (London and borough specific), the majority of rough sleepers (62%) did not have history of being the armed forces, in care or in prison. However, 3% of rough sleepers in Wandsworth reported being in the armed forces, 7% had experiences of being in care and 26% had been in prison. This is similar to the proportions seen across other London boroughs. Whilst some services use a trauma-informed approach, not all services that rough sleepers come into contact with do, which can be indicated for use when working with individuals with experience of institutional settings.

Housing resource

When comparing housing resources in Wandsworth (considering Wandsworth Council properties and Housing Association houses which include both in-borough and out of Borough properties), there is a gap between the forecasted need and actual resource for people to be housed. In 2021/22 this gap was 252 households fewer available for housing than required[85].

Table 14: Forecasted compared to actual housing resource, Wandsworth, 2021/22

Household type	Forecast housing resource 2021/22	Actual housing resource 2021/22	Difference
1 bed	538	437	-101
2 bed	336	255	-81
3 bed	162	109	-53
4 bed	58	37	-21
5+ bed	3	7	+4
Total	**1097**	**845**	**-252**

An overarching recommendation from the Institute of Health Equity report, Evidence Review: Housing and Health Inequalities in London, was for the GLA and local authorities in London to continue using expertise and experience to advocate for national government action to provide secure, good quality homes for all and recommendations for increasing the supply of social housing were clear[86].

It can be reasonably assumed that, should the actual housing resource stay the same whilst need for housing increases, the health consequences for individuals and families related to homelessness and living in temporary accommodation is likely to increase too.

85 Agenda for Housing Committee on Wednesday, 22nd June, 2022, 7.30 p.m. - Wandsworth Borough Council
86 Alice Munro, Jessica Allen and Michael Marmot, Evidence Review: Housing and Health Inequalities in London, London: Institute of Health Equity

Health services and support for the homeless population in Wandsworth

There are a number of local and national initiatives and services providing health and wellbeing support to the homeless population in Wandsworth. Demand for these services is high and capacity within teams may provide challenges managing this.

Homeless Health Nursing Service

The Homeless Health Nursing Service is an open-access, outreach service which delivers care in non-NHS settings such as the streets, in daycentres, hostels, hotels, bed and breakfasts, churches and specialist GP surgeries[87]. Services are tailored to individual need. The criteria for use of the service includes any form of homelessness (i.e. any form of temporary accommodation, street homeless, any form of supported housing or sofa-surfing).

The Homeless Health Nursing Service in Wandsworth is funded by Central London Community Healthcare NHS trust and operates across Wandsworth as well as in Westminster, Hammersmith and Fulham and the Royal Borough of Kensington and Chelsea. The team is small and has two lead nurses across all boroughs with one health advocate and one nurse to cover Wandsworth. Demand for the service is high and increasing.

Homelessness Inclusion Team

The Homelessness Inclusion Team (HIT) is a pilot service in St George's University Hospitals NHS Foundation Trust. It was originally funded by the Office of Health Improvement and Disparities Out of Hospital Care models (homelessness fund) launched in November 2021. Since then, it has been funded by the South West London ICS until March 2023.

The service accepts people from in and out of London and the number of Richmond residents supported is small. The service supports people facing all forms of homelessness (including sofa surfing, facing eviction or already in a homeless hostel or temporary accommodation) but approximately half of referrals were rough sleeping at the point of acceptance.

The volume of work for the team is high and most focuses on ensuring that patients are safely housed. The team have submitted a funding bid to extend the project and to expand the team to include a mental health worker.

SPEAR

The charity provides support to those facing or experiencing homelessness across South West London (Richmond, Wandsworth, Kingston, Sutton and Merton). This includes the following services[88]:

- An outreach team for rough sleepers that works to support them onto a housing pathway and helps them to link into support services. In addition, the outreach team has navigators who work with clients with complex needs or who are particularly entrenched in street homelessness.

[87] https://clch.nhs.uk/services/homeless-health
[88] https://www.spearlondon.org/our-services/

- Homeless Health Link service which supports people experiencing homelessness to access local healthcare services, receive diagnoses and joined up care, and gain a better understanding of their treatment.

Homelessness, Refugee and Asylum Seeker Team (HRAT)

In Wandsworth, from 1st April 2019, Central London Community Health (CLCH) took over the delivery of the Homeless, Refugee and Asylum Seeker Team (HRAT) health visiting team from St George's Hospital community services. The main objectives of the HRAT are to deliver the National Healthy Child Programme (HCP) to this population. Refugees, asylum seekers and other young families recently arrived from outside the UK, often with no recourse to public funds, require health assessment, advice and guidance, including how to register with a GP, and may present with complex medical and social needs.
The service provides additional targeted interventions that enable or improve access to:

- Healthcare.
- Education, training, or employment.
- Housing and health-related welfare benefits.
- Advocacy.
- Referrals to local services, for example food banks and other health and social care services.

All clients receive face to face mandated touch points and health visiting interventions. Health visitors also regularly visit accommodation to conduct opportunistic interventions, identify need, provide support and onward referral for targeted services. Higher rates of referral for children with developmental delay have also been noted. The homeless health visiting team receive regular and needs led supervision from internal CLCH mental health teams to enhance mental health outcomes.

Health visitors also have regular meetings with housing colleagues to share information regarding families moving in, out or within the borough to ensure continuity of care.

Rough Sleeping Drug and Alcohol Treatment Grant Funded Service

Substance misuse and mental health issues frequently co-exist. The rough sleeping drug and alcohol treatment grant (RSDATG) was set up to fund local areas to implement evidence-based drug and alcohol treatment and wrap around support for people sleeping rough or at risk of sleeping rough, including those with co-occurring mental health needs[89].

As of April 1st 2023 assertive outreach and access to treatment has been provided for those who are at risk of or who are rough sleeping. The service provides access to harm reduction advice and support, engagement and motivation and referral routes to treatment. In Wandsworth the service is now supported by a high tolerance facility which enables individuals to access and maintain their accommodation if they are still drinking or using substances. Drinking is allowed on premises, but drug use is not. People are encouraged to keep their substances safe within their own space and access the range of services available. In Q1 this year a Band 7 nurse delivering support for those with co-occurring mental health and substance use disorders will formally start. Prior to April 2023, the service was operating in a more basic form. Between 1st April 2022 and 31st December 2022, 58 unique individuals engaged with the RSDATG funded service.

[89] https://www.gov.uk/government/publications/rough-sleeping-drug-and-alcohol-treatment-grant-2022-to-2024-funding-allocations

Support needs of the homeless population in Wandsworth

Health data relating to people who are homeless is difficult to obtain as there is no single database that can be used, and the definition of homelessness is not consistent between data collection systems. Data is available predominantly for people who are known or present to services. Therefore, some individuals who are homeless will not be represented in this data or may be represented in multiple services.

The following work informed this section of the needs assessment:

- A desk-based review of local data relating to homeless health
- Informal, semi-structured interviews with stakeholders in the local area working in homelessness services, or services supporting homeless populations in the form of informal.
- An audit of 27 users of the Homeless Health Nursing Service in Wandsworth (between September-October 2022). Further detail relating to the audit can be found in the appendix.
- A survey providing qualitative input from 4 service users of the HHNS at Southcroft church, Wandsworth.

Where the information was available, the type of homelessness the person was experiencing or exposed to in relation to the health needs data has been highlighted below. Further details can be found in the appendix.

Further information can be found in the appendix.

Support needs

Support needs of the statutory homeless population

Of those residents that were owed a duty between April 2021 and March 2022, 936 individuals in 621 households were noted to have support needs, which represents 43% of all households owed a duty[90]. The percentage of support needs in the statutory homeless population in Wandsworth is higher than in the general population as presented in table 15, further data for comparison to the general population can be found in earlier sections of this HHNA.

The most common support needs of households were:

1) History of mental health problems seen in 15%
2) Physical ill health and disability, seen in 13%
3) At risk of / has experienced domestic abuse 12%

Less common support needs included:

- Drug dependency needs (3%)
- Alcohol dependency needs (3%)
- History of rough sleeping (3%)
- Offending history (3%)

[90] Tables on homelessness - GOV.UK (www.gov.uk)

Table 15: Support needs in Wandsworth statutory homeless population compared to estimates in the general population, 2022.

Support need	Percentage of Wandsworth statutory homeless population with support need	General population
Mental health problems	15%	25%
Physical ill health and disability	13%	-
Domestic abuse*	12%	5% annually
Drug dependence needs	3%	3%
Alcohol dependency needs	3%	1%
Offending history	3%	-

Support needs that individually accounted for percentages of 2% or lower in this population include: history of repeat homelessness, learning disabilities, young person aged 18-25 requiring support to manage independently, access to education, employment or training, at risk of/has experienced abuse, at risk of/has experienced sexual abuse or exploitation, old age, care leaver, young person aged 16-17, young parent requiring support to manage independently, former asylum seeker or served in HM Forces.

It is important to note that the initial assessment for HRA 2017 eligibility may not pick up all support needs and these may later be identified in the main assessment. These assessments also rely heavily on the housing team and the individual to identify their needs which is difficult and may not always be appropriate.

Each year, the Council offers housing to a limited number of applicants. The Council's allocation policy gives reasonable preference to various groups through the operation of different housing queues. Following assessment, applicants are allocated into 'queues' based on need as follows:

- General needs queue
- Homeless queue
- Transfer queue
- Council interest queue
- Older persons housing queue
- Physical disabilities queue
- Supported queue (includes mental health, learning disabilities and resettlement)
- Social care queue (includes care leavers, fostering and child protection)
- Pan London mobility scheme (social housing tenants from other London boroughs)

Around a quarter (201 of 845) of people on the housing queues have additional health or social needs. These individuals therefore have additional risk factors for poor health and wellbeing that are impacted on by being homeless and may have worse health outcomes as a result.

Table 16: Number of residents on housing queues with additional needs relevant to health and wellbeing, 2021/22 Wandsworth

Type of queue	Total number of applicants (2021/22)
Older persons housing queue	122
Physical disability queue	15
Supported queue	42
Social care queue	22
Total	*201*

It is important to note that the initial assessment for HRA 2017 eligibility may not pick up all support needs and these may later be identified in the main assessment. These assessments also rely heavily on the housing team and the individual to identify their needs which is difficult and may not always be appropriate. As part of the stakeholder engagement work for the needs assessment, the housing department highlighted training needs around identifying and responding to certain health and care needs at the stage of the initial assessment. There was particular reference to managing the needs of individuals with autistic spectrum disorder. This may be an area where health colleagues can provide support to ensure that the assessment and plan for individuals are appropriate at an earlier stage in the process. Health colleagues highlighted that it is not always clear what is needed or helpful to housing colleagues to support residents with applications. Joint working between housing and health colleagues may help to clarify this.

Support needs of the rough sleeper population

CHAIN annual reports[91] from 2021/2022 highlight support needs by borough, however, the data is not complete as 16% of assessments made by support workers in this data set did not have a support needs assessment documented.

In Wandsworth, of the 189 rough sleepers assessed:

- 107 (56%) had mental health support needs compared to 52% across all outer London boroughs.
- 71 (38%) had more than one of: alcohol, drug or mental health support needs compared to 34% across other London boroughs.
- 63 (33%) had alcohol support needs, compared to 30% in all outer London boroughs.
- 52 (28%) had drug support needs compared to 31% across all outer London boroughs.
- 55 (29%) had no support needs relating to alcohol, drugs, or mental health needs, compared to 27% across all outer London boroughs.

The burden of drugs, alcohol and poor mental health within the local rough sleeping population is high, though it is generally similar to other outer London boroughs.

Support needs of those accessing social prescribing services

While homelessness is not specifically coded as part of the data collection in the Wandsworth social prescribing service and there are limitations around the consistency of coding in the social prescribing system there is important information that can be gathered from the available data[92].

Of 406 people, those who had been referred to the social prescribing team between October 2021 and October 2022 and allocated to the cohort in which ‘housing issues’ were their primary concern:

- 62% had social needs.
- 20% had mental health issues.
- 8% were socially isolated.
- 14% had a physical condition recorded including: type 2 diabetes, prediabetes, overweight or obesity, cancer, cardiac conditions, post-COVID-19/long COVID-19, long term condition management, chronic pain or physical inactivity – though this is thought to be an underestimation of chronic health conditions in the cohort due to coding.

Some individuals may have had a combination of these issues.

[91] CHAIN Rough sleeping snapshot in England: autumn 2021 - GOV.UK (www.gov.uk)
[92] Elemental, Social Prescribing Wandsworth October 2022

The ‘housing issues’ cohort is one of the largest groups in all social prescribing cohorts, and while not all are likely to be homeless, some will be. Though housing issues can relate to numerous things, those working in the service report that a number of individuals are homeless, threatened with homelessness or awaiting assessment by the Council.

The social prescribing team is unable to deal with housing issues directly but provides an advocacy role or helps individuals to navigate the system and fill in required paperwork or support with onward referrals to other local services.

It was highlighted that the emergency housing line for professionals with urgent homeless enquiries was highly valued by staff and useful. The service does not accept referrals if the individual has a high-end mental health need, unless their mental health is stable enough to use the service and is for those aged 18 and above (though one service within the borough accepts aged 13 years and above).

Rough sleepers are unlikely to be represented in this data set, primarily due to access issues, and the data is more likely to reflect the needs of those who are homeless but in accommodation with access to mainstream services.

Mental health needs

Poor mental health can be a cause and consequence of homelessness and data highlights high levels of need in the homeless population in Wandsworth. One of the key priorities of the South West London Homeless Health programme, as highlighted in the ‘policy context’ section of this needs assessment, is to improve the mental health offer for people experiencing homelessness.

The 2013 Wandsworth Homeless Health Needs Assessment (see appendix) included a survey of 97 homeless people (71% males and 29% females aged between 18-55 years). Of this population: 7% were rough sleepers, 3% were squatting and 85% were accommodated in supported, hostel, B&B or temporary accommodation. The survey highlighted:

- 61% reported a mental health diagnosis.
- 42% reported a diagnosis of depression.
- 23% reported a co-occurring diagnosis.

Both talking therapies and practical support were deemed to be helpful and desired by the participants of the survey to improve the mental health of this population.

Whilst the data is not directly comparable, it is useful to reflect on as it demonstrates the longstanding nature of local issues relating to homelessness. Data from the Wandsworth Mental Health Needs assessment showed that in 2017/18, of the 822 households who were homeless and in priority need, an estimated: [93]

- 104 people had a psychotic illness (12%)
- An estimated 94 had major depression (11%)
- Estimated 190 had a personality disorder (23%)

Of the 137 rough sleepers recorded in June 2022 an estimated:

- 23 had severe depression (17%)
- 19 were self-harming (14%)
- 26 were experiencing suicidal thoughts (19%)
- 82 had a personality disorder (60%)
- 7 had bipolar disorder (5%)
- 5 had schizophrenia (4%)

[93] Bethan Harries, Melissa Barker, Graeme Markwell & Natalie Daley Wandsworth Mental Health Needs Assessment, Public Health Team, Wandsworth Council available at: https://wandsworth.gov.uk/media/12915/mental_health_needs_assessment.pdf

The data highlights that the complexity of mental health needs experienced by those who are homeless. Such forms of mental ill health are likely to impact on how and whether an individual is able to interact with services.

Mental health and wellbeing need in rough sleepers

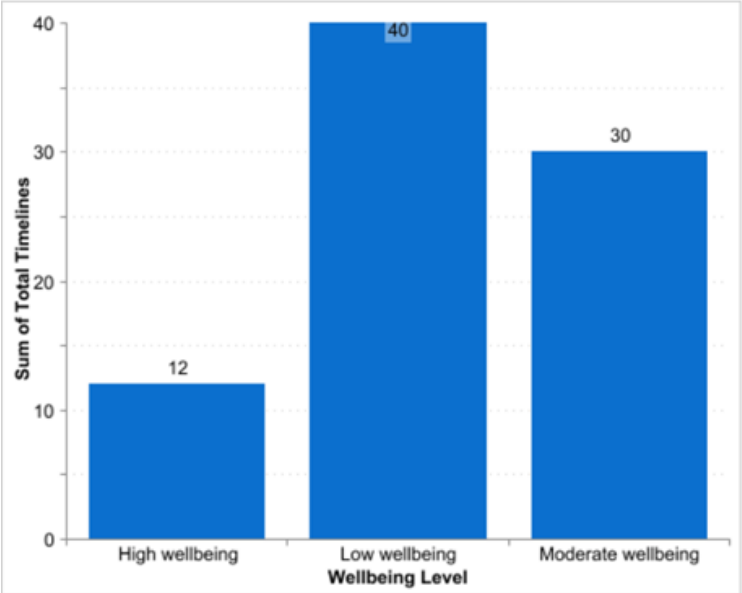
CHAIN annual reports from 2021/2022 highlight that in Wandsworth, of the 189 rough sleepers assessed, 56% had mental health support needs compared to 52% across all outer London boroughs[94].

The SPEAR Homeless Health Link service is part of the broader offer from SPEAR works to identify and challenge health inequalities faced by people who are homeless in Wandsworth. It connects homeless people with health services and support including GP registration, dentistry, mental health support, nutrition, social services, sexual health services, podiatry and general wellbeing service.

Between 1st December 2021 and 30th November 2022, 127 patients were seen by the Homeless Health Link service across both Richmond and Wandsworth. Of those, 63% have had an assessment using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) which gives an indication of mental wellbeing. This found:

- The majority (55%) had a 'low wellbeing' level.
- A large proportion (41%) had a 'moderate wellbeing' level.
- Just 16% had a score indicating 'high wellbeing' level.

Graph 8: WEMWBS Score for patients in the Homeless Health Link Service (SPEAR) December-November 2021/22, Richmond, and Wandsworth



In the same time frame, the Health Link team worked with 35 people in Wandsworth. 40% of their clients were noted to have mental health problems – the majority being depressed or anxious.

It's important to note that only around half of people reporting mental health problems had received a formal diagnosis and those working in the service highlighted that initial assessments may not identify the complexity of mental health need. Reasons for this include time needed to build the trust required for clients to feel safe enough to disclose mental

[94] CHAIN Rough sleeping snapshot in England: autumn 2021 - GOV.UK (www.gov.uk)

health problems to the team; and it often takes time to gain access to historical notes relating to mental or physical health notes from health services. Therefore, these numbers may be lower than actual numbers of individuals within the service experiencing mental health problems.

Individuals accessing the homeless health nursing service

An audit of 27 users of the homeless health nursing service was conducted between September and October 2022. This showed that 18% of people presenting to the service had mental health problems as their primary presentation. These included low mood, depression, suicidal ideation, self-neglect and poor sleep. Nine patients (33%) had a history of mental health problems, which did not always relate to their presenting complaint. These included depression/low mood, suicidal ideation or suicide attempt, post-traumatic stress disorder, personality disorder, eating disorder, schizophrenia, unspecified mental health problem and anxiety. Some patients had multiple mental health diagnoses. Further details of the audit can be found in the appendix.

Individuals accessing social prescribing services

The social prescribing team only accepts referrals from those whose mental health is stable enough to use the service. Data shows that the mental health burden in patients seen by the service with housing issues was high and reportedly difficult to manage. The recorded 20% of those with housing issues who had mental health problem is thought to be an underestimate, as mental health needs featured in almost all service users facing housing issues, homelessness or threatened homelessness. It was also noted that mental health needs associated with housing issues may not always be a diagnosed mental health condition. Examples reported by staff included:

- Suicidality related to housing situation (e.g. sheltered accommodation or housed far from support network).
- Stress and extreme anxiety due to lack of clarity around threatened homelessness and limited contact available between residents and the housing department.
- Difficulty engaging with other health interventions due to pre-occupation with imminent homelessness and prioritisation for the individual.
- Mental health issues around conditions of the home (damp, infestations etc).
- Stress related to overcrowding in the home.
- Lack of continuity of care when individuals are rehomed out of borough.

These presentations often lead to referrals to Improving Access to Psychological Therapies (IAPT) services. However, it was also noted by those working in the homeless sector that engagement with mental health services for patients was reported to be difficult in some circumstances given their pre-occupation with their housing situation.

Rough sleepers with co-occurring mental health and substance misuse conditions

The most recent data available from the Office for Health Improvement and Disparities[95] for Wandsworth (1st July 2022-30th September 2022) identified that the mental health need among clients funded through the grant is higher than seen or recorded in other homeless populations locally. 74% of clients were recorded as having a mental health need. Of the 7 people who were rough sleeping:

- 4 had a treatment need but had not engaged with mental health services

Of the 28 service users deemed at risk of rough sleeping:

[95] Rough Sleeping Drug and Alcohol Treatment Grant. Monitoring Pack, v2.2. Wandsworth . 30th September 2022 period 1st July 2022 – 30th September 2022 Office for Health Improvement and Disparities.

- 7 had engaged in mental health treatment prior to engaging with the RSDATG funded service.
- 4 had engaged with mental health treatment since engaging with the RSDATG funded service.
- 7 had a mental health need but had not engaged with mental health services.
- 8 did not need mental health treatment.

It was highlighted in stakeholder engagement that those with no fixed address and who are using drugs or alcohol face challenges accessing mental health support. It is particularly difficult for people to engage with mental health services while rough sleeping and becomes easier when individuals are in accommodation. This is often due to referral criteria for mental health services excluding people who use drugs or alcohol or who are homeless from using the service. Stigma experienced by homeless people or who are using drugs or alcohol when attempting to access mental health services locally has been reported and this acts as an additional barrier to access. Furthermore, local mental health services are typically delivered within mainstream service models rather than outreach models or in locations where homeless populations attend, creating evermore barriers to access.

However, those in the RSDATG service who were in accommodation (i.e. at risk of rough sleeping rather than currently rough sleeping) were more likely to engage with mental health prior to and since engaging with the service, highlighting that once in accommodation, accessing services for rough sleepers is easier than when rough sleeping. This has been re-iterated by those working with the SPEAR team locally.

Homeless individuals supported by the Homelessness Inclusion Team

Those working in the service reported that the burden of mental health issues in the patients referred into the service is high. An audit into the effectiveness of care was undertaken in October 2022 and found that of the 20 patients included in the audit:[96]

- 65% had mental health problems.
- 1 in 5 patients had co-occurring mental health and addiction problems.

This audit looked at a sample of 10% of patients seen and examined whether everything that could be done for the patient had been done whilst under the HIT including engagement with mental health services. In only 10% of admissions was mental health noted to be managed thoroughly, commonly linked to patient engagement, discharge from psychiatry services (such as liaison psychiatry) or the HIT being unable to meet needs.

The audit indicated that those who are seen as inpatients by the HIT team have high mental health needs and are often managing both mental and physical health problems, with addiction problems often co-occurring too.

The volume of work for the team is high and the majority of the work focusses on getting patients safely housed. The team have currently submitted a funding bid to extend the project and to expand the team to include a mental health worker.

It is important to note that this service accepts patients from all over London and from outside of London. However, approximately 60% of accepted referrals were individuals from Wandsworth, Merton, or Croydon. Around half of referrals were rough sleeping at the point of acceptance, others were sofa surfing, being evicted or already in a homeless hostel or temporary accommodation.

[96] St George's Homelessness Inclusion Team 9 month evaluation report 29th November 2021-31st August 2022

Physical health needs

Poor physical health can be a cause and consequence of homelessness. Data linking physical health problems and homelessness is limited as most health services do not routinely record housing status. Often, individuals working in health services do not know if a person is homeless unless it is disclosed, or the individual is visibly rough sleeping.

Individuals accessing the SPEAR Homeless Health Link service.

From 1st December 2021 – 30th November 2022, the SPEAR Homeless Health Link team worked with 35 people in Wandsworth. Almost half (46%) had physical health problems, the highest proportion of which were dental or musculoskeletal complaints, in keeping with the physical health problems when the 2013 homeless health needs assessment was undertaken.

Individuals access the homeless health nursing service.

An audit of 27 users of the homeless health nursing service in Wandsworth was undertaken between September-October 2022. Individuals using the service presented with the following physical health needs:

- Musculoskeletal problems
- Abdominal complaints
- Alcohol-related issues (including Wernicke's encephalopathy and withdrawal)
- Cancer
- Contraception
- Pregnancy
- Skin (including leg ulcers, insect bite)
- Kidney problems
- Poor diabetic control
- Poor memory
- Breathing problems
- Bereavement

Almost all patients had at least one co-morbidity. These included:

- Chronic physical health conditions (77%)
- Co-occurring substance misuse issue (60%)
- Mental health issues (33%), often linked to their presenting complaint.
- Learning difficulties (7%)

The complexity of need in this population highlights the need for holistic and generalist approaches to care; and the necessity for longer appointments to allow for opportunistic management of acute and chronic issues with patients that do not routinely present or use mainstream models of healthcare.

Substance misuse needs

Drug and alcohol support needs are seen in both the statutory homeless and rough sleeper populations, although are higher among rough sleepers. They are also higher than in the general population in Wandsworth.

Table 18: SPEAR Substance and alcohol misuse needs by percentage in rough sleeper population, compared to statutory homeless population, Wandsworth 2022

	% of rough sleepers	% of statutory homeless population
Substance misuse need	26%	3%
Alcohol misuse need	25%	3%

Individuals supported by the Homeless Health Nursing Service

Of the 27 patients in the Homeless Health Nursing Service, 60% (16) had substance misuse problems:

- A quarter of this group had concurrent alcohol and drug use problems.
- 11 patients used only alcohol (41% of all patients.)

Individuals supported by the Homelessness Inclusion Team.

Those working in the HIT reported that a large percentage of the patients have drug and alcohol problems. An audit of the service in October 2022 found that of the 20 patients included, 65% had problems with addiction and 20% of patients had co-occurring mental health and addiction problems. [97] The audit noted that a quarter of addiction problems were managed thoroughly as an inpatient but none after discharge. This was thought to be due to a lack of communication with addiction services following discharge.

Individuals accessing the rough sleeping drug and alcohol treatment grant funded service.

Data from July 2022 to December 2022 shows that 74 people were engaged in the service over this period. 62 were at risk of sleeping rough and 12 were rough sleeping. 17 had problematic opiate use while 12 had problematic alcohol use (with no other problematic drug use).

Support needs expressed by users of the Homeless Health Nursing Service

Four attendees of the Homeless Health Nursing Service at Southcroft Church were surveyed on what matters most to them in relation to their health and wellbeing. The survey focussed on values and an asset-based approach to health and wellbeing.

Even though there are very few responses, themes around mental health was prominent - not necessarily referring to diagnosable conditions but reference to ‘stress’, ‘worry’ and ‘good spirits’ feature along with reference to mirtazapine, a prescription medication for common mental health problems such as depression, and occasionally obsessive-compulsive disorder or anxiety.

Basic needs such as being able to work, getting rest or sleep and eating breakfast were highlighted to support individuals to feel well and have more good days along with maintaining or making meaningful relationships, with reference to social connection and support from primary care around medication.

[97] St George’s Homelessness Inclusion Team 9 month evaluation report 29th November 2021-31st August 2022

Table 17: Responses from service users of Homeless Health Nursing Service, Southcroft Church, Wandsworth, 2022

What matters to you the most?	**What helps / supports you to take care of your health and wellbeing?**
"To have no stress, not too much thinking"". *"I'm worried about my health - my lung function, worried about problems with my spine, and numbness in my hands and shoulder"".* *"Family – I want to be healthy for my family".* *"Good spirit, to be in good spirits".*	*"Not sure"* *"My GP has done a lot to help me with my medication".* *"When I'm not drinking alcohol, and when I eat breakfast, it helps".* *"Getting rest"*
What does a 'good day' look like for you?	**What would support you to have more frequent 'good days'?**
"Some days are okay". *"With my health, I don't really have good day"".* *"When I get up in the morning, eat breakfast like toast and can go for a walk in the park with my girlfriend".* *"When I can go to work, and be in good health is a good day".*	*"Talking to family and spending time with my friends supports me".* *"Getting access to medicines like mirtazapine that help me get some sleep helps".* *"Having a job, and not drinking alcohol helps".* *"To have someone you love by your side".*

Further information related to the survey can be found in the appendix.

Healthcare services

Demand for services

Homeless Health Nursing Service

Demand on the service has increased in the last year. From April 2021 to March 2022 there were 68 clinical contacts per month for 1.8 WTE staff. Between April 2022 and September 2022 there was an average of 100 contacts per month for the same staffing levels, representing a 47% increase in clinical contacts per month. The duration of an appointment can vary between 35-68 minutes and follow-up of case work can vary from 20-45 minutes per contact, highlighting the complexity of the caseload. Therefore, over one month, the service is providing between 29.3 hours – 60.3 hours of additional clinical and case work compared to last year.

Social Prescribing

Of the 3717 patients referred to the social prescribing service between October 2021 and October 2022, 406 (10%) of those referrals included 'housing issues' as one of the reasons for referral, highlighting the impact that poor or insecure housing can have on local services.

Homeless, Refugee and Asylum Seeker Team

The table below outlines the caseload for the HRAT in April and May 2019. The levels correspond to the Child Protection Levels of Need Framework. The levels are described as follows[98]:

Level 1 (universal): the child has no additional needs.
Level 2 (early help/targeted support): the child has emerging needs requiring early help.
Level 3 (child in need): the child is at significant risk of not achieving positive outcomes if they don't receive support from specialist services.
Level 4 (child protection and specialist support): the child is suffering or likely to suffer significant harm.

Table 18: Case load of the HRAT service in April and May 2019

Child Protection level[1]:	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Homeless Children	-	180	6	7
Rough sleepers/Refugees and asylum-seeking children	-	29	2	-
Total	n/a	**370**	**16**	**7**

In February 2022, the total caseload for the homeless health visiting team was 265 (245 at level 2; 16 at level 3 and 4 at level 4).

Access to care

General Practice

The data around homelessness within general practice is limited as there is currently no standardised way to be identify someone as homeless on EMIS. In addition, patients face

98 Wandsworth Level of Need Framework to Multi-Agency Partners Homeless, Refugee and Asylum Seeker Team

barriers to getting appointments and some may choose not to disclose their housing status. Therefore, it is difficult for GPs to identify those may be or at risk of homelessness.

Barriers to healthcare for people who are homeless include[99]:

- Lack of ID or an address.
- Language, literacy, and cognitive issues.
- Mental health and addiction issues.
- Poverty (e.g. having no credit on one's phone).
- Digital exclusion.
- Practical issues e.g. 'Who will look after my dog?'.
- Lack of trust.
- Embarrassment.
- Concerns about NHS charges.

Work by the charity Doctors of the World highlighted that patients without identification are frequently wrongly turned away from GP registration, despite NHS England guidance stating that this should not be a barrier[100].

In Wandsworth, as of December 2022, 54% of all GP practices (21 of 39) were signed up to the Doctors of the World 'Safe Surgeries' initiative supported by NHS England. The initiative makes clear that a lack of ID or proof of address, immigration status or language should not be barriers to patient registration. Safe surgeries should commit to taking steps to tackle barriers faced by inclusion groups to accessing healthcare. Below is the list of GP practices signed up to the Safe Surgeries initiative:

- Balham Park Surgery
- Battersea Fields Practice
- Battersea Rise Group Practice
- Bolingbroke Medical Centre
- Bridge Lane Group Practice
- Brocklebank Practice
- Chartfield Sugery
- Chatfield Health Care
- Elborough Street Surgery
- Lavender Hill Group Practice
- Mayfield Surgery
- Southfields Group Practice
- St John's Hill Surgery – Begg Practice
- Streatham Park Surgery
- The Alton Practice
- The Earlsfield Practice
- The Greyswood Practice
- The Haider Practice
- The Junction Health Centre
- Thurleigh Road Practice
- Tudor Lodge Health Centre

[99] Gunner, E et al, 2019, Elwell-Sutton, T et al, 2017
[100] Doctors of the World, 2017, 2018

A key focus of the South West London Homeless Health Programme is improving access to primary care. Local data shows that GP registration among groups of homeless people already linked to services is relatively high:

- Between 1st December 2021 – 30th November 2022, the Health Link team has worked with 35 people in Wandsworth, 89% of which were registered with a GP, or were already registered.
- As many as 96% of those at risk of rough sleeping and in the RSDATG service were registered with a GP.
- Of the homeless population seen by the Homeless Inclusion Team (HIT) in St George's, GP registration was checked for 85% of patients, and whilst the majority (85%) were registered with a GP, 15% had no GP or an inappropriate GP unlikely to be providing care.
- Furthermore, following discharge from the HIT team, only around 30% of cases continued to be managed thoroughly after discharge, though GPs were identified and contacted in around 90% of these cases and GP engagement was noted to be high, the reality of getting appointments was difficult.

However, stakeholders reported that despite this, getting an appointment, particularly for rough sleepers, was very difficult. The following data gives some understanding of registration to GP services locally for people experiencing homelessness. Reasons reported for this include:

- Digital exclusion.
- Experience of stigma in waiting rooms or by staff when attempting to make an appointment.
- Difficulty keeping track of appointments and attending within certain times (particularly mornings).
- Historical distrust or poor experience of healthcare system.
- Appointments inappropriately short given the complexity of need.
- Being refused registration.
- Difficulty prioritising health in current social situation.

Battersea Fields practice is an example of a surgery that has good relationship with the SPEAR rough sleeping team and can accommodate appointments for rough sleepers, but the demand for primary care in this cohort is high.

Effectiveness of care

An audit of the HIT was undertaken in October 2022 to look at the effectiveness of the care provided. This involved a review of the care received by a sample of 10% of the patients seen. It showed that a full, holistic assessment was completed and documented for 55% of patients. Physical health was noted to have been managed thoroughly during admission in 75% of admissions, with 70% of cases having their medications managed thoroughly. However, following discharge only around 30% of cases continued to be managed thoroughly. Although GPs were identified and contacted in around 90% of these cases and GP engagement was noted to be high, getting an appointment was difficult. It should be noted that the audit is not limited to Wandsworth patients.

A key focus of the team's work is ensuring that patients are safely housed. Housing outcomes achieved between admission and discharge, across the service's entire patient cohort (not just the those included in the audit), show how effectively this is being carried out:

- Rough sleeping decreased by 77% (39 people prevented from rough sleeping).

- Over half of rough sleepers were found temporary accommodation or hostel placements on discharge.
- Rough sleeping, insecure housing and sofa surfing situations collectively reduced by 55%.
- The percentage in temporary accommodation placements on discharged increased from 8% on admission to 31% on discharge.

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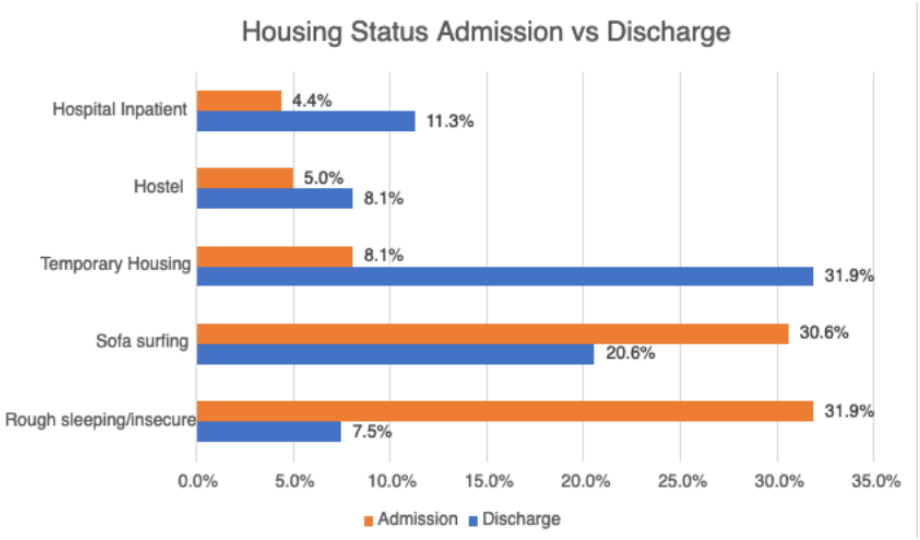
Graph 10: Housing status of individuals accepted as referrals by the HIT team Nov-June 2022 at both admission and discharge, St George's Hospital, London



The HIT team are an example of where specialist teams within health settings can provide an opportunistic and proactive approach to improve a person's physical and mental health as well as improving housing situation when provided with capacity. Furthermore, patient feedback is very positive[101].

Kingston and West Middlesex currently do not have similar schemes, despite homeless residents in Wandsworth presenting there to access care.

[101] Rough Sleeping Drug and Alcohol Treatment Grant. Monitoring Pack, v2.2. Wandsworth . 30th September 2022 period 1st July 2022 – 30th September 2022 Office for Health Improvement and Disparities.

Stakeholder views

Informal, semi-structured interviews were conducted with 25 people working across the council, healthcare and voluntary and community services across Wandsworth to support homeless people. A qualitative analysis of interviews was undertaken and presented as strengths, opportunities, gaps and challenges and local priorities were identified by stakeholders. The key findings are presented in table 20.

Table 19: Stakeholder views of homeless health needs presented as strengths, opportunities, gaps and challenges relating to Homeless Health services in Wandsworth, December 2022

Strengths	**Opportunities**
• Growth in the sector. • Multidisciplinary approach during Everyone In/Homes for Ukraine – positive, well received. • Housing First. • Homeless health days well received. • Training in inclusion health positively received. • Volunteers and high interest in the borough.	• Momentum across all sectors for joint working, priority in multiple sectors. • Expansion of several teams planned. • Ram Street clinical space. • Existing primary care initiatives that may be better utilised. • Mental health commissioning priorities for low level mental health support across the council. • Re-engage prisons through homeless health. • Physical health assessments as part of the RSDATG service • Homeless health days and health clinic days with. Wandsworth Community Empowerment Network planned.

Gaps
<u>Healthcare</u>
• Current mental health provision not meeting needs.
• Access to primary care and generalist care is difficult, despite often being able to register with services.
  ○ Management and prevention of long-term conditions is minimal.
  ○ Musculoskeletal needs are high.
• Homeless Inclusion Team
  ○ No current community handover process
• Continuity of care difficult – particularly when there are multiple moves or when moved out of borough.
• Dental care and podiatry are difficult to access.
• Access to phlebotomy and prescribing difficult and inconsistent across services.
	Challenges
	• Complexity of need and time needed with individuals to build trust.
	  ○ Entrenched rough sleepers/opioid use – particularly challenging to build relationships.
	• Mental health is not a priority for individuals facing homelessness.
	• Mental health burden is not always diagnosable.
	• Homelessness is not always visible to health services.
	• Access to mental health support remains challenging with co-occurring substance misuse and mental health.
	
	<u>Housing</u>
	• People moved out of the borough.

• Secondary care is not always flexible regarding individual needs for appointments.
• Over-reliance on voluntary sector to provide healthcare.
 	
<u>General</u>
• Housing that is appropriate for needs is lacking and demand is greater than supply.
• Communication between teams and with individuals who are homeless are complex.
• Engagement with prisons is low.
• Not enough 1:1 support for individuals (e.g. admin/service navigation) – build rapport and trust.
• Training for frontline staff around homelessness and inclusion health
• No health and wellbeing offer for statutory homeless population beyond signposting to mainstream services.
• No clear collective local homeless network/'offer' that all partners are aware of.
• No deep dive into homelessness among children and families in current needs assessment.
• No day centre service in the borough.
• Relationships/social connection.
	• Forecasted housing supply not able to meet demand which will have a detrimental impact on health and health services.
	• Conditions of housing exacerbating health conditions.
	
	<u>General</u>
	• COVID-19 aftermath and the cost-of-living crisis.
	• Basic needs not met (food, warmth)
	• Staffing – capacity, burnout and recruitment are challenges across most services.
	• Difficult to know how to manage people with no recourse to public funds.
	• Mainstream models of care not always accessible
	• Communication
	  ○ Between teams – not well established across the homelessness sector.
	  ○ With clients – digital exclusion, confusing, overwhelming with multiple services.
	• Stigma and organisational prejudice around homelessness witnessed locally, particularly where substance misuse is involved.
	• "It's difficult to quantify or overstate the amount of time and work needed for a complex patient in a complex situation".

Consensus around the key principles underpinning work on homeless health from the stakeholder analysis included:

General principles:

- To build on the momentum of the expansion of homelessness services locally over recent years and work more collaboratively as a network.
- Prioritise basic needs to support health in people experiencing homelessness.
- Ongoing work to understand and reduce inequalities in people experiencing homelessness locally.
- Advocate for and support prevention work around the main causes of homelessness locally (family no longer accommodating, end of tenancy, domestic abuse).
- The complexity of health need in this population to be considered in all future service planning for the homeless population.
- To increase engagement and co-creation of services with residents experiencing homelessness.

Specific needs were highlighted:

- Increased mental health provision for homeless and rough sleeper populations locally is needed; need is high in homeless population and not met with current service provision.
- Primary care and prevention of long-term conditions to be prioritised in rough sleepers including access to GPs, practice nurses, musculoskeletal services, dental services, and podiatry services.
- Reconsideration of where and how current health services are delivered for homeless populations locally, particularly in the case of rough sleepers and there currently being no in-borough day services.
- Reduce the number of accommodation moves a person makes as it disrupts continuity of care. Where this is not possible, improve ways of working where individuals are moved.
- Building on the success of the Homelessness Inclusion Pathways team at St George's, supporting the community handover process.
- Maximizing on the expansion of the Rough Sleeper Drug and Alcohol Grant service to further understand health needs within rough sleepers locally, using data already being regularly collected to do so.
- Explore options of how people at risk of or experiencing homelessness can be supported in their relationships.
- Deep dive health needs assessment for children and families experiencing homelessness.
- Support for staff working in the homelessness sector given difficulty recruiting and retaining staff.

Further information and detail on the above findings from the stakeholder analysis can be found in the appendix.

Recommendations

Two stakeholder engagement workshops were held to develop draft recommendations and establish local priorities. It was agreed that further work around homelessness should build on the principles of:

- Reducing health inequalities in people experiencing homelessness
- Prioritising basic needs of people experiencing homelessness to support health

Specific priorities and recommendations identified based on this needs assessment, along with enablers, were identified as presented in table 21.

Table 21: Priorities, recommendations and enablers from Wandsworth Homeless Health Needs Assessment, January 2023

Priority	Level of priority	Recommendation(s)	Enablers
To increase collaborative working in the homeless sector to improve the health of people experiencing homelessness.	High priority Short term	Identify systems and processes to collaborate both operationally and strategically and avoid duplication of work. Establish approach for communicating needs identified locally to Integrated Care System (ICS). Improved communication and cross-training between health and housing relating to understanding of services available and how sectors can support each other. Re-establish multidisciplinary team (MDT) for complex patients with housing to understand their needs. Consider joint declaration on action on homelessness between Housing, Adult Social Care and the South West London Integrated Care Board.	Engaged stakeholder group identified while carrying out the homeless health needs assessment. Established meetings potential vehicle for action and collaboration: • Homeless Health Programme (ICS) – SWL Steering group. • Borough level rough sleepers monthly meeting (multi-agency). • Weekly housing meetings (Fridays). • MDT meeting hosted during ‘Everyone In’ could be re-established and re-purposed for discussion of complex cases and is supported by partners. • Presenting findings of homeless health needs assessment to Senior Management Team in the Council. New three-year Homelessness and Housing Strategy due – Housing department presenting to Senior Management team in April 2023

			Adult Social Care Assurance Framework and peer review (from April 2023) will review evidence of relationships between Public Health and Adult Social Care including evidence of effective working and shared goals. Housing team identified training requirements around how to manage certain needs e.g. autism spectrum disorder. Healthcare partners have identified training needs on understanding what information is useful for them to share with the housing team and at what stage. Therefore, upskilling across sectors may be valued by both partners.
To improve the mental health offer for people experiencing homelessness.	High priority Short (rough sleepers) and medium term	Improve access to mental health services locally. Improve access to community mental health team for assessments. Improve mental health offer for people with co-occurring conditions of mental illness and substance misuse.	Funding from NHSE identified and in place for mental health prevention across Merton and Wandsworth via the South West London Transformation group. Decision on use pending. Adult Social Care and Public Health are working with the Ethnicity and Mental Health Improvement Project (EMHIP) identifying hubs and locations in each area in Wandsworth where there is a mental health offer and plan to overlay community mental health teams services and other mental health service providers onto that for mental health support and assessments. Adult Social Care and South West London steering group currently recruiting for a co-occurring conditions role. Work is planned to review co-ordination of services for co-occurring substance misuse, poor physical health and poor mental health. Working group to be set up in 2023/24 financial year. Grant funding in place. New South West London level Rough Sleeping and Mental Health Programme planned for April 2023 -

			steering group meetings currently taking place, opportunity to influence the service. Wandsworth RSDAG service actively recruiting psychologist and co-occurring conditions nurse – capacity expanding and good link with psychiatry clinicians. St George's Homeless Health Inclusion Team recently bid to expand the team to include mental health worker. South West London Homeless Health Programme priority to improve mental health offer. Pan-London co-occurring conditions programme with South West London ICS lead and funding until 2024 Mental health needs assessment recently undertaken by the Public Health team has furthered collaborative working and commitment within the Council.
Reconsider *where* and *how* health services are delivered for rough sleepers.	High priority Short-medium term	Locate services in places that rough sleepers are already attending. Consider outreach models for services where access is particularly difficult. Provision of day services in Wandsworth, with potential for co-location of services, including those supporting health and wellbeing, co-created with people experiencing homelessness. Health and wellbeing days to be continued as a system in short-term whilst establishing improved access to care in the medium-term.	Housing department plans for Rough Sleeper Hub in Wandsworth – core of new rough sleeper strategy could enable co-location of services. Collaborative work around shaping services located at the hub to support health holistically. New clinical space in Ram Street, Salvation Army although there is ambiguity regarding the ability to use it. Funding identified at stakeholder meeting for continued support for Homeless Health and Wellbeing Days – Head of Transformation (ICS) and Prevention and Wellbeing - Targeted services team (DASCPH) currently discussing. Opportunity to cross over health and wellbeing days with 'Health Clinics' run by Wandsworth Community

		Collective approach to outreach across services to reduce re-telling of stories.	empowerment network (WCEN) who are interested in engaging regarding homelessness and health. Health bus (Public Health) with clinical space currently undergoing review of use and funding, opportunity for collaboration to deliver outreach services. Adulty Social Care prevention and wellbeing (mental health and wellbeing) team reviewing where mental health services are delivered locally with aim to bring services to places in which key providers and organisations already have an established location that is being used to improve access to mental health services.
Improving access to primary care appointments for rough sleepers.	High priority Short and medium term	Creatively using schemes in place in primary care to improve access to appointments for rough sleepers. Consider outreach model for generalist and primary care appointments for rough sleepers. Support access to appointments following physical health assessment by RSDATG if physical health needs identified. Support community handover from Health Inclusion Team at St George's to primary care. GP practices to work collaboratively with Homeless Health Nursing Service and SPEAR Homeless Health Link Service across the borough.	South West London Homeless Health Programme priority to improve access to primary care. Severe mental illness health checks, high need multiple long term conditions schemes or home visits to day centres could be utilised to improve access for rough sleepers and are already in place. Opportunity for primary care to attend health and wellbeing days or 'Health Clinics' run by WCEN who are interested in engaging. Potential for primary care service via health bus depending on funding, in rough sleeper hub or in Salvation Army clinical space. Supporting local practitioners with special interest in homeless and inclusion health to improve services for access to primary care for rough sleepers e.g. GP SPIN fellows.

		Consider increasing Homeless Health Nursing Service capacity further given demand and support in applications for funding with health needs assessment findings.	Battersea Fields Practice has good links with homeless health services. Homeless Health Nursing Service applying or funding to expand team.
Improved access to preventative health support, dentistry, podiatry and musculoskeletal services for people experiencing homelessness, particularly rough sleepers.	Medium priority Medium term	Review of musculoskeletal, dental and podiatry services with focus on issues relating to access for rough sleepers. Review of preventative health services for people experiencing homelessness, including access to healthy food, physical activity options, safe spaces for sleep/rest and enabling meaningful social connection.	SWL Transformation group reviewing dental and podiatry support in Kingston and Richmond, awaiting further understanding of the London approach before continuing. Deputy Director Transforming Primary Care, Wandsworth offered to further discuss and support in review of access to musculoskeletal services in Wandsworth for people experiencing homelessness. Use of Homeless Health days to provide access to services. Social prescribing link workers are in place. Rough Sleeper Hub.
Targeted, collaborative work to reduce health inequalities in people experiencing homelessness.	High priority Short term	Education and training across services to reduce stigma around homelessness, advocate for trauma informed care and highlight services available for homeless populations. Cross-service understanding of local services that support basic needs for people who are homeless. Deep dive into health needs of children's and families experiencing homelessness.	Glassdoor, SPEAR and Health Inclusion team have all developed materials for educational sessions which could be shared. SPEAR have resources with local services available to people who are homeless which could be developed and distributed. Wandsworth Community Empowerment network interested to engage around improving homeless health. The ICB has a statutory role in reducing inequalities. Pan London co-occurring conditions programme with South West London ICS lead and funding until 2024

Increasing social support for people who are homeless to support and maintain relationships beneficial for health.	High priority Short-medium term	Prioritise social support in people who are homeless. Expand 1:1 support available for people experiencing homelessness, to navigate services and reduce story telling.	Social prescribing team for personalisation of support Adult Social Care Prevention and Wellbeing Team looking at work relating to 'every door is the right door', with 1:1 key worker enabling navigation of services with a named individual.
Adapting as a network to support residents and meet needs when resources not available.	Medium - Long term	Sustainable approach needed to maintain access to services or link with out of borough services when people are moved. Collaborative working and creative thinking to establish homeless network approach to this challenge.	Social prescribing link team in place. Housing team increasingly looking at home improvements agency – adaptations to properties to enable to meet needs rather than moving.

Stakeholders also felt that the findings of this needs assessment should be used, where possible, to advocate for:

- Good quality, secure, affordable housing for Wandsworth residents.
- An increase in the supply of housing for homeless people locally, noting planning in Wandsworth often relates to high density housing, not in keeping with the needs of children and families.
- Reducing moves where possible, particularly out of borough, given the knock-on effect on health and dissolution of continuity of care when people are moved.
- Consideration of homeless health as part of the new Homeless and Housing Strategy in Wandsworth
- Further prevention work around causes of homelessness locally, acknowledging that prevention in this area is difficult to define.
- Recognition locally that homelessness is increasing, and demand for housing continues to outweigh supply. Therefore, acknowledging that without interventions to prevent homelessness, it is reasonable to assume that health needs associated with homelessness are likely to continue increase locally.
- Acknowledging that homelessness in childhood is an adverse childhood experience with subsequent short- and long-term health and wellbeing outcomes.

Acknowledgements

We kindly thank the following contributors who gave valuable input to the Homeless Health Needs Assessment

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	Gemma Thapermall	Homeless co-ordinator Glassdoor charity
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Appendix

Homeless Health Survey, 2013

Wandsworth Homeless Health needs survey summary, 2013

A survey of 97 homeless people undertaken by the Public Health Team in 2013 included a sample population included 71% males and 29% females aged between 18-55 years.

Of this population: 7% were rough sleepers, 3% squatting, 85% accommodated in supported, hostel, B&B or temporary accommodation) highlighted:

Physical health needs:

- 47% Joint aches and musculoskeletal problems.
- 42% Dental problems.
- 34% Chest pain or breathing problems.

Mental health diagnosis reported:

- 61% report a mental health diagnosis.
- 42% report diagnosed depression.
- 23% report dual diagnosis.

Substance misuse:

- 28% report using drugs.
- 36% report drink problem or in recovery from drink problem.
- 74% smoked.

Disability:

- 51% consider themselves disabled.
- 30% state mental health as a cause of disability.

Healthcare Services:

In last 6 months:

- 39% used GP >5 times.
- 40% visited A&E.
- 9% visited A&E >5 times.
- 36% Admitted to hospital.
- 6% admitted >5 times.

GP and Dentistry:

- 81% were registered with GP.
- 49% registered with dentist.

Healthy Lifestyle:

- 26% report No fruit or veg daily.
- Only 6% eat 5 portions of fruit and vegetables a day.
- 45% report NO regular exercise.
- 26% Don’t know how to access sexual health advice.

When asked:

1) **What works for Mental Health?**
- 27% state talking therapies.
- 27% state practical support.

2) **What would you want for mental health support?**
- 35% state talking therapies.
- 24% state practical support.

Homeless health needs audit, Homeless Health Nursing Service, 2022

A recent audit of 27 users of the Homeless Health nursing service in Wandsworth (between September-October 2022) found:

- 5 were female (19%), the other 22 were male (81%)
- Average age was 48 years (ranging between: 21-65 years). The average age of female service users (43 years) was slightly younger than the average age of male users (50 years). There were 21 year olds in both male and female groups, and the youngest homeless female was also pregnant.
- Ethnicity data was available for 13 of patients seen. 11 were White British, 1 patient was Black African, 1 patient Mixed (Black/White). Ethnicity data from the rest of the cohort was not available.
- In terms of nationality, 13 identified British (48%), other groups included in this sample were from 8 were from Europe (30%) with the majority being Polish, Irish and Italian in that order, 1 person was Sri Lankan and 1 person was African. Nationality data for others in the cohort was not available.

The majority of patients were at the time, placed in the Putney hotel, 25% were street homeless and 7% were sofa surfing. The reason for attending Putney hotel was as one of the homeless drop-in centres closed in September 2022.

Presenting health complaints

In relation to the type of health problems presenting within the time of this audit:

- 18% Musculoskeletal: 5 (mainly related to pain including hand, knee, 2xfoot, back, neck and leg problems).
- 18% Mental health problems: 5 (including low mood, depression, suicidal ideation, self-neglect and poor sleep).
- Abdominal complaint: 3.
- Alcohol related = 2 (Wernicke's encephalopathy and withdrawal).
- Cancer: 1.
- Contraception: 1.
- Pregnancy: 1.
- Skin: (2x leg ulcers, 1x insect bite).
- Kidney problems: 1.
- Poor diabetic control: 1.
- Poor memory: 1.
- Breathing problems 1.
- Others included: poor sleep, bereavement, victim of fraud, poor memory.

All except 2 patients had co-morbidities with 70% of patients seen having multiple co-morbidities. Co-morbidities within this cohort in order of frequency included:

1) **Chronic physical health conditions:** 77% had chronic physical health conditions.
   - 11 patients had cardiovascular disease (hypertension or history of cardiovascular event such as a DVT or stroke).
   - 6 patients had musculoskeletal problems.
   - 5 patients had respiratory disease.
   - 4 patients had neurological comorbidities.
   - 3 patients had GI disease (including liver disease, ulcerative colitis, GORD).
   - 3 patients had a history of traumatic head injury.
   - 2 patients had diabetes, one with significant complications associated with poor control.
   - 2 patients had chronic skin complaints: eczema and chronic ulcers.

2) **Co-occurring substance misuse issue:** 60% (16 patients) had substance misuse problems.
   - A quarter of this group had concurrent alcohol and drug use problems.
   - 11 patients used only alcohol (41% of all patients).
   - Only 1 patient used substances without alcohol.

3) **Mental health issues:** 9 patients (33%) had mental health problems, this often linked to their presenting complaint. In order of frequency:
   - Depression/low mood (4)
   - Suicidal ideation or attempt (3)
   - PTSD (2), Personality disorder (1)
   - Eating disorder (1)
   - Schizophrenia (1)
   - Unspecified mental health problem (2)
   - Anxiety (1)

   The reason number of diagnosis' exceeds number of patients is that a number had multiple mental health problems.

4) **Learning difficulties**: 2 patients had recorded learning difficulties of ADHD and in one case co-occurring dyslexia.

This audit highlights the need for generalist health care within the homeless population alongside supporting mental health and substance misuse.

The wide range of presenting complaints along with the burden of chronic disease speaks to the complexity of need within this population and the need for holistic and generalist approaches to care in this population. The complexity seen within the case mix also highlights the need for longer appointments to allow for opportunistic management of acute and chronic issues with patients that do not routinely present or use mainstream models of healthcare. This work occurs simultaneously alongside managing the case work associated.

Homeless health and wellbeing qualitative questionnaire, 2022

A more recent survey of a small sample just four attendees at Southcroft Church accessing the Homeless Nursing survey on 22nd December 2022 focussed on values and an asset-based approach to health. Of the four participants, an interpreter was required for two of the interviews. Colour coding is used below to link participants to their responses:

Participant demographics:

- Participant 1: 37 years, male, rough sleeper
- Participant 2: 51 years, male, living in a hostel,
- Participant 3: 41 years, male, rough sleeping

- Participant 4: Unknown

When asked: 'When thinking about your health…'

What matters to you the most?	**What helps / supports you to take care of your health and wellbeing?**
'To have no stress, not too much thinking' *'I'm worried about my health - my lung function, worried about problems with my spine, and numbness in my hands and shoulders'.* *'Family – I want to be healthy for my family'.* *'Good spirit, to be in good spirits.'*	*'Not sure'* *'My GP has done a lot to help me with my medication'.* *'When I'm not drinking alcohol, and when I eat breakfast it helps'.* *'Getting rest'*
What does a 'good day' look like for you?	**What would support you to have more frequent 'good days'?**
'Some days are okay'. *'With my health, I don't really have good days'.* *'When I get up in the morning, eat breakfast like toast and can go for a walk in the park with my girlfriend'.* *'When I can go to work, and be in good health is a good day'.* '	'Talking to family and spending time with my friends supports me'. *'Getting access to medicines like mirtazapine that help me get some sleep helps.'* *'Having a job, and not drinking alcohol helps.'* *'To have someone you love by your side.'*

Even though there are very few responses, themes around mental health was prominent (not necessarily diagnosis but 'stress', 'worry' and 'good spirits' feature.)

Meaningful relationships and social connection featured as well as support from primary care around medication.

Basic needs such as being able to work and eating breakfast were highlighted to support individuals to feel well and have more good days.

These are important considerations for shaping services available to people experiencing homelessness. Another important incidental learning point here was around having a readily available interpreter for any future engagement with the local homeless population and for service design.

Stakeholder engagement: Key findings

Wandsworth Homeless Health Needs Assessment: stakeholder views
The following groups were consulted as part of the Homeless Health Needs Assessment undertaken by the Public Health Team:

SPEAR outreach team:

- Outreach team manager
- Homeless Health Link Lead
- Team Leader

Richmond and Wandsworth Consortium:

- Manager of Richmond and Wandsworth Homeless Pathway, Richmond & Wandsworth Consortium (WCDAS & RCAS), St Mungo's
- Housing Liaison and Tenancy Sustainment Worker, St Mungo's

Glassdoor Charity

- Glassdoor Charity, Homeless Co-ordinator

Local Authority:

- Head of Housing Services (Assessment and Adaptation), Department of Housing Services
- Senior Commissioning Manager, Prevention and Well being, Targeted services, Department of Adult Social Care and Public Health
- Commissioning manager, Prevention and Well being, Department of Adult Social Care and Public Health
- Commissioning Officer, Mental Health and Well being, Department of Adult Social Care and Public Health
  Commissioning Officer: Commissioning & Quality Assurance – Department of Adult Social Care and Public Health
- Service Manager: Richmond& Wandsworth Mental health and Substance misuse Social Care Team, Department of Adult Social Care and Public Health
- Interim Access Service Manager, Department of Adult Social Care and Public Health
- Public Health Lead, Adult Social Care and Public Health

Additional

- Personalised Care manager, Social Prescribing, Enable
- Primary Care Commissioning lead
- Assistant Head of Primary Care, Transformation
- Lead for Pathways team, St George's & previous Homeless GP Lead
- Team Leader for Advanced Homeless Pathway
- General Adult Psychiatrist, Wandsworth Community Drug and Alcohol Service lead for Enhanced Homeless Pathway (SLAM)
- Homeless Health Nursing Service (lead nurse and nurse practitioner)
- Citizen's Advice

Recommendations and Enablers:

GENERAL:

To build on the momentum of the expansion of homelessness services locally and think about how services can work more collaboratively as a network:

- Consider re-instating provider partnership meetings used during Everyone In and in response to Ukrainian refuge support, though purpose and aims of group may need to be re-considered.
- Consider MDT approach across services for complex cases, where individuals may be known to multiple services, such as health, social care and housing.
- Identify meetings and forums of those working on homelessness, where input may be of value from other stakeholders.
- Support St Georges HIT Pathways team to develop community handover process of care following admission.

- Review communication pathways between all teams involved with people experiencing homelessness:
    - In relation to information sharing when an individual is first seen by a team to avoid duplication and reduce time spent finding historical information that is available with other services.
    - Understanding what information from healthcare is helpful for housing teams when completing assessments and making decisions around appropriate housing and how this may be supported.
    - Consider ways to improve communication between housing and residents / health services / social care involved with supporting people experiencing homelessness.
    - Re-establish communication with prison services, perhaps using health as a 'vehicle' to re-establish relationships with local prisons.
    - When moving people out of borough occurs, a directory of how to contact and refer to services out of borough to identify transfer of care if needed should be available and shared learning between services of how to engage without services in other boroughs may be useful.
- Develop and share teaching materials around homelessness health and consider how this may be distributed across services.
- Hold a networking event or create virtual resource in which all homelessness Services that are available are presented.
- Consider option for evaluation strategy relating to Homeless health and provision of new services to monitor progress.

Prioritise basic needs to support health in people experiencing homelessness

- Using findings of health needs assessment to support and advocate for secure, good-quality homes for all and recommendations for increasing the supply of social housing locally.
    - Supporting the case for expansion of the Housing First program locally where feasible
    - Advocating for reducing the number of accommodation moves, particularly out of the borough for individuals in need of health services
    - Advocating to reduce the time families spend in temporary accommodation due to the impact on health and wellbeing in the short and long-term
- Prioritise access to food, warm homes, education and employment for individuals experiencing or at risk of homelessness.
- Consider options for occupational health support for individuals presenting to the Council threatened homeless or homeless as unable to work due to poor physical or mental health with a particular focus on mental health and musculoskeletal health.
- Supporting the prevention of homelessness from institutional settings (i.e. armed forces, care leavers, prisons).
- Consider the feasibility of health input or health and wellbeing offer for individuals presenting as homeless to the council based on need.
- Promote the Warm Homes, Warm Spaces projects and Winter Night Shelters networks within homeless health networks.

Ongoing work to understand and reduce inequalities in people experiencing homelessness locally:

- Clearer communication around confidentiality in health care relating to refugees, asylum seekers.

- Increased clarity around local processes in response to people with 'no recourse to public funds'.
- Recognise over-representation of Black, Asian and minority ethnic groups experiencing all forms of homelessness; and mapping of strategic work to prevent homelessness in Black, Asian and minority ethnic communities locally.
- Recognising homelessness locally as an adverse childhood experience.

'Deep dive' into children and families experiencing homelessness with a focus on:

- Single-parent families.
- Impact of homelessness on child health locally.
- Women's health and screening.
- Families in temporary accommodation.
- Domestic abuse.
- Recognising homelessness as an adverse childhood experience.

Support prevention work around the main causes of homelessness locally (family no longer accommodating, end of tenancy, domestic abuse)

- Multiagency approach.
- Support work around prevention of domestic abuse locally and increased support for those experiencing domestic abuse.

Explore options of how people at risk of or experiencing homelessness can be supported in their relationships:

- Exploring locally available support around preventing relationship breakdown leading to homelessness if appropriate i.e. family support, early intervention.
- Expanding provision of 1:1 support/key worker/case worker to navigate services (including health services) to reduce repetition of storytelling, and duplication of work to aim to increase engagement and build trusting relationships with individuals.
- Supporting and promoting meaningful, positive social connections in people experiencing homelessness and in those at risk of homelessness.

The complexity of health needs to be considered in any future services:

- Extended time needed during appointments or contacts with individuals (e.g. outreach, or complex needs addressed in a single appointment).
- Trauma-informed approaches to be used in services.
- Prepare health services for increase in demand, as forecast by the housing department, due to the cost-of-living crisis and COVID-19.

SERVICES:

Increase mental health provision for homeless and rough sleeper populations locally as need is high and not met with current service provision:

- Recognising homelessness causes poor mental health and exacerbates existing mental health conditions therefore prevention of homelessness is key to helping protect the mental health of residents.
- Homelessness not always diagnosable or for referral but detrimental to health and wellbeing – increased low-level support could be beneficial.
- Difficulty for individual to engage with mental health services if threatened homelessness or homeless, therefore joint approach with housing and mental health teams needed to support ability to engage.

- Improve access to community mental health team for assessments and ability for direct referrals from outreach teams.
- Engage with current RAMPH service workshops (at SWL level) to influence services and use needs assessment to inform the provision of local services.

Reconsider ***where* current services are delivered for homeless populations locally:**

- Locate services in places people experiencing homelessness are already accessing or as outreach models.
- Utilise new Ram Street clinical space to deliver care that is historically in a mainstream setting.
- Currently no day service provision in Wandsworth – 'hub' model would be supported by the findings of the need assessment and would be an opportunity to bring health services to where people are.
- Virtual consultations for secondary care appointments with health advocates in day centres if attending hospital appointments likely to be a barrier to accessing care
- Prescribers with outreach teams.
- Homeless health days to continue with increased regularity throughout the year as capacity allows, could have some crossover with 'Health Clinics' run by WCEN.

Primary care and prevention of long-term conditions to be prioritised in rough sleepers:

- Increase registration to Safe Surgeries DOTW initiative, though recognising registration may not be the main barrier to accessing appointments locally.
- Explore feasibility of using existing primary care services creatively e.g. home visit structure with visits to day centres or clinics in above locations where a homeless person has a named GP but struggles to access, staying with a named GP locally despite address move.
- Consider community provision of homeless health clinics: GP with special interest in homelessness / SPIN – dedicated clinics regularly rather than relying on voluntary support.
- Use needs assessment findings to support the Homeless Health Nursing Team's bid to expand.
- Review opportunistic services at recent homeless health days and consider if capacity and scope for broader offer for opportunistic engagement around health (e.g. through NHS health checks).

Musculoskeletal services, dental services and podiatry needs are currently not being met in the homeless population across Wandsworth – review local provision and access:

- Further work to understand feasibility of community dental service in Wandsworth.
- Musculoskeletal service mapping exercise including local physical activity options available to people experiencing homelessness.
- Such services could be included within homeless health days.

Maximizing use of the RSDATG service: health care assessments data set in relation to understanding the physical and mental health burden of rough sleepers using the service:

- Utilising the healthcare assessment in RSDATG service structure to identify risk factors and support for ongoing referral e.g. If back to GP but not able to access?
- Utilise the format of the healthcare assessment undertaken by the RSDAG service and replicate it in other services (e.g. Homeless Health Link service).
- Healthcare assessments offered in the RSDATG service.

To increase engagement and co-creation of services with residents experiencing homelessness as partners:

- Possible opportunities to engage via the WCEN and SPEAR and consider focus groups to further inform this or later homeless health needs assessments.
- Ensure translation services are available to achieve representative engagement.
- Further exploration of ways to engage with the voluntary sector around supporting homeless health.
- Make use of opportunities for community engagement in the development of new services (e.g. Community Hub) Staff.
- Recognising that capacity is under pressure and recruitment in the homeless sector is difficult, consider how staff in the homeless sector can be supported.