Richmond Homelessness Health Needs Assessment 2023

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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[1].

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[2].

Between 2010 and 2021/22, homelessness demand to local authorities has run at consistently higher levels compared to before 2010 leading to increased use of temporary accommodation across London, England and locally.[3] 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.

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'*[4].

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.
- 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.

[1] https://england.shelter.org.uk/media/press_release/homelessness_in_england_rises_by_11_per_cent_in_just_three_months
[2] https://www.instituteofhealthequity.org/resources-reports/evidence-review-housing-and-health-inequalities-in-london/full-report.pdf
[3] https://democracy.wandsworth.gov.uk/documents/s94990/22-161%20Wandsworth%20Annual%20Resources%20report.pdf
[4] Shelter: What is Homelessness? (2022) here

The population of homeless people is diverse and includes people of all ages and is constantly changing. 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
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

[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)

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 in order 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.

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

[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
[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

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 the 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 either they: - 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. - 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

[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)
[12] Homelessness code of guidance for local authorities: Chapter 6 (22 Feb 2018) Department for Levelling Up, Housing and Communities available at: here

	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
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 i.e. 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. 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[13].
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[14].
Prevention dut	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.

[13] 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

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

	- 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); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).
Co-occurring condition	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 (HHNA) are to understand:

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

The HHNA 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[15].
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[16].
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[18]. For someone who is homeless, their place of residence is often not an option for assessment, (e.g. if the person is experiencing

[15] Sustainable Development Goals https://sdgs.un.org/goals
[16] WHO: Housing and Health guidelines https://www.who.int/publications/i/item/9789241550376
[18] 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[17]. 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.	domestic abuse or if there is no fixed abode). This has 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

[17] 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[19].
Public Health England: Improving health through the home (2016)[20]	'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[21].	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)[22]:	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[23].

[19] Adults Safeguarding and homelessness. A briefing on positive practice. Local Government Association. March 2020.
[20] https://www.gov.uk/government/publications/joint-action-on-improving-health-through-the-home-memorandum-of-understanding
[21] https://www.gov.uk/government/publications/improving-health-through-the-home/improving-health-through-the-home#working-together
[22] Homelessness Reduction Act 2017 (legislation.gov.uk)
[23] 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)[24]	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[25]	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

[24] 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]
[25] 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[26]	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 travel 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 immigration status; and subsequently their ability to access housing and cases of homelessness as result can arise. [27]
Domestic Abuse Act, 2021[28]	The Domestic Abuse Act, 2021 changed homelessness legislation to give automatic priority for homelessness assistance to survivors 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 one of the main

[26] 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].
[27] 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
[28] Domestic Abuse Bill: factshets (2020) Home Office available at: https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets

	domestic abuse. The new statutory definition of 'domestic abuse' also replaces the term 'domestic violence'.	reasons women stay in households where they are at risk of or experiencing domestic abuse. Housing instability and lack of affordable housing options also heighten the risk for women experiencing domestic violence.
Levelling Up, 2022[29]	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[30].	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)[31]	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)[32]	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	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

[29] 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]
[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] 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
[32] 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

	sleeper did not experience a second night on the streets.	the last. In the long-term it aims to reduce the number of people sleeping rough
Mayor of London Rough Sleeping Plan of Action, (2018)[33]	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)[34]	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.

[33] 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

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

		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. 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[35] as highlighted in Figure 1.

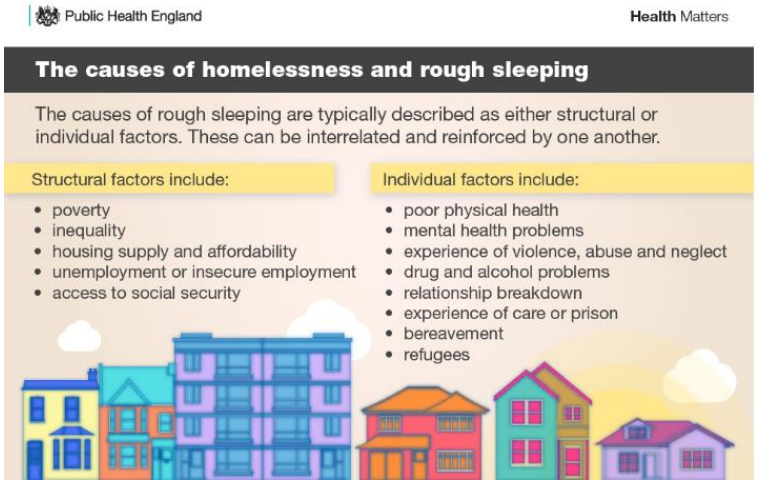


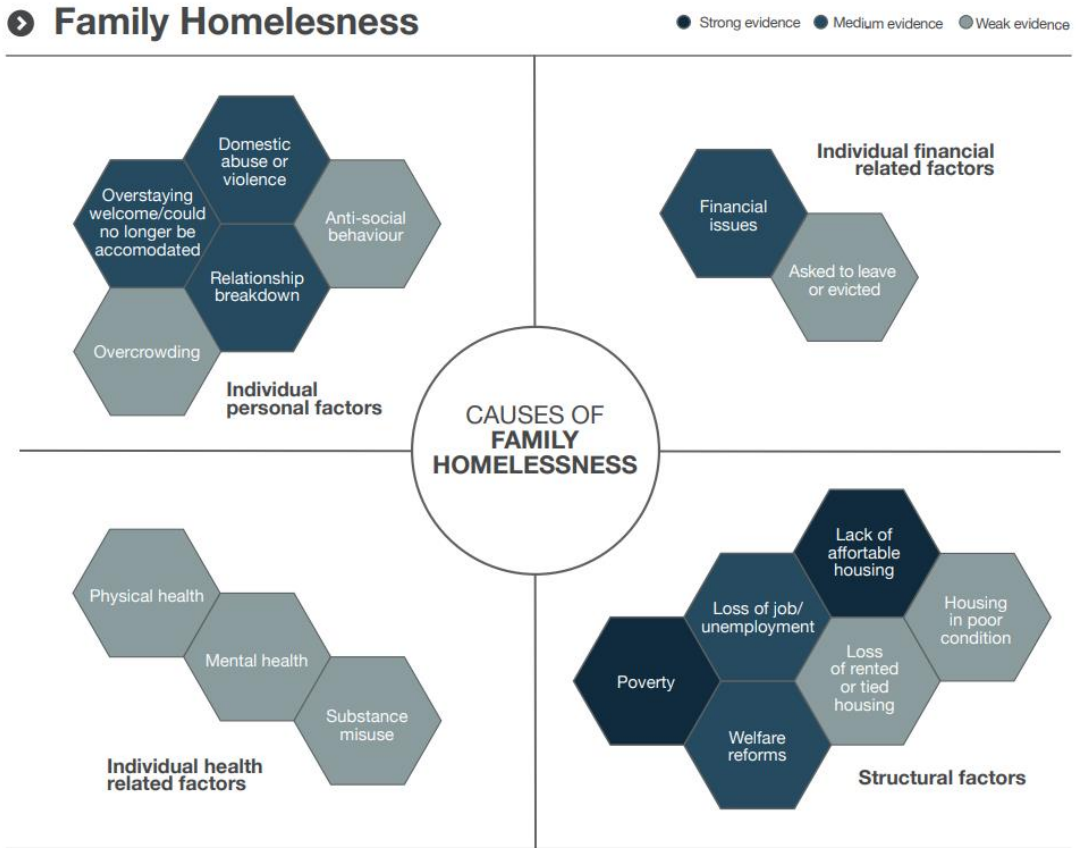
Figure 1: The causes of Homelessness and Rough Sleeping, Public Health England

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[36], 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

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

One review also highlighted the different causes of homelessness in different populations including families (Figure 2), single people (Figure 3) and rough sleepers (Figure 4).[37] The figures below illustrate these causes 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.



The causes of homelessness for families in the UK with the strongest evidence **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.

[37] Breaking the cycle of trauma. Evolve Housing and Support. 18 June 2018. Available https://www.evolvehousing.org.uk/wp[1]content/uploads/2018/06/Evolve_Trauma_Homlessness_Report_Master_June2018.pdf§

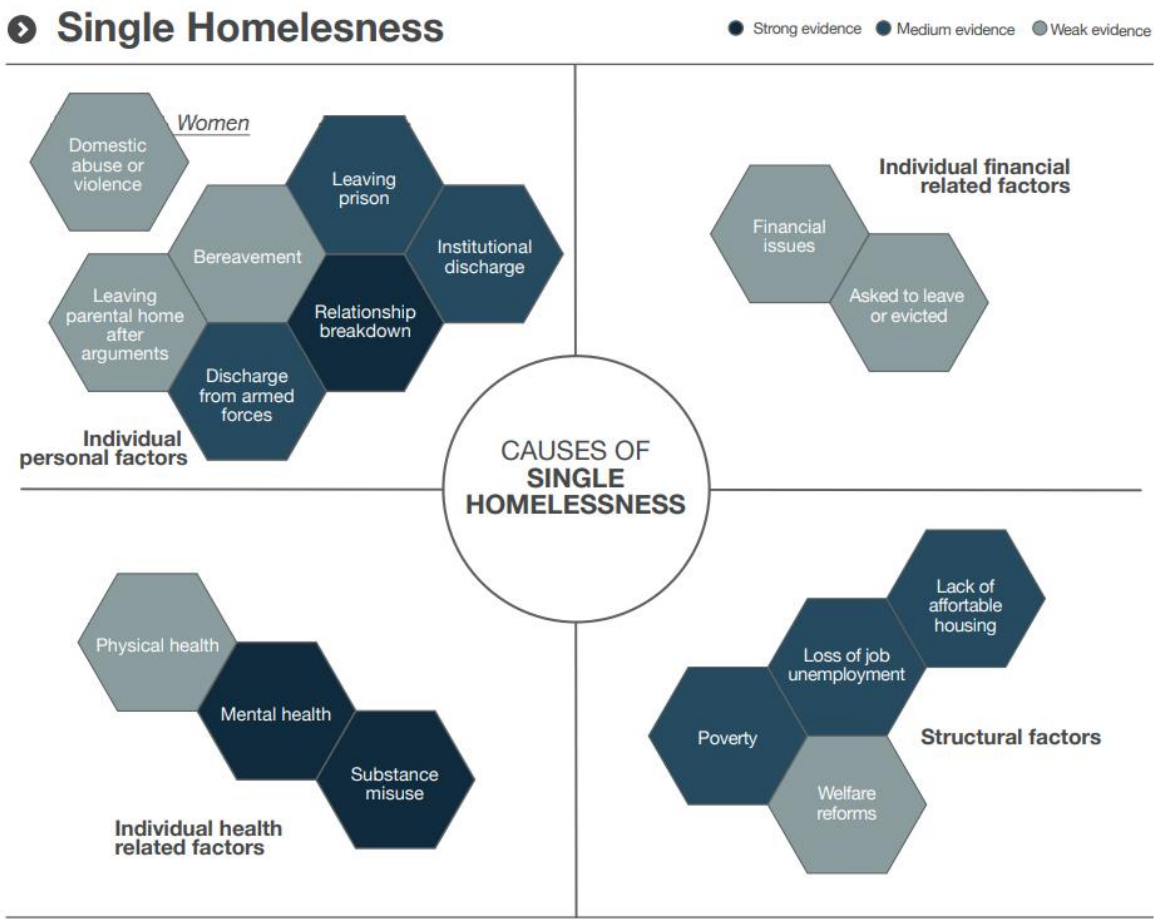


Figure 3: The causes of single homelessness, UK, March 2019

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.

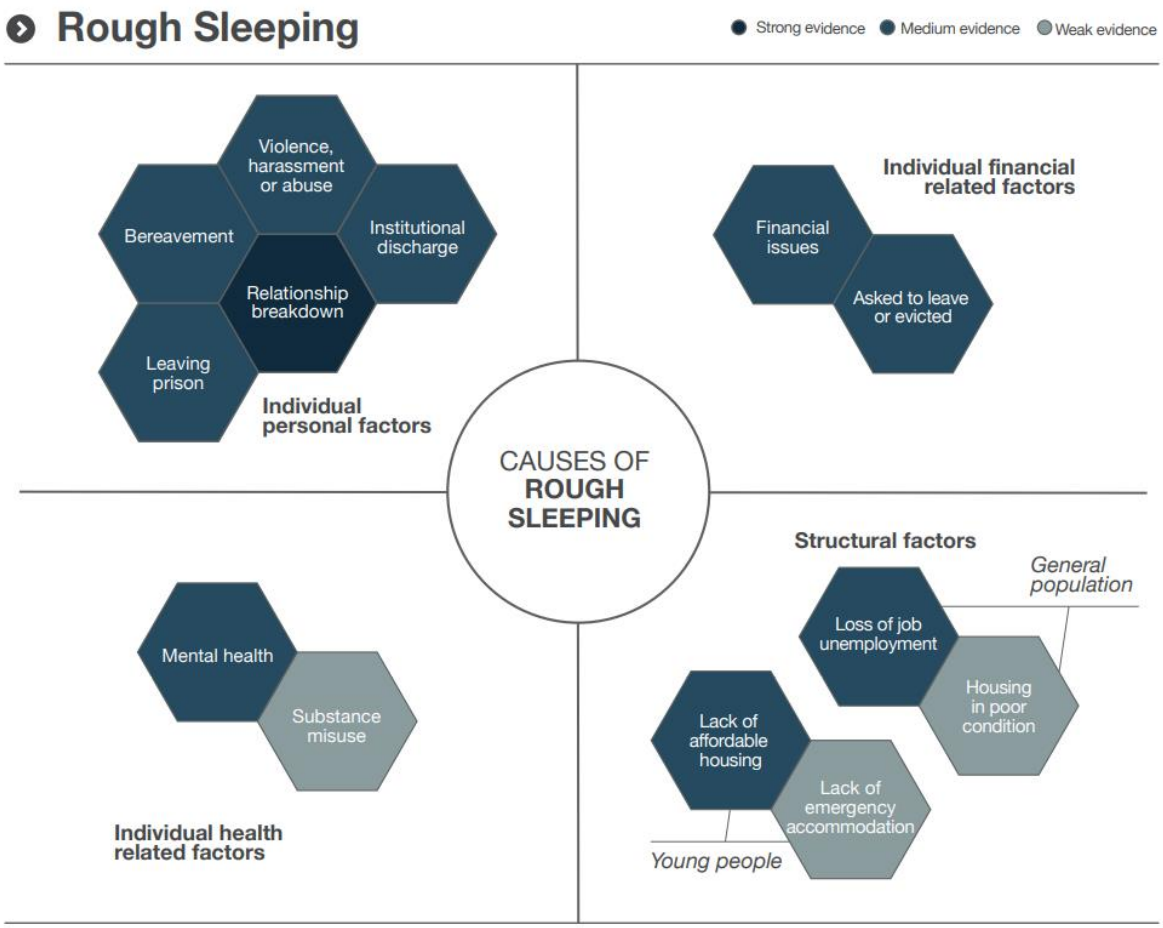


Figure 4: The causes of rough sleeping, UK, March 2019

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.

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 Richmond

Data for this section is largely 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 Richmond.

This statutory homeless population of people represents the number of households deemed to fall under Richmond 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 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 people in Richmond that were assessed as homeless or threatened with homelessness between April 2021- March 2022 were:

1) Family or friends no longer willing to accommodate (16% of those were owed a relief duty, 33% of those were owed a prevention duty).
2) End of private rented tenancy (9% of those were owed a relief duty, 31% of those were owed a prevention duty).
3) Domestic abuse (32% of those were owed a relief duty, 8% of those were owed a prevention duty).

[38] Live tables for Homelessness https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

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

Reason	% of homeless population owed relief duty	% of threatened homeless population owed prevention duty
Family of friends no longer willing to accommodate	16%	33%
End of private rented tenancy	9%	31%
Domestic abuse	32%	8%

Domestic abuse is the most common reason in Richmond for people becoming homeless and owed relief duty accounting for 1/3 of applicants in this group.

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 is that 4% of people who were homeless and owed a relief duty had left an institution with no accommodation available. However, this 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 be recorded 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.

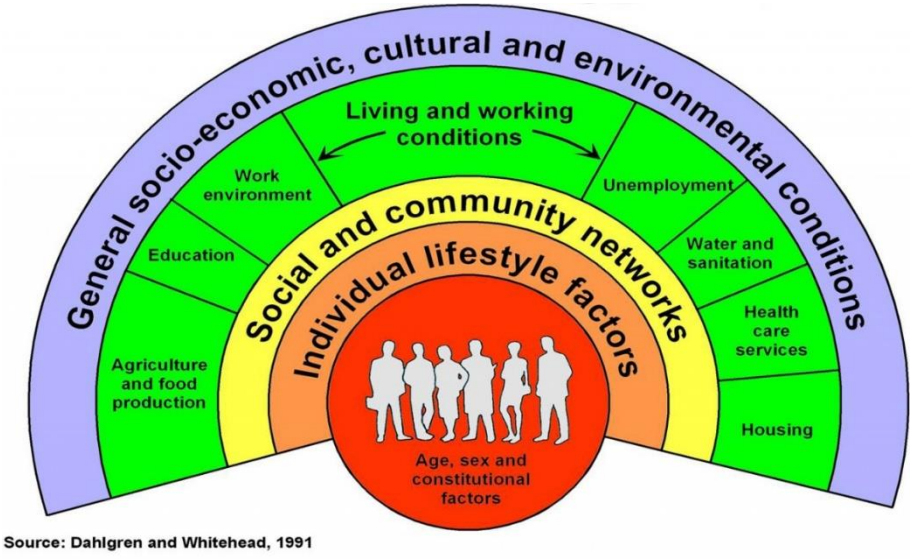


Figure 5: The Social Determinants of Health.: Dahlgren and Whitehead, 1991

The quality of housing plays a critical role in creating, maintaining and supporting good health; and housing that is inadequate, unsuitable or poor quality 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.
2) Housing security
    - Housing security in the private rented sector in London.
    - Homelessness.

[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

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 (207) 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

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

difficulty identifying deaths of those housed under the scheme, meaning that the number of deaths may have been underestimated[51].

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% in the UK working-age population.

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
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[5960]

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 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[63]. 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

63 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/

general population[64]. The inpatient cost of a single homeless person has been estimated at between five to eight times the cost of the non-homeless population[65].

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[66], this highlights the importance of improving access to and experience of health and social care services for homeless people.

64 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.
65 Department of Health Office of the Chief Analyst (2010). Healthcare for Single Homeless People. London: Department of Health.
66 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[67]. 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[68].

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.

[67] 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
[68] 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

		• Needs risk being overlooked by parents. **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. Childhood trauma 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)[69], and 10% of the	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.

[69] 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

	general population experiencing four or more.	• 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. Poor mental health is higher in groups at risk of housing insecurity, housing subject to overcrowding and those living in poor housing conditions.	• 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. • 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	There are 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 or exacerbated by substance misuse. Rates of drug use are four times higher in homeless	• Homelessness can be a route into addiction for people who are rough sleepers, or in accommodation where others are using drugs or alcohol.

	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[70].	• 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 criminal justice system	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.
People with severe and multiple disadvantage	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.

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

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 Richmond

Data for this section is largely derived from the Department for Levelling Up, Housing & Communities[71]. 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 Richmond.

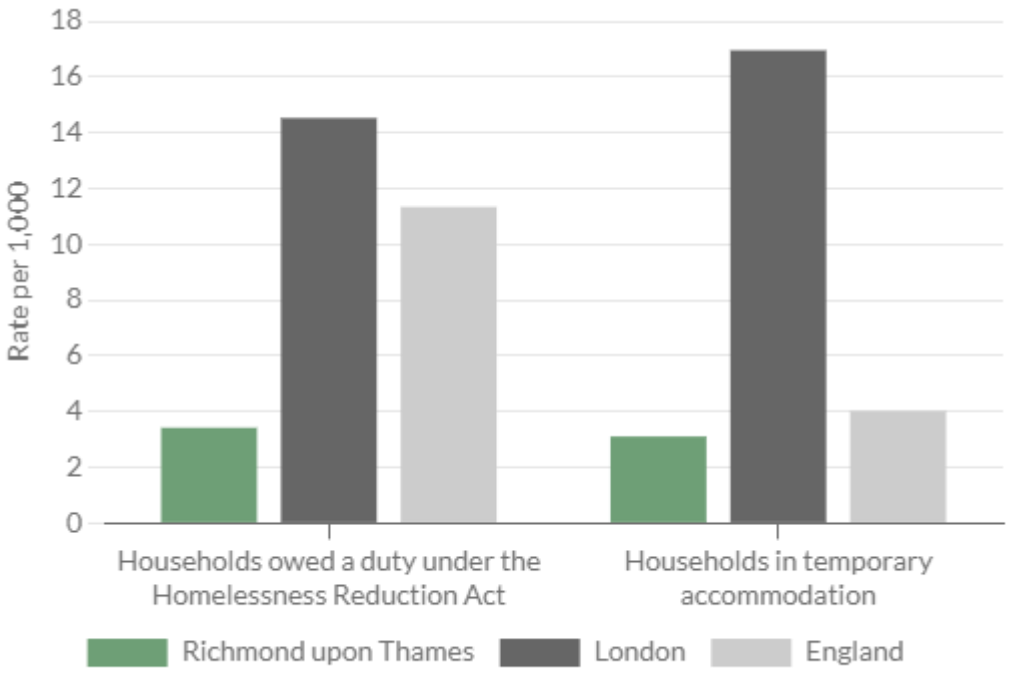
The statutory homeless population represents the number of households deemed to fall under Richmond Council's legal obligation or duty to house after being found to be homeless following an assessment. Consequently, those awaiting assessment are not captured in this data.

Homelessness assessments

As the graph below shows, as of 2020/21 Richmond had a lower rate of households owed a duty under the HRA at 3.4 per 1000 households (n=287), compared to the London (14.5 per 1000 households) and England averages (11.3 per 1000 households)[72].

In 2020/21, the borough also had a lower rate of households in temporary accommodation (3.1 per 1000 households) compared to the London average (17 per 1000 households) and is similar to the England average (4 per 1000 households).

Graph 1: Statutory homelessness and households in temporary accommodation, Rate per 1000, 2020-2021, Richmond, London, and England



Source: MHCLG[73]

71 Live tables on homelessness https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
72 PHE PHOF Fingertips: Homelessness https://fingertips.phe.org.uk/search/homeless#page/1/gid/1000041/pat/15/ati/6/are/E12000007/iid/93736/age/-1/sex/-1/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/ine-yo-1:2020:-1:-1_ine-ct-113_ine-pt-0_car-do-0
73 DataRich Homelessness https://www.datarich.info/housing/#/view-report/85fe651fd2af40e0bf133770aaa91687/___iaFirstFeature/G3

Between April 2021 and March 2022, Richmond Council assessed 390 households and found that 99% (385 households) assessed were owed a duty and the majority of those people assessed and owed a duty were homeless at the time, with fewer being threatened with homelessness within the next 56 days.

- 70% were homeless at the time of assessment and owed a relief duty.
- 30% were threatened with homelessness and owed a prevention duty.

Between April and June 2022, a further 117 households were assessed as being owed a duty, with 73% homeless and 27% threatened with homelessness meaning 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 are 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 70% of those owed a duty under HRA are owed a relief duty[74].

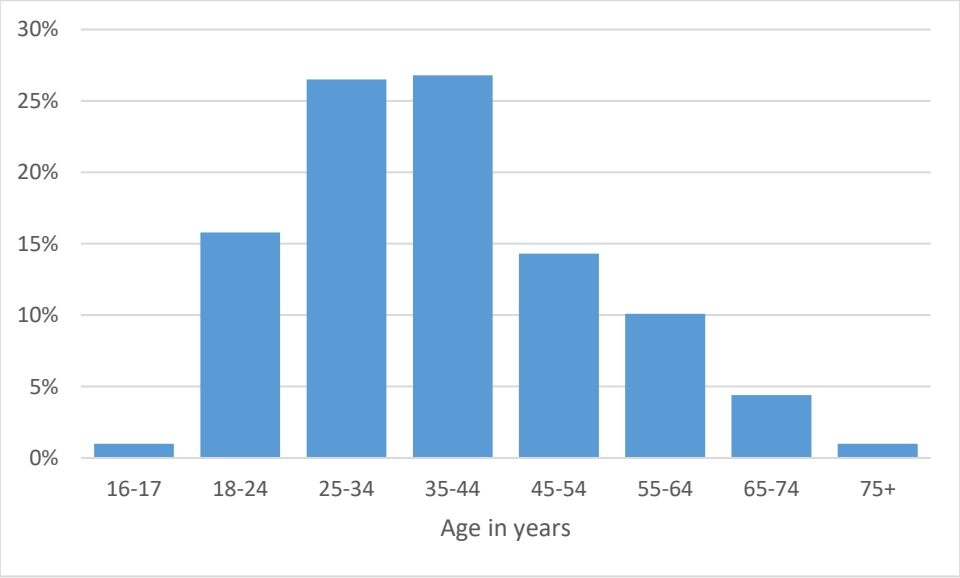
It is important to reiterate that this does not represent the true number of those who are homeless or and does not include those awaiting assessment, rather those that are statutory homeless following an assessment.

Demographics of the statutory homeless population

Age

More than half (54%) of main applicants applying for assessments were aged 25-44 years old.

Graph 2: Age of main applicants owed a prevention or relief duty, April 2021-March 2022, Richmond



However, using the demographic data from the Census 2020 in Richmond as a comparator, the data shows that, after considering the age distribution of the population, a larger proportion of adults aged 25-54 years were main applicants for assessment by the Council as homeless compared to other age groups[75].

74 Live tables on homelessness https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
75 Census 2020 https://www.datarich.info/census-2021/

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

Age bracket	Percentage of homeless applications	Percentage of Richmond population Census, 2021[76]	Proportion
16-24*	1%	19%	0.05
25-34	16%	23%	0.70
35-44	27%	32%	0.84
45-54	27%	32%	0.84
55-64	10%	24%	0.43
65-74	4%	18%	0.22
75+	1%	15%	0.06

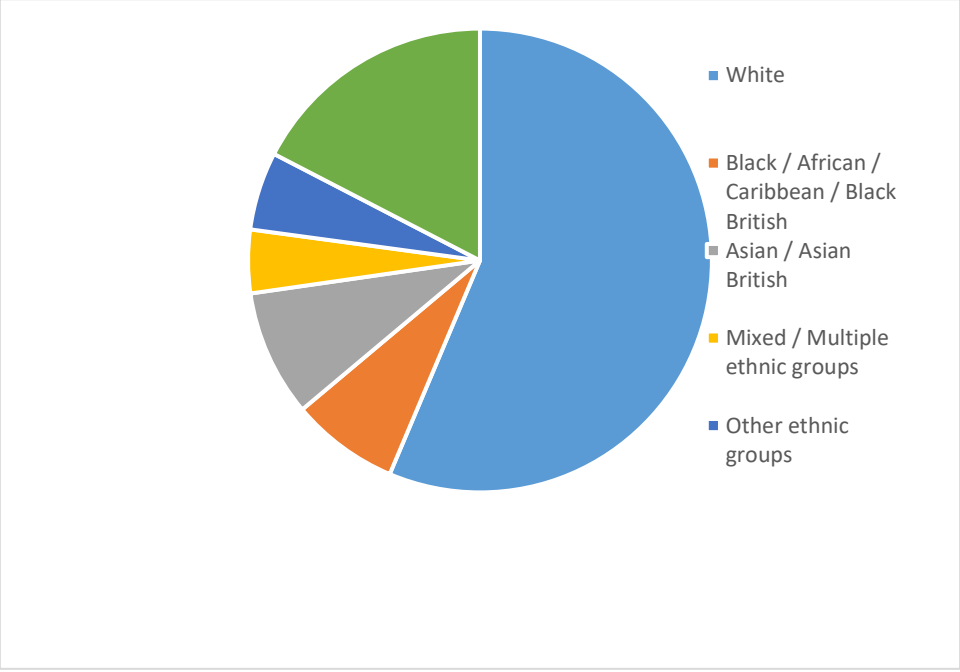
*NB: ONS census data includes those aged 15 in the youngest bracket therefore may not be directly comparable.

Ethnicity

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

- 56% of main applicants were White.
- 8% were Black/African/Caribbean/Black British.
- 9% were Asian/Asian British.
- 4% were Mixed/Multiple ethnic groups.

Graph 3: Ethnicity of main applicant to Richmond Council owed a duty under the homelessness reduction act (HRA) April 2021-March 2022



Whilst ethnicity groups are not directly comparable, data from the 2021 Census shows that 80.5% of the Richmond population is White and 19.6% are from Black, Asian or other minority ethnic groups, with the following estimated breakdown:

- 1.9% Black/Black British/Black Welsh African/Caribbean.
- 8.9% Asian/Asian British/Asian Welsh.

76 Population report for Richmond Upon Thames. https://www.datarich.info/population/#/view-report/63aeddf1d7fc44b8b4dffcd868e84eac/___iaFirstFeature/G3

- 5.5% Mixed or Multiple ethnic groups.
- 3.3% Other ethnic group.

Therefore, of the population applying to the Council as homeless and found to be owed a duty, there is an over-representation of Black residents and an under-representation of White residents, compared to the local demographics.

Furthermore, the Richmond Housing and Regeneration department presented equalities information relating the lettings and housing department queues as of 31st March 2021. During 2020/21, the number of households accepted as homeless was mostly proportionate to the number of households presenting as homeless for each ethnic group. However, the White and Black ethnic groups receive a higher proportion of acceptances compared to the number of homeless applications received than other ethnic groups[77].

		White	Mixed / multiple ethnic groups	Asian / Asian British	Black / African / Caribbean / Black British	Other	Unknown	Total
Homeless applications received	No.	509	60	105	87	51	146	958
	%	53.13%	6.26%	10.96%	9.08%	5.32%	15.24%	100%
Cases admitted into temporary accommodation	No.	109	10	17	15	19	29	199
	%	54.77%	5.03%	8.54%	7.54%	9.55%	14.57%	100%
Prevention duty: cases closed	No.	17	3	5	14	5	6	50
	%	34.00%	6.00%	10.00%	28.00%	10.00%	12.00%	100%
Homeless cases prevented *	No.	47	4	5	2	1	2	61
	%	77.05%	6.56%	8.20%	3.28%	1.64%	3.28%	100%
Relief duty: cases closed	No.	13	1	0	1	0	3	18
	%	72.22%	5.56%	0.00%	5.56%	0.00%	16.67%	100%
Homeless cases relieved *	No.	30	6	13	7	10	4	70
	%	42.86%	8.57%	18.57%	10.00%	14.29%	5.71%	100%
Cases accepted: duty to house	No.	50	7	8	12	4	5	86
	%	58.14%	8.14%	9.30%	13.95%	4.65%	5.81%	100%

* these are cases where the Council has either prevented or relieved an applicant's homelessness by securing suitable accommodation of more than 6 months. These do not include all of the council's prevention schemes due to the availability of ethnicity data

Table 9: Housing Advice Homeless cases by ethnicity groups 2020-2021

Regarding the percentage of homeless cases that were prevented, as seen in the above table, the White ethnic group had the largest representation (77% of all homeless preventions), whilst only representing 53% percent of homeless approaches to the Council. In contrast, Black/African/Caribbean/Black British groups only represented 3% of all homeless cases prevented, despite representing 9% of all homeless approaches.

Nationality

Nationality data for the statutory homeless population in Richmond is relatively incomplete. The majority of applicants were UK nationals (80%) followed by non-EEA citizens who made up 12% of applicants[78].

Employment

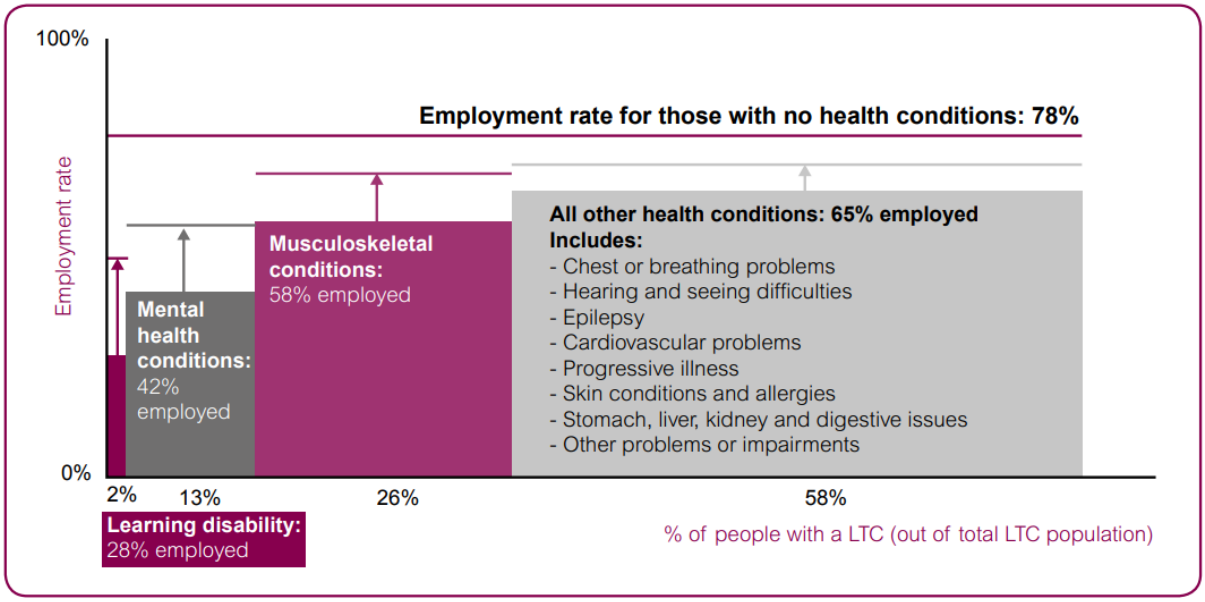
A higher percentage (38%) of applicants were registered as unemployed compared to the London unemployment rate of 6% for those aged 16 years and over. 22% of the population assessed to be homeless or threatened homeless were not working due to long-term illness or disability[79].

This highlights the complex interaction between poor health, employment and homelessness. Employment rates are higher for those with no health conditions (as seen in

77 Equalities analysis: Housing advice, homelessness and provision of temporary accommodation 2020/21https://www.richmond.gov.uk/media/23210/2020_2021_equalities_analysis_lettings_and_housing_department_queues.pdf
78 Live tables on homelessness https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
79 Labour market in the regions of the UK: October 2021 https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/regionallabourmarket/october2021

graph 4). Despite the benefits of being in work for people with long-term conditions, including improved health and social outcomes, there are inequalities in employment rates in this group. These inequalities depend on the type of long-term health condition, and it is likely that 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[80].
- Individuals unemployed for more than six months have lower wellbeing than those unemployed for less time[81].
- Varying employment rates of those with certain health conditions in particular, people with a history of substance misuse[82], and those affected by poor mental health[83] are barriers to securing and sustaining employment.



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

Graph 4: Employment rate for people with long term conditions and people with no health conditions, Labour force survey, 2014

Work by Shelter[84] found that almost half of the 194 families with dependent children surveyed in their research were not in work or training. The research found:

- 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.

80 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.
81 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
82 https://www.gov.uk/government/uploads/system/
83https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212266/hwwb-mental-health-and-work.pdf
84 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

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.

Almost two-thirds (61%) of those applying, found to be threatened with homelessness and owed a prevention duty had dependent children. The rest were either single adults, a couple or three or more adults without dependent children.

- 34% were single adults (44% male, 56% female)
- 4% were a couple or two adults without dependent children.
- 1% were three or more adults without dependent children.

Of those with dependent children, the majority were single parent females with dependent children (37%).

Table 10: Household type with dependent children threatened with homelessness, owed a Prevention Duty. April 2021-March 2022, Richmond

Household type	**Percentage**
Single parent (female)	37%
Single parent (male)	0
Couple with dependent children	21%
Three or more adults with dependent children	3%

Homeless

Of those who were homeless and owed a relief duty, 30% had dependent children, whilst the majority (70%) did not have dependent children. There was a higher proportion of single males who were homeless without dependent children compared to any other group.

- 69% were single adults (57% male, 43% female).
- 1% were a couple without dependent children.
- 1% had 3 or more adults without dependent children.

Of those with dependent children who were homeless and owed a relief duty, again the majority (25%) were single parent females[85].

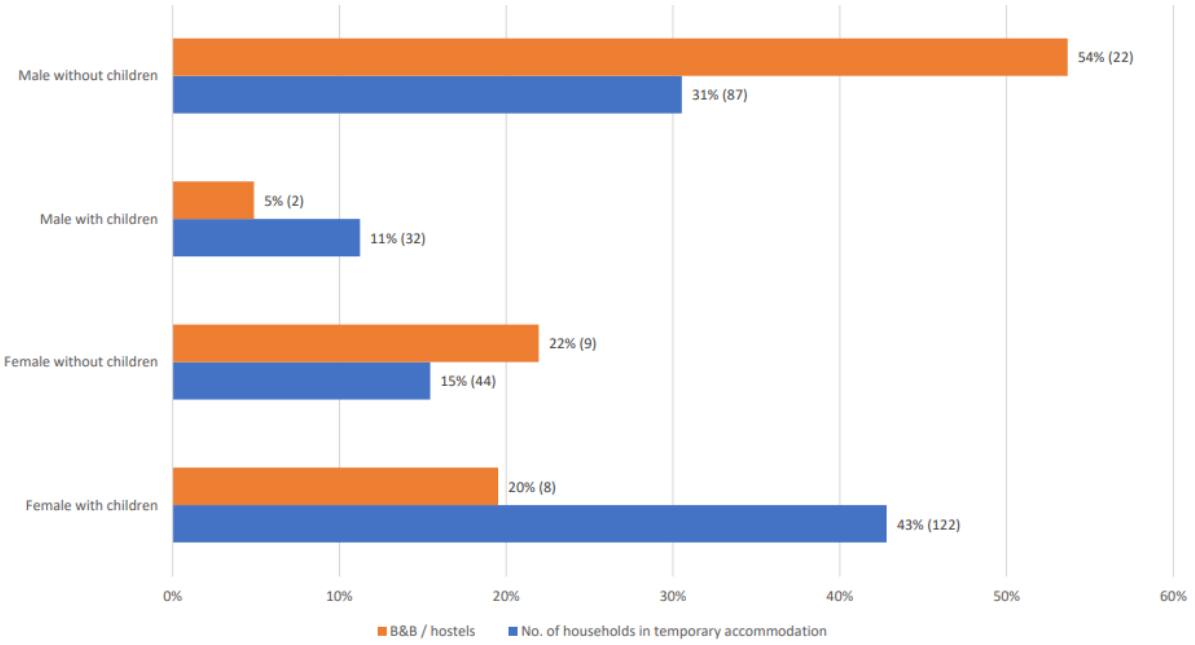
Table 11: Household type with dependent children homelessness, owed a Relief Duty. April 2021-March 2022, Richmond

Household type	**Percentage**
Single parent (female)	25%
Single parent (male)	1%
Couple with dependent children	3%
Three or more adults with dependent children	1%

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

As of March 2021, in Richmond, the largest proportion of applicants in any type of temporary housing accommodation were households with children. The combined total of those groups were 154 households, which equated to 55% of all households in temporary accommodation at that time as seen below.

Graph 5: Comparison of all temporary accommodation, B&B and hostel admissions by gender and with or without children, as of 31st March 2021, Richmond.



A large proportion of Richmond 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. Homelessness in childhood is also considered an adverse childhood experience.

A 2004 report from Shelter [86], in which almost 200 families with dependent children were surveyed, found that:

- Almost all families (90%) felt 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.

86Shelter: 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?

Chart 1: 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[87], 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.

In Richmond, females with children spend the longest amount of time in temporary accommodation compared to other groups, which is thought to be due partly to being the largest group in temporary accommodation and partly as larger accommodation is needed, which is more difficult to acquire and makes moving more difficult.

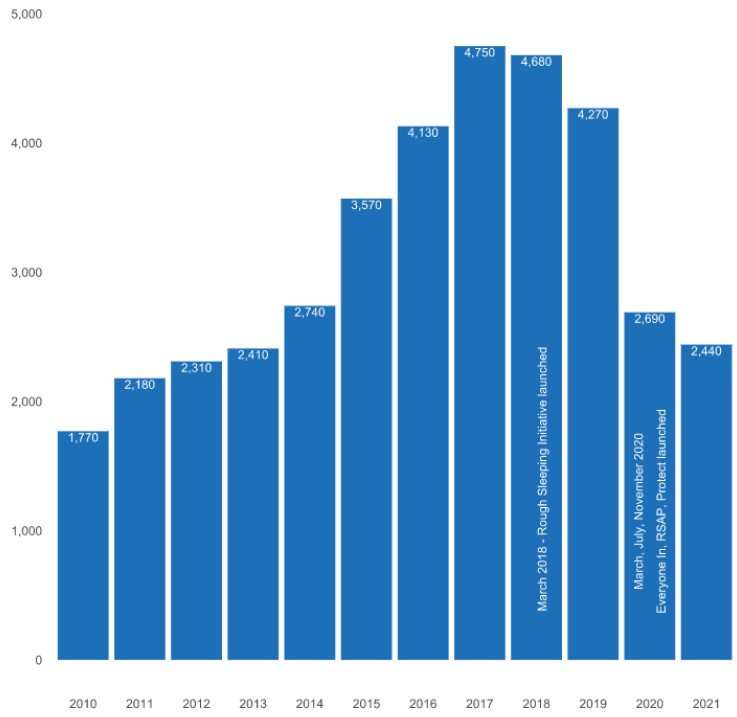
B&B and hostel accommodation is only offered to households with children on a short-term basis, and as shown in graph 5, males without children are commonly housed in this type of accommodation in Richmond.

Rough sleeper population in Richmond

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 appears to have fallen for the fourth year in a row since 2017[88].

[87] 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

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



Graph 6: Estimated number of people sleeping rough on a single night in autumn in England since 2010

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

Locally, CHAIN data 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% were returners.

This compares to 61 rough sleepers seen in Richmond, with 52% being new/flow, 33% stock and 15% returners. Most recent data from quarter one of 2022/23 shows a further 23 rough sleepers in Richmond. However, conversations with those working with rough sleepers locally suggest that this is an underestimate.

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 Richmond, 93 people who were majority rough sleepers were provided with emergency accommodation as a result of the COVID-19 Everyone In campaign. Of that, 29 people were still in accommodation awaiting a more permanent arrangement, but as many as 87 (94%) had been 'closed' and rehoused into a more permanent form of accommodation. This demonstrates that the Everyone In initiative

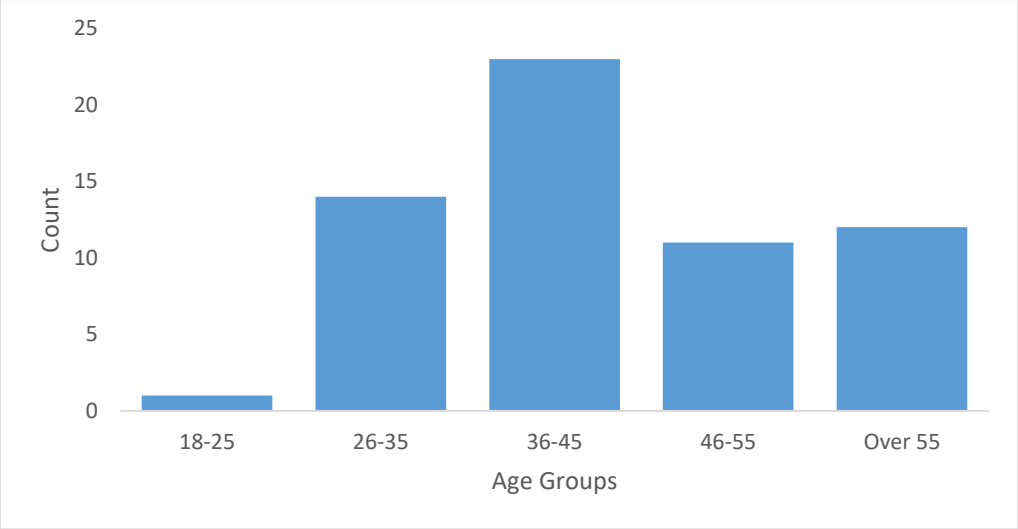
successfully housed people who were otherwise rough sleeping in a relatively short time frame.

Demographics of Richmond's rough sleeping population

Age

Data from 2021/22 shows that there was a lower representation of 18–24-year-olds and a higher representation in both the 36-45 years and over-55 years age groups compared to combined ages of outer London boroughs, suggesting a slightly older population of rough sleepers in Richmond compared to London.

- 2% were aged 18-25 years compared to 10% in all outer London boroughs.
- 23% were aged 26-35 years compared to 27% in all outer London boroughs combined.
- 38% were aged 36-45 years compared to 29% in all outer London boroughs combined.
- 18% were aged 46-55 years compared to 22% in all outer London boroughs combined.
- 20% were aged over 55 years compared to 12% in all outer London boroughs combined.



Graph 7: Count and age distribution of rough sleepers in Richmond, 2021-2022

Gender

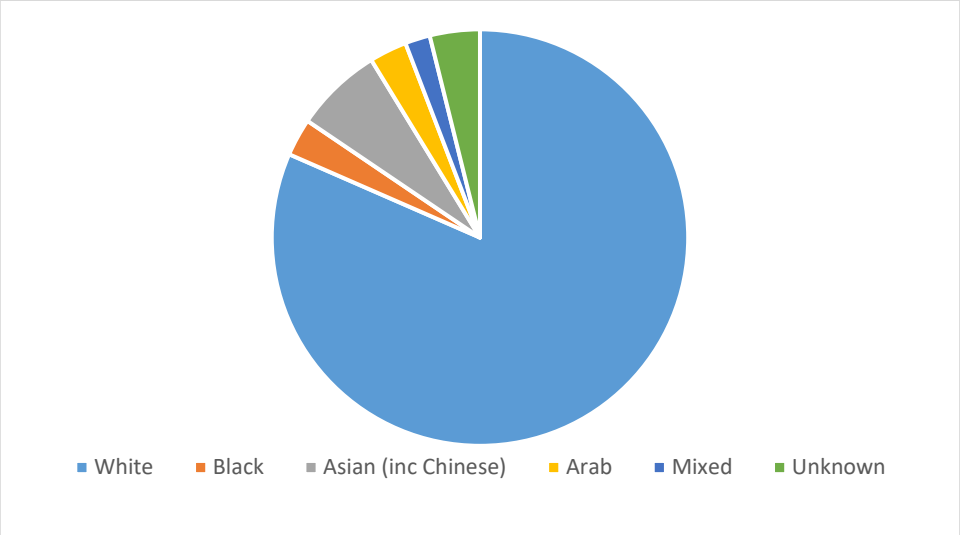
In Richmond (2021/22), 92% of rough sleepers were male and 8% female, with none identifying as non-binary. The proportion of males is slightly higher than those seen across other outer London boroughs, but numbers are smaller and therefore may be less accurate.

Ethnicity

Of rough sleepers in Richmond (2021/22), 84% were White which is in line with borough demographics. 3% were Black which is an over-representation compared to borough demographics from 2019 GLA estimates.

7% were Asian, 3% Arab, 2% Mixed ethnicity and 4% unknown. These estimates don't directly enable comparison with the borough estimates for ethnicity due to lack of data, this was similar to the ethnicity breakdown for Asian, Arab, Mixed and unknown groups in all

outer London boroughs combined. However, the numbers are small in Richmond so small changes can be reflected with larger changes in percentage breakdown [89].



Graph 8: Ethnicity breakdown of Rough Sleepers, Richmond, 2021-22

Nationality

Three quarters of the rough sleepers identified in Richmond between 2021/22 were UK nationals. A small number were Central and Eastern European (n=6), Asian (n=5) with the remainder (n=4) noted as 'not known'.

Experience of institutional settings

Locally, based on CHAIN data from 2021/22, 37% of rough sleepers did not have a history of being in one of the following named institutions - the armed forces, in care or in prison.

In Richmond, 6% of rough sleepers reported being in the armed forces, 14% had experiences of being in care and 42% had been in prison. A higher proportion of rough sleepers had experiences of institutional settings in Richmond compared to the London averages (7% in care and 28% in prison). This could indicate a more complex case load compared to other outer London boroughs, with increased exposure to institutionalised settings and the complexities around trauma and poor health outcomes associated[90].

Table 14: Percentage of rough sleepers with a history of institutional setting, by percentage in Richmond rough sleepers compared to Outer London borough rough sleepers, 2021/22

Institution	Richmond Rough Sleepers	London Rough Sleepers
Armed forces	6%	-
Care	14%	7%
Prison	42%	28%

Whilst some services locally take a trauma-informed approach to care, often indicated when working with individuals with a history of institutional settings, not all services that rough sleepers come into contact with do.

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

Health services and support for the homeless population in Richmond

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

The Vineyard Community Centre and The Vineyard Surgery

The Vineyard Community Centre provides support to those who are homeless or at risk of homelessness on Monday to Friday mornings. This includes community nursing care. Three days a week, support is provided by Glass Door to those experiencing or at risk of street homelessness/complex crisis[91].

A number of GPs work on a voluntary basis to support the health needs of homeless populations in Richmond, including at The Vineyard Surgery, offering drop-in appointments in the Vineyard Community Centre.

Nursing Services

Outreach nursing support is provided to homeless people in Richmond, primarily through voluntary or parish nursing (such as that provided at the Vineyard Community Centre) rather than formal nursing services. The lack of a formal service results in inconsistent provision and this is a gap in homeless health provision in Richmond, particularly for rough sleepers.

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 accepted 246 referrals within the first nine months of the service and, as of November 2022, had received 300+ referrals within the last year. 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[92]:

[91] https://www.vineyardcommunity.org/
[92] https://www.spearlondon.org/our-services/

- 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.
- 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.

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[93].

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, 24 unique individuals engaged with the RSDATG funded service.

[93] 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 Richmond

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 25 patients over 8 weeks between September and November 2022 from a GP working on a voluntary basis in Richmond. The majority of patients had recently been rough sleeping. 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.
- Healthwatch Richmond report on 21 experiences of health and social care from people experiencing homelessness from May 2020[94].

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.

Support needs

Support needs of the statutory homeless population

Of those residents that were owed a duty between April 2021 and March 2022, 375 support needs were identified in individuals and approximately half of households (n=190, 49%) were noted to have support needs[95]. The percentage of support needs in the statutory homeless population in Richmond appear to be 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 needs assessment.

The most common support needs of households were:

1) History of mental health problems (29%).
2) Physical ill health and disability (14%).
3) At risk of/has experienced domestic abuse (13%).

Less common support needs included:

- Learning disability (6%).
- Drug dependency needs (6%).
- Alcohol dependency needs (5%).
- Offending history (5%).
- At risk of /has experienced sexual abuse/exploitation (4%).
- History of rough sleeping (3%).
- History of repeated homelessness (3%).
- A young person aged 16-25 requiring support to manged independently (3%).

[94] Patient Experience to inform the JSNA, Healthwatch – Richmond upon Thames https://www.healthwatchrichmond.co.uk/sites/healthwatchrichmond.co.uk/files/Patient%20Experience%20to%20Inform%20the%20JSNA%20by%20Content%20for%20website.pdf

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

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

Support need	Percentage of Richmond statutory homeless population with support need	General population
Mental health problems	**29%**	1 in 4 (25% lifetime risk)
Physical ill health and disability	15%	-
Domestic abuse*	13%	5% annual
Learning disabilities	6%	2% (Mencap)
Drug dependence needs	6%	3%
Alcohol dependency needs	6%	1% (YouGov, 2017)
Offending history	5%	-

Support needs that individually accounted for percentages of 2% or lower in this population include: access to education, employment, or training, at risk of/has experienced abuse, 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.

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.

Each year, the Council offers housing to a limited number of applicants. The properties that become available for letting are predominantly housing association properties but may also include properties in the private rented sector[96]. 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).

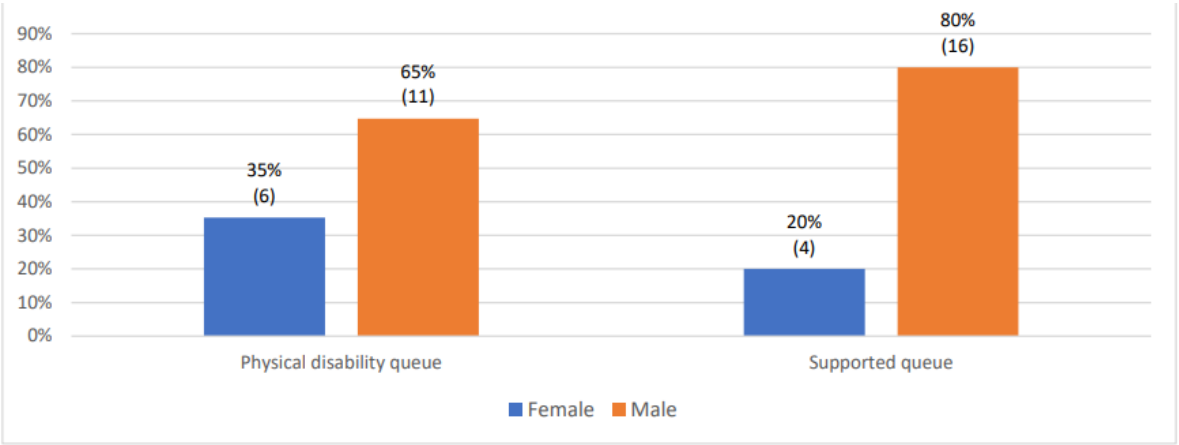
[96] Equalities analysis, Lettings and Housing Department queues
https://www.richmond.gov.uk/media/23210/2020_2021_equalities_analysis_lettings_and_housing_department_queues.pdf

- Social care queue (includes care leavers, fostering and child protection).
- Pan London mobility scheme (social housing tenants from other London boroughs).

Data from the lettings and housing department queues, as of 31st March 2021, gives some further insight into the inequalities of support needs of those applying to the Council as homeless.

Of note, there appeared to be a higher burden of both physical disability and support needs in males who were homeless compared to females. This was found to be a significant difference although the numbers are small which affects the reliability.

Graph 9: Comparison of proportion and percentage of those in the physical disability and supported queues for housing applications for males and females. 31st March 2021. Richmond.



* there were no joint applicants in the supported queue and a very small number of households with children

Support needs of the rough sleeper population

CHAIN annual reports 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 Richmond, of the 42 rough sleepers assessed during the CHAIN data collection:

- 32 (76%) had mental health support needs compared to 52% across all outer London boroughs.
- 19 (45%) had drug support needs compared to 31% across all outer London boroughs.
- 16 (38%) had alcohol support needs compared to 30% in all outer London boroughs.
- 26 (60%) had more than one of: alcohol, drug or mental health support needs compared to 34% across other London boroughs.
- Only 5 (9%) 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. When comparing rough sleepers in Richmond to other outer London boroughs, the level of complexity relating to support needs is higher than the average in all support need areas, with particularly high mental health need and a higher proportion of rough sleepers reporting multiple needs. Fewer rough sleepers in Richmond had no support needs compared with other boroughs[97].

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

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 Richmond. 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.

In Richmond, identified within the Richmond Mental Health Needs Assessment[98], as of 2017/18, there were 207 households who were homeless and in priority need. Of those:

- An estimated 26 people had a psychotic illness (13%)
- An estimated 24 had major depression (12%)
- An estimated 48 had a personality disorder (23%)

This further identifies that the mental health needs of those who are homeless are complex, and it is worth noting that such forms of mental ill health are likely to impact how and whether an individual can interact with services.

A report from Healthwatch Richmond, including views of 21 people who were experiencing homelessness and had recent experiences of health and social care, found that there was a concern regarding mental health problems in 39% of responses[99]. Concerns highlighted that:

- It was difficult to engage with mental health home treatment teams when homeless.
- Communication and co-ordination with the community mental health team was challenging.
- Discharge from mental health units to temporary accommodation or to the streets following a mental health crisis was particularly detrimental to mental health.
- Access to medication was difficult and took longer with no fixed address.
- Local community centres were suggested as a preferred location for delivery of mental health services.

It was also highlighted through stakeholder interviews that referrals for mental health assessments and accessing support is difficult, with some local mental health services unable to or unwilling to accept people who are homeless or without a fixed address. This was particularly problematic for people with drug and alcohol needs as referrals were not always accepted or possible due to the referral criteria. Mental health assessments were also noted to be difficult to arrange for people with no fixed address or when people were rough sleeping.

Mental health and wellbeing need in rough sleepers.

The Richmond Mental Health Needs Assessment identified that, as of June 2022, of the 35 rough sleepers recorded an estimated:

- 6 had severe depression.
- 5 were self-harming.
- 7 were experiencing suicidal thoughts.
- 21 had a personality disorder.

The SPEAR Homeless Health Link service is part of the broader offer from SPEAR which works to identify and challenge health inequalities faced by homeless people in Richmond. It

[98] Bethan Harries, Melissa Barker, Graeme Markwell & Natalie Daley Richmond Mental Health Needs Assessment, Public Health Team https://richmond.gov.uk/services/public_health/public_health_publications/mental_health_needs_assessment
[99] Patient Experience to inform the JSNA, Healthwatch – Richmond upon Thames https://www.healthwatchrichmond.co.uk/sites/healthwatchrichmond.co.uk/files/Patient%20Experience%20to%20Inform%20the%20JSNA%20by%20Content%20for%20website.pdf

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.

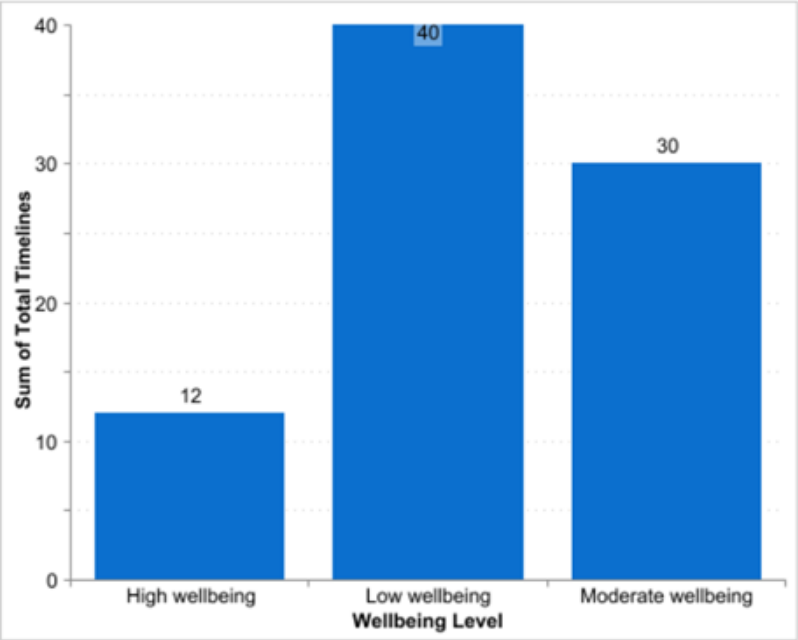
Between 1st December 2021 and 30th November 2022, the Health Link team worked with 92 people in Richmond. Of this rough sleeper population:

- 63% had mental health problems – the majority suffering from depression or anxiety. It is important to note that only around half of people reporting mental health problems had received a formal diagnosis.

A total of 127 patients have been seen by the Homeless Health Link service across both Richmond and Wandsworth in the above timeframe. 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.
- 16% had a score indicating 'high wellbeing' level.

Graph 10: WEMWBS score for patients in the Homeless Health Link Service (SPEAR) December-November 2021/22, Richmond, and Wandsworth.



Those working in the service also 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 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.

A number of GPs work on a voluntary basis to support the health needs of homeless populations in Richmond, including at The Vineyard Surgery. An audit from a GP working on a volunteer basis in Richmond of 25 patients over 8 weeks between September and November 2022 found that over half (56%) presented with mental health issues including:

- 4 cases of PTSD
- 3 cases of significant psychosis
- 7 cases with combinations of anxiety, low mood, and self-harm

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

The most recent data available from the Office for Health Improvement and Disparities[100] for Richmond (1st July 2022-30th September 2022) on the RSDATG identified that the mental health need among the clients funded through the grant is higher than seen or recorded in other homeless populations locally.

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.

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:[101].

- 65% had mental health problems.
- 1 in 5 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 most of the work focuses on getting patients safely housed. The team have 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 outside of London; and approximately 60% of accepted referrals were individuals from Wandsworth, Merton, or Croydon. Whilst few Richmond residents were noted in the population, they are reflected in the data. Around half of referrals were rough sleeping at the point of acceptance. Others were sofa surfing, facing eviction or already in a homeless hostel or temporary accommodation. 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

100 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.

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

routinely record housing status. Often, individuals working in the health service do not know if a person is homeless unless it is disclosed, or the individual is visibly rough sleeping.

Physical ill health was identified as a support need in 11% of Richmond's statutory homeless population and 22% of the statutory homeless population who were unemployed or were not working due to long-term illness or disability[102].

Individuals accessing the SPEAR Homeless Health Link service.

Work with 92 rough sleepers in Richmond by the SPEAR Homeless Health Link team between 1st December 2021 and 30th November 2022 found that 65% had physical health problems, the highest proportion of which were dental or musculoskeletal complaints. This was also reported during the stakeholder interviews.

Individuals accessing primary care.

An audit of 25 patients seen during an 8-week period between September and November by a GP providing care in a voluntary role to homeless people in Richmond identified the following presentations:

- Podiatry issues.
- Chest symptoms.
- Chronic pain.
- Gastric problems.
- Ear, nose, or throat problems.
- Bites.
- Neurological symptoms.
- Septic arthritis.
- Atrial fibrillation.

Some patients had multiple presentations, illustrating the complexity of clinical cases.

The complexity of need in this population highlights the importance of 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.

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

Drug and alcohol needs

Data shows clear needs in relation to substance misuse in the homeless population; these are more prevalent among rough sleepers. The GP audit highlighted that there is frequent concurrent alcohol and drug use and addiction among patients.

Substance misuse needs of rough sleepers

Data from April 2021 to March 2022 showed that 45% of rough sleepers in Richmond had drug support needs compared to 31% across all outer London boroughs. 38% had alcohol needs compared to 30% in all outer London boroughs. Almost two-thirds of Richmond's rough sleepers (62%) had more than one of alcohol, drugs or mental health support needs compared to 34% of the total population of rough sleepers across other London boroughs, indicating high levels of complex needs in the local population[103].

Individuals accessing the Homelessness Inclusion Team

Among 20 patients seen by the HIT, 65% had problems with addiction and 20% had co-occurring mental health and addiction problems. An audit of the service found that a quarter of addiction problems were managed thoroughly during their inpatient stay but none after discharge. This was thought to be due to a lack of communication with addiction services following discharge.

Individuals supported by the rough sleeping drug and alcohol treatment grant funded service

Data from July 2022 to December 2022 shows that 22 people were engaged in the service over this period. 13 were at risk of sleeping rough and nine were rough sleeping. Four had problematic opiate use while eight had problematic alcohol use (with no other problematic drug use).

Healthcare services

Access to care

General Practice

The data around homelessness within general practice is limited as there is currently no standardised way to identify someone as homeless on EMIS. In addition, patients face barriers to getting appointments and some may choose not to disclose their housing status. Therefore, it is difficult for GPs to identify those who may be or are at risk of homelessness.

Barriers to healthcare for people who are homeless include[104]:

- 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[105].

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[103] CHAIN annual report outer boroughs. April 2021 – March 2022
104 Gunner, E et al, 2019, Elwell-Sutton, T et al, 2017
105 Doctors of the World, 2017, 2018

In Richmond, as of December 2022, 60% of all GP practices (15 out of 25) 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 as a minimum requirement. Safe surgeries should commit to taking steps to tackle barriers faced by inclusion groups to accessing healthcare.

Table 16: GP surgeries in Richmond signed up to Doctors of the World Safe Surgeries initiative as of December 2022

GP practices signed up as a Safe Surgery:

- Acorn Group Practice.
- Broad Lane Surgery.
- Cross Deep Surgery.
- Glebe Road Surgery.
- Jubilee Surgery.
- Kew Medical Practice.
- Park Road Surgery.
- Parkshot Medical Richmond.
- Richmond Lock Surgery.
- Richmond Medical Group.
- The Groves Medical Centre.
- The Paradise Road Practice.
- The Vineyard Surgery.
- Woodlawn Medical Centre.
- York Medical Practice.

A key focus of the South West London Homeless Health Programme is improving access to primary care. Local services show variable levels of GP registration among their service users:

- 92% of 92 people working with the SPEAR Homeless Health Link team had been or were already registered with a GP.
- Only two (20%) of the 10 clients in the RSDATG service in Q2 (1st July 2022-30th September 2022) were registered with a GP. The low rate may be in part due to a lack of data recording as the service is new.
- 85% of those seen by the HIT, for whom GP registration status was checked (85%), were registered with a GP. 15% had no GP or an inappropriate GP unlikely to be providing care. However, following discharge from the team, only around 30% of cases continued to be managed thoroughly after discharge. Although GPs were identified and contacted in about 90% of these cases and GP engagement was noted to be high, getting an appointment was difficult.

However, even when people are registered with a GP, stakeholders reported that accessing appointments was difficult, particularly for rough sleepers. 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 the healthcare system.
- Appointments inappropriately short given the complexity of need.
- Being refused registration.
- Difficulty prioritising health in current social situation.

Service models that reportedly achieved good access include the voluntary GP service within SPEAR, drop-in appointments by The Vineyard Surgery at the Vineyard Community Centre and appointments in places already attended by rough sleepers, but the demand was high. Within the voluntary service at SPEAR, 30-minute appointments are usually provided, due to the complexity of cases. This compares to much shorter consultations at mainstream GP services. This service currently has no access to primary care systems, therefore is not able to offer prescriptions and has limited ability to follow up over the longer term, therefore following the initial consultations, the service often aims to link rough sleepers back to registered GP's, though this is challenging for the reasons outlined above.

This highlights the need for good generalist care, with adequate resources in this group alongside access to specialist services where needed. It is important to note that this service is entirely voluntary and, along with GP engagement at The Vineyard Surgery, is highly valued and needed for the homeless population in Richmond. However, structures in place to support these services are minimal. Therefore, there is no plan in place should individual circumstances of the volunteers change which is a precarious model of care for people experiencing homelessness, particularly rough sleepers.

The Richmond primary care network (PCN), which includes Parkshot Medical Practice, Seymour House & Lock Road Surgery, Kew Medical Practice, Vineyard Surgery and Paradise Road Surgery, has identified homelessness as an area of focus for targeted work as part of tackling neighbourhood health inequalities work within the PCN network's directed enhanced services. A PCN in Kingston has also identified homelessness as a need in their local area.

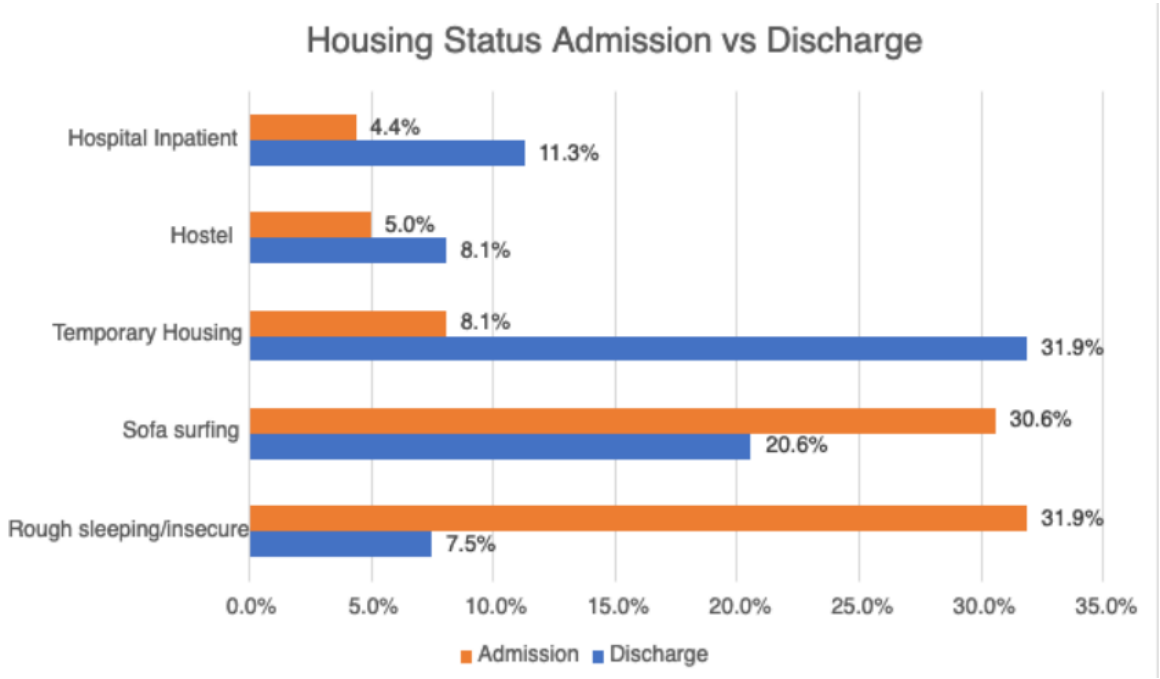
Effectiveness of care

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 Richmond 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.

Graph 11: 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 allocated resource and capacity to do so. Furthermore, patient feedback is overwhelmingly positive.

Kingston and West Middlesex, where homeless residents in Richmond present to access care, currently do not have similar schemes.

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 17.

Table 17: Stakeholder views of Homeless Health needs presented as strengths, opportunities, gaps and challenges relating to Homeless Health services in Richmond, 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. • 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.

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.
  ○ No inpatient HIT in Kingston or West Middlesex hospitals.
• 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.
• Secondary care is not always flexible regarding individual needs for appointments.
• Over-reliance on voluntary sector to provide healthcare.
	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.
	• 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).

<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 homeless nursing service.
• Relationships/social connection.
	• 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 the health of 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

- Increased mental health provision for homeless and rough sleeper populations locally is needed; need is high 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.
- 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.
- Build on the success of the HIT at St George's, supporting the community handover process and consider pilot programmes at Kingston and West Middlesex hospitals.
- Build on the expansion of the RSDATG service to further understand health needs within rough sleepers locally, using data already being regularly collected.
- 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 18.

Table 18: 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) discussions 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 as a 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. 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 identified (Richmond Mind) and in place to provide mental health support at The Vineyard and Etna centre for people with complex issues with outreach capabilities (e.g. drug and alcohol and mental health services). Opportunity to extend for another year. 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. RSDATG 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 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 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 (e.g. build on the model at The Vineyard in other areas of the borough). Consider outreach models for services where access is particularly difficult. Health and wellbeing days to be continued as a system in the short-term whilst establishing improved access to care in the medium-term. Collective approach to outreach across services to reduce re-telling of stories.	The Vineyard is a valued model of service delivery. 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. Community Outreach Bus (Public Health) with clinical space currently undergoing review of use and funding, opportunity for collaboration to deliver outreach services.
Improving access to appointments to primary care 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. Consider increasing Homeless Health Nursing Service further given demand.	A primary care network in Richmond identified 'homelessness' as an area of focus for targeted work as part of the 'tackling neighbourhood health inequalities' work within the PCN network contract's directed enhanced services. A PCN in Kingston has also identified homeless as a need in their local area which provides an opportunity for collaborative working. SWL Homeless Health Programme priority to improve access to primary care. Use of severe mental illness health checks, high need multiple long term conditions schemes or home visits to

		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.	day centres could be utilised to improve access for rough sleepers and are already in place. Potential for primary care service via community outreach bus depending on funding, in rough sleeper hub or in Salvation army clinical space. Supporting local practitioners with a special interest in Homeless and Inclusion health to improve services for access to primary care for rough sleepers e.g. GP SPIN fellows.
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.	South West London Transformation Group reviewing dental and podiatry support in Kingston and Richmond, awaiting further understanding of the London approach before continuing. Use of Homeless Health days could provide access to services. Social prescribing link workers are in place. Pan London co-occurring conditions programme with South West London ICS lead and funding until 2024
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.	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. The ICB has a statutory role in reducing inequalities.

		Deep dive into health needs of children's and families experiencing homelessness.	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 them 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 Richmond residents.
- 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.
- Further prevention work around causes of homelessness acknowledging 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 intervention to prevent homelessness, it is reasonable to assume health needs associated with 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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Appendix

Key findings of the stakeholder engagement

The following groups were consulted as part of the homeless health needs assessment:

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
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- Public Health Lead, Adult Social Care and Public Health

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 input 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 to 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 groups 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 need 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.
- Particular complexity highlighted in Richmond rough sleepers and those accessing the RSDATG service.
- Prepare health services for increase in demand as forecast by the housing department, due to the cost-of-living crisis, COVID-19 pandemic.

SERVICES:

Increase mental health provision for homeless and rough sleeper populations locally as need is 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 the Vineyard Community Centre to deliver care that is historically in a mainstream setting.
- 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 prioritized in rough sleepers.

- Increasing registration to Safe Surgeries DOTW initiative (60% uptake in Richmond, 54% uptake in Wandsworth), 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.
- Consider Homeless health nursing provision in Richmond as currently no formal homeless health nursing service.
- 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 Richmond – review local provision and access.

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

Consider building on the success of the Homelessness Inclusion Pathways team at St George's and supporting pilots in Kingston and West Middlesex hospitals.

- Feasibility scoping exercise in hospital settings building on experience and learning from St George's team.

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 i.e. If back to GP but not able to access?

- Utilise the format of the healthcare assessment undertaken by the RSDATG service and could replicate in other areas for individuals not using the service (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

- Translation services would be needed as an additional resource in these processes to increase representative engagement.
- Further exploration of ways to engage with the voluntary sector as the health needs assessment progresses around supporting homeless health.
- In the development of any new service (e.g. Community Hub) opportunity for community engagement work.

Staff

- Recognising that capacity is under pressure and recruitment in the homeless sector is difficult, consider how staff in the homeless sector can be support.