

Health and Homelessness in Coventry



About this report

This report presents the findings of a project facilitated and funded by the NIHR (National Institute of Health and Care Research) [Coventry HDRC \(Health Determinants Research Collaboration\)](#) to understand health and homelessness in Coventry. The work was led by a seconded embedded researcher from the University of Warwick and undertaken in partnership with the Housing and Homelessness team at Coventry City Council and colleagues in the NHS, social care, public health, housing, and voluntary and community sectors. The aim of the work was to understand the relationship between health and homelessness, identify existing evidence, understand barriers and facilitators to improving the health of people experiencing homelessness in Coventry, and identify priorities for future research.

The work comprised:

- Scoping existing available national and local evidence regarding health and homelessness
- Attending meetings and engaging with Coventry City Council staff and wider stakeholders to understand the challenges, barriers and enablers to improving health of people experiencing homelessness
- Engaging with people with lived experience of homelessness to understand what is important to them about their health and their priorities
- A workshop with stakeholders and Coventry Public Voices Group to share learning and establish priorities for future research (areas of research interest).

This report is intended to inform and be used by Coventry City Council, within Coventry HDRC, its partners, and the wider research community, to help develop local health and care strategies for people experiencing, or at risk of, homelessness and inform future research. It contributes to the local evidence base regarding health and homelessness in Coventry and builds on existing work already undertaken to understand and evaluate local provision using the NICE (National Institute for Health and Care Excellence) guidelines for homelessness support, and the Coventry Homelessness and Rough Sleeping Strategy 2025-2029.

It is important to note that this report focuses mainly on the issues and challenges faced by rough sleepers and people experiencing what is known as “multiple exclusion homelessness” (Fitzpatrick et al., 2011); that is, people who experience deep and multiple exclusions from society due to e.g. drug and alcohol problems, mental health difficulties, complex trauma, ‘street activities’ such as sex work, begging or survival shoplifting, and other issues associated with their homelessness. However, we recognise that understanding and addressing health and homelessness is equally important for other groups including, but not limited to, vulnerable families and children, people leaving care, residences or prison, vulnerable migrants, and other inclusion health groups. Future research with these populations is recommended within this report.

A list of key public sources of evidence and other useful resources regarding health and homelessness have been included at the end of this report. The list should not be

interpreted as exhaustive but instead we suggest that the resources, alongside this report, are used as a starting point to support future local research and analysis.

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The Homelessness Forum

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1. Introduction

The relationship between health and homelessness

It is now well established that homelessness is both a cause and consequence of poor health (Jackson et al., 2024). People experiencing homelessness have some of the poorest health outcomes and worst health inequalities in the UK (Marmot et al., 2020). The average age at death for people rough sleeping is approximately 43 years for women and 45 years for men, more than 30 years below the national average for life expectancy (ONS, 2024).

A number of factors contribute to poor health and health outcomes among people experiencing homelessness. People experiencing homelessness often experience wider risk factors for ill-health, such as poverty, exposure to violence, psychological trauma, self-neglect, and substance misuse (Public Health England, 2021). People experiencing homelessness are also at greater risk of communicable or infectious diseases, such as TB (Tuberculosis), experience premature (non-geriatric) frailty, and frequently live with one or more chronic disease, such as respiratory, heart/circulatory problems, or gastrointestinal issues, among other conditions (Aldridge et al., 2018; Lewer et al., 2019; Rogans-Watson et al., 2020; Dawes et al., 2025). A recent report by the Homeless Link (2025) found that approximately 80% of people experiencing homelessness were managing multiple debilitating health conditions and 69% had received a physical health diagnosis before becoming homeless. People who rough sleep additionally often experience what has been called the “tri-morbidity” of physical and mental ill-health and substance misuse (Hewett and Halligan, 2010), and substance misuse issues often worsen or become a way for many people to cope with their feelings about their homelessness (McVicar et al., 2015).

For some people physical or mental ill-health, substance misuse, or experiences of abuse or trauma, for example, may have occurred earlier on in their lives and are part of the complex circumstances that have led to their homelessness (Liu et al., 2021; Nilsson et al., 2019). For other people, these issues may have arisen more directly or recently, and/or worsened, because of their homelessness (Adams et al., 2023). Either way, many of these issues and experiences create challenges in themselves for individuals to seek support with their health, and continue to contribute to people’s homelessness, making it harder for people to recover and sustain their housing outcomes. This means that understanding and improving the health of people experiencing homelessness is very important, to prevent homelessness, and to avoid worsening or repeated and long-term homelessness.

Managing health conditions for people experiencing homelessness however can be very difficult due to the unsettled nature of homeless lives. People experiencing homelessness may struggle to prioritise their health alongside other challenges, and also face barriers related to the way healthcare services are delivered, including inflexible provision, negative attitudes or stigma from some staff, and lack of accessible preventative and primary care (Omerov et al., 2020). These issues mean that treatment is often not sought until problems are very severe and urgent and acute care services tend to be very highly used. There is evidence that the rates of people experiencing rough sleeping are at least 4 times higher to attend A&E than housed people (Jackson et al., 2024).

For all these reasons, people experiencing homelessness have been established as a national priority health inclusion group (NHS England (NHSE), 2023a; Public Health England, 2021) and reducing the impact of homelessness is a key priority within the recent Marmot review of health inequalities (Marmot et al., 2020). Coventry, as the first designated 'Marmot city', is committed to tackling homelessness and to addressing barriers to improving the health of people experiencing homelessness in Coventry. This includes both people without housing (people who are 'roofless' or rough sleeping) and people who are vulnerably housed: that is, people who may be living in emergency or temporary accommodation, 'sofa surfing', staying with relatives/friends/acquaintances, or living in other precarious housing situations (such as living in a squat). Coventry City Council is proactively working in partnership with colleagues in the health, social care, housing and voluntary and community sectors to achieve this, in line with the One Coventry Plan, and this report aims to support the evidence base for this work.

A national priority

There are a number of national policy developments and drivers that have helped raised the profile of health and homelessness as an issue for local action for Coventry.

Firstly, tackling homelessness has been rising in the national policy agenda as part of [NHS England's strategic priority to reduce health inequalities](#) (NHSE, 2023a). These policy efforts have been underpinned by a focus on [inclusion health](#) (Public Health England, 2021) - an umbrella term used to describe people who are socially excluded and experience multiple and overlapping forms of disadvantage, including people experiencing homelessness. Other people who are among inclusion health groups include individuals experiencing drug and alcohol dependence, individuals engaged in sex work, migrants in vulnerable circumstances, Gypsy, Roma and Traveller communities, and those in contact with the criminal justice system. Public Health England (2021) note it is important to recognise that different inclusion health groups have distinct needs and there are differences in experiences, e.g. between men and women (see for example Luchenski et al., 2017; Bimpson et al., 2021; Johnson, 2025). However, housing precarity and risk of homelessness, if not actual homelessness, is very often a shared experience among inclusion groups, therefore addressing homelessness is a major concern (NHSE, 2023a, 2023b).

The [2020 Marmot review](#) of what has happened regarding health inequalities since 2010 (Marmot et al., 2020) highlights that homelessness has been rising nationally. It notes that homelessness and rough sleeping rates rose substantially by 165 percent in England between 2010 and 2017 (ibid: p.115). The total number of households in temporary accommodation increased by 74 percent between 2010 and 2018 and the number of children living in temporary accommodation increased by 69 percent (ibid: p.115). At the end of 2018, 83,600 households were homeless, including 125,020 children (ibid p.115). The review has identified homelessness as a priority area for action on health inequalities.

The [National Plan to End Homelessness](#) policy paper published in December 2025 similarly

asserts that the number of people rough sleeping is two and a half times higher than 2010, and a record 132,410 households, including 172,420 children, were living in temporary accommodation in England on June 30th 2025 (HM Government, 2025).

Some of these recent policy initiatives are supported by frameworks and/or recommended actions to help Integrated Care Boards and health and care organisations address health and homelessness outcomes:

- The 2022 [National Institute for Health and Care Excellence \(NICE\) Integrated health and social care for people experiencing homelessness guidelines \(NG214\)](#). The guidelines contain evidence-based principles that aim to improve access to and engagement with health and social care, and ensure care is coordinated across different services, for people experiencing homelessness. Coventry has used these guidelines to conduct an initial baseline assessment of health and care support for people experiencing homelessness.
- [NHSE's 2023 national framework for action on inclusion health](#) (NHSE, 2023b). The framework outlines specific steps NHS providers can take to improve outcomes for inclusion health populations and highlights some examples of good practice.
- The [Core20PLUS framework](#), developed by NHSE, is an approach to inform action to reduce health inequalities at national and system level. The 'Core20' population represents the most deprived 20% of areas in England; the 'PLUS' refers to population groups identified locally as experiencing additional or intersecting health barriers. The '5' highlights five major disease types or clinical areas where inequalities are particularly marked and require accelerated improvement. The PLUS groups identified locally for Coventry and Warwickshire are newly arrived and transient communities, including people who are homeless.
- The [Homelessness Reduction Act 2017](#) introduced a Duty to Refer on specified public bodies, including emergency departments, urgent treatment centres, inpatient services, and social services, to refer people who they think may be homeless or threatened with homelessness to a local housing authority. This aims to ensure closer collaboration and partnership working between different parts of the public sector to prevent homelessness. It has also placed duties on local authorities to intervene at earlier stages to prevent homelessness.
- The '[Everyone In](#)' initiative implemented in 2020 enabled local authorities, and provided the (short-term) resources, to provide temporary accommodation for all rough sleepers to keep them safe during the Covid-19 pandemic. The policy has been seen as positive for enabling housing teams to help all rough sleepers and demonstrating what can be achieved through joint working, however, it did not provide long-term sustainable support (Cromarty, 2021).
- In 2022, the Government set out a cross-government strategy to '[end rough sleeping for good](#)'. The strategy is built on 3 pillars – prevention, crisis, and relief. The

[National Plan to End Homelessness](#), published in 2025, updates and expands these prevention strategies.

Local developments

In line with the above national policies and recommendations, a wide range of support and activity has already been implemented across Coventry to help improve health outcomes for people experiencing homelessness. Some of this activity includes:

- A Homelessness Pathways Lead at UHCW to support admissions, discharge and in-patient stays among patients experiencing homelessness
- A specialist primary care service – the Anchor Centre – to provide GP and primary care services for individual's experiencing homelessness
- Establishment of a specialist Coventry Homeless Mental Health Team at CWPT
- Sexual health outreach and drop-in support for people experiencing homelessness
- TB outreach and awareness-raising
- A range of drop-in support at CGL for people experiencing homelessness and substance misuse issues
- Some training and awareness raising around oral health
- A Vulnerable Adults Forum to promote close partnership working and sharing of information between stakeholders, for individuals experiencing homelessness with complex needs
- A Homelessness Forum to promote the voice of people with lived experience.

In October 2024 Coventry City Council used the national [NICE homelessness guidelines](#) to conduct a baseline assessment of how well it was meeting the local health and care needs of people experiencing homelessness. The early baseline assessment work (facilitated by Amy Parker, Public Health) identified some key themes for further work and local action:

Access

- Outreach
- Re-engagement
- Flexibility

Assessment

- Housing Need and Duty to Refer
- Comprehensive

Training

- Reduce stigma
- Reduce discrimination

Accommodation

- Intermediate care
- Palliative care

Support

- Long-term
- Multidisciplinary
- Peer-support

Mental health

- Crisis support
- Dual diagnosis support

Dental Care

- Access to basic dental care

The Coventry **Homelessness and Rough Sleeping Strategy 2025-2029** further sets out the vision, strategic direction and priorities for the city in relation to homelessness for the next five years. It identifies a) early intervention and prevention, b) crisis and targeted support, and c) move on and tenancy sustainment, as key themes and areas for action. Underpinning these themes are 4 principles to drive action:

- Partnership – we will work in partnership to address homelessness in the city
- Intelligence led – we will use intelligence, data and research to influence what we do and how we do it
- Improving life chances and health outcomes – we will ensure our actions help to enhance life chances and health outcomes for people at risk of homelessness or who are homeless.
- Maximising opportunities – capitalise on the opportunities available to prevent and relieve homelessness.

A **Health and Homelessness Strategy Group** has also been established to develop local strategy around health and homelessness and identify and build on areas of good practice, including multidisciplinary and outreach approaches.

A **Coventry and Warwickshire People Experiencing Homelessness (PEH) Healthcare Inequalities Strategy Group** is additionally considering how to address health and homelessness and improve outcomes at a system level, across Coventry and Warwickshire.

This report builds on this existing work and activity to consider where further evidence could make the most impact on health and homelessness, and to understand the barriers and enablers to improving the health of people experiencing homelessness in Coventry.

2. Existing evidence

Individual journeys – example cases

We wanted to start this section by grounding it in the lived experience of people experiencing homelessness. The following are example cases of individuals that have been compiled from some typical scenarios and experiences to illustrate some of the health challenges and complex lives of people experiencing homelessness. They do not represent all journeys or the full range of experiences.

JT: 47-year-old male with a history of street homelessness and council declaration of intentional homelessness. He has a background of substance misuse including crack cocaine and heroin. His physical health issues include a left below-knee amputation, COPD, Hepatitis C, and unhealing wounds. JT struggles with trust and consistently disengages from support services. He recently left a hospital visit prematurely meaning an abnormal chest x-ray went unreported. He has not been seen by his support team for two weeks and his whereabouts are currently unknown raising serious concerns for his wellbeing.



KD: 35-year-old woman with a history of street homelessness and rough sleeping. She was previously declared “intentionally homeless” by the council. KD has longstanding alcohol dependency and intermittent use of synthetic cannabinoids (“Spice”). Her health needs are complex: she lives with uncontrolled epilepsy, chronic anaemia, and significant mobility issues following a previously untreated ankle fracture. She also experiences ongoing gastrointestinal problems related to prolonged alcohol use. KD struggles to engage with health services due to anxiety, hypervigilance, and a strong fear of institutional settings. Her epilepsy has recently worsened, leading to multiple unassessed seizure episodes in public spaces. She recently left A&E before being seen and has declined follow-up appointments offered by the hospital outreach team. KD has not attended her scheduled community health check-ups and missed two appointments with her homelessness keyworker, raising serious concern for her welfare.



Why evidence is important

A key aim of [Coventry's HDRC](#) is to improve local data and evidence, to support evidence-based decision-making and address health inequalities. Understanding, using and improving data and evidence about health and homelessness, and carrying out research, can help us to:

- understand people's journeys and the issues and experiences that have contributed to, and arisen from, their homelessness, so we can better prevent and support people to recover from homelessness
- understand people's experiences of using services and what works for them, to inform service development
- understand staff and professionals' experiences of providing services, and the challenges and enablers they face to supporting and improving the health and lives of people experiencing homelessness
- accurately identify population needs, and understand epidemiology and patterns of service utilisation, to inform public health and healthcare strategies.

We sought to understand what data and evidence was available nationally, and being collected locally, to tell us about the healthcare needs and experiences of people experiencing homelessness. We also sought to identify limitations and challenges with current data and evidence, suggest some ways in which data and evidence could be improved, and highlight wider challenges and considerations for researchers.

The national data included in this section are not exhaustive but present some key and publicly accessible sources of information, to support the evidence-base. Similarly, the local data presented is not exhaustive but aims to give a snapshot and indication of some of the data collected by local healthcare organisations and services, that can contribute to the picture of health and homelessness in Coventry.

Further resources are signposted at the end of this report to support further research and analysis.

National evidence

Health needs of people experiencing homelessness

The [Homeless Health Needs Audit \(HHNA\)](#) is a tool used by local organisations for gathering data about the physical and mental health needs of people experiencing homelessness and how they access services. HHNA data has been analysed nationally by the Homeless Link in four waves since 2012. The most recent wave (2022-25) has formed the basis of a recent report by the Homeless Link, [The Unhealthy State of Homelessness \(November 2025\)](#). Their report finds that:

- 81% (587) of respondents reported having at least one physical health condition. This figure marks a continuing decline in the physical health of people experiencing homelessness, with an increase of 8 percentage points in those reporting physical health conditions since wave 1 (wave 1: 73%)
- The most common *diagnosed* physical health condition was asthma (21% (142 respondents)), followed by chronic breathing problems including bronchitis, and emphysema, obstructive airways disease (19% (132 respondents)).
- 'Dental/ teeth problems' are now the most commonly *reported* physical health condition, affecting 48% (339) of respondents, and this is an increase from earlier waves. Only 37% of respondents were registered with a dental practice.

In terms of mental health, the report finds that 77% (560) of respondents reported at least one mental health condition. Depression and anxiety disorder appear most prevalent, whilst dual diagnosis, PTSD, and personality disorders have seen the largest increases. Almost half (49% (344)) of respondents reported self-medicating with drugs or alcohol to help them cope with their mental health, and of those receiving mental health support, only 32% felt their needs were met. Three quarters of respondents (72%, (510)) meanwhile reported using drugs in the last 12 months, and 49% (131) of respondents were at high risk of exceeding the Chief Medical Officer's (CMO) low-risk drinking guidelines.

Healthcare use by people experiencing homelessness

In terms of healthcare use it is also clear from HHNA data that, although 89% (626) of respondents were registered with a GP, access and engagement with primary and preventative care (such as screening and vaccinations) remains low among people experiencing homelessness (Homeless Link, 2025). An earlier study by Elwell et al. (2017) meanwhile suggests that people experiencing homelessness are approximately 40 times less likely to be registered with a mainstream general practice than a non-homeless person.

Many sources of national and international evidence (e.g. Homeless Link 2025; Jackson et al., 2024; Vohra et al., 2022) confirm that people experiencing homelessness are intensive users of accident and emergency services (A&E). Exact figures reported within evidence sources vary, which may be due to wider challenges with recording homelessness (see the section on Evidence challenges and research considerations below). But these sources (ibid) suggest that people experiencing homelessness are at least four times more likely than the general population to use A&E for healthcare. They are also more likely to experience delayed discharge and more frequent re-admittance to care (Vohra et al., 2022). It is estimated that the cost, measured through use of public services, of a person sleeping rough is £12,260 per year, compared to £3,100 per year for an average adult (Campos-Matos, 2023). This is very serious and distressing for the individual and costly to the public purse.

The recent HHNA data reported by the Homeless Link (2025) shows that just over half of respondents (52%, (350)) had used A&E services at least once in the past year.

HHNA data reported by Jackson et al. (2024) meanwhile shows that, for inclusion health groups (which include people experiencing homelessness), physical health problems/conditions (32%), self-harm/attempted suicide (18%), mental health problems/condition (14%), and accidents (10%) are the most common A&E attendance reasons.

Jackson et al.'s (2024) report also shows that people experiencing homelessness are more likely to have emergency (unplanned) inpatient admissions, as opposed to elective (planned) admissions, than the general population. Similarly to A&E attendances, HHNA data shows physical health problems or conditions (37.3%), mental health problems/conditions (13.4%) and self-harm/attempted suicide (13.4%) as the most common reasons for admission amongst people experiencing homelessness.

Barriers to accessing primary healthcare, mental health, and substance misuse services are known to contribute to higher rates of utilisation of the emergency department by people experiencing homelessness (Bowen et al., 2019; Gunner et al., 2019).

Finally, the latest HHNA data (Homeless Link, 2025) shows that the number of people being discharged onto the streets stands at the highest rate since HHNA data collection began. Nearly a third (32%, (77)) of respondents were discharged onto the streets, and a further 18% (44) were discharged into accommodation that was not suitable for their needs.

Local evidence

Acute care

Locally, the housing status of patients is recorded by UHCW to help identify patients that are homeless. A Homelessness Pathways Lead is now in post at UHCW to support admissions, inpatient stays, and discharge processes for people experiencing homelessness, and to help UHCW to fulfil its Duty to Refer obligations. These obligations involve referring patients that are identified as homeless to appropriate housing authorities/services under the Duty to Refer 2017. This involves working with the patient, in a person-centred and trauma-informed way, to ask questions and understand more about the patient's housing or homeless situation, to inform the referral. Reasons for not receiving a referral, where one would be appropriate, or not being seen by the Pathways Lead at all in some cases, are that a patient often absconds/self-discharges before this can be carried out (usually from A&E/the Emergency Department). If the homeless patient does not require a Housing referral (for example because they are already in temporary accommodation), they will still frequently require coordination and support for their discharge and follow-up(s), including with social care, because of the complexity of their needs and challenges.

Evidence from the Homelessness Pathways Lead at UHCW shows that 195 homeless

patients attended UHCW, were admitted, and seen by the Pathways Lead between January 2025 and July 2025. Primary and secondary presenting conditions for these patients is set out in the table below:

	Infections	Mental health	Alcohol withdrawal	Seizures	Falls	Cellulitis	Overdose	Substance Misuse	TB	Other	Data not available
Primary presenting condition, No. and percent (%) of patients	33 (17%)	15 (7.6%)	12 (6%)	11 (5.6%)	9 (4.6%)	6 (3%)	6 (3%)	3 (1.5%)	1 (0.5%)	94 (48%)	5
Secondary presenting condition, No. and percent (%) of patients	1 (0.5%)	15 (7.7%)	46 (23.8%)	1 (0.5%)	0	0	0	49 (25%)	0	1 (0.5%)	5

Of the 195 patients included in this dataset, 94 (48%) presented for Other physical conditions, which could include, for example, existing health conditions, accidental wounds or injuries. These were the most common primary presenting conditions. Infections (not including TB or cellulitis, which are recorded separately in the dataset) were the second highest primary presenting condition (33 patients/17%).

Secondary presentations, where they occurred, and data was available, included Substance misuse (49 patients or 25%) and Alcohol withdrawal (46 patients or 23.8%), which were the most common, followed by Mental health (15 patients or 7.7%). There is a need to understand more about the relationship between primary presenting conditions and secondary presentations, as this could suggest that mental health and drug/alcohol issues are underlying, contributing, or being impacted by, people's primary presenting condition/health issue.

Regarding overdose (6 patients/3%), further evidence and analysis would be helpful to understand whether overdose was intentional and whether overdose related to prescription medication or illicit substances. There is also a need to understand more about the nature of mental health presentations (e.g. specific conditions, whether diagnosed/undiagnosed, and medication issues, for example). Understanding more about the nature of Other presenting conditions, as the most common primary presentation recorded for this cohort, would also be helpful.

In terms of patient experience, the Homelessness Pathways Lead has developed a separate patient feedback questionnaire for homeless patients, which is completed with

individuals while they are at the hospital. This feedback form has been developed separately because many homeless patients are unable to engage with the standard UHCW request for feedback which is received by patients via text message, as the majority of homeless patients do not have phones and/or phone credit to respond, or they have other priorities at the time the message is received following discharge.

A needs-mapping tool is also under development by the Homelessness Pathways Lead to support identification, coordination, and triaging of care and support needs for people experiencing homelessness, and further work to analyse this tool as it develops would be helpful.

Primary care

Evidence from the Anchor Centre in September 2025 shows that 571 registered adult patients were recorded as homeless (430 male, 141 female), that includes those rough sleeping and those vulnerably housed, for example in temporary or emergency accommodation, staying with friends/family/acquaintances, or sofa-surfing, etc.

The ages and genders of registered patients recorded as homeless are shown in the following table:

Age in years	Male	Female
Less than 19 years old	0	0
20-29	35	24
30-39	104	48
40-49	138	34
50-59	107	25
60-69	39	8
70-79	7	1
80-89	0	1
90+	0	0

Further data from the Anchor Centre shows that 55 homeless patients were made appointments for inhouse Counselling between January 2025 - September 2025; 153 appointments were held during that period.

84 patients were made appointments with the social prescriber between January 2025 and September 2025, and 154 appointments were held.

128 patients were offered BBV screening (for blood-borne viruses such as HIV, Hepatitis B, and Hepatitis C) between January 2025 and September 2025.

Further data and analysis to understand uptake among patients would be helpful.

Further data and analysis of the nature of health conditions of patients registered as homeless, service utilisation (including e.g. regarding preventative, screening, and

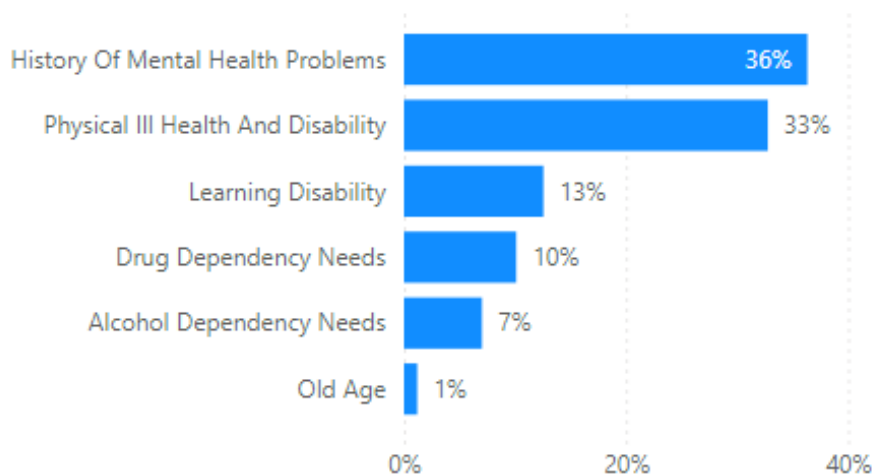
vaccination programmes, as well as treatment), and outcomes, would also be helpful to support local population health management approaches and primary healthcare strategies.

Housing

We looked at Housing service data for the period January 2025 to mid-March 2026 to understand more about the health and wider support needs of people approaching the Housing service in this period. Applicants are assessed after they approach the service, based on their individual circumstances. Following these assessments, the council determines which statutory duties they are owed under homelessness legislation. The typical progression of duties is Prevention – Relief – Final, but applicants can be placed directly into any subsequent duty if their circumstances make them eligible.

During assessments, applicants are asked whether they have any health conditions. Our data for the period January 2025 to mid-March 2026 includes 3750 unique assessments (NB this figure reflects assessments undertaken and does not include total approaches made to the council). The health support needs of the applicant declared by the applicant and recorded during the 3750 assessments for that period is presented below.

Support Needs of Main Applicant - Health



Health support needs of main applicant, (%) of 3750 assessments, January 2025 – March 2026.
(Data taken 17th March 2026).

The data shows that history of mental health problems and mental health support needs was the highest recorded support need (36%), followed closely by physical ill-health and

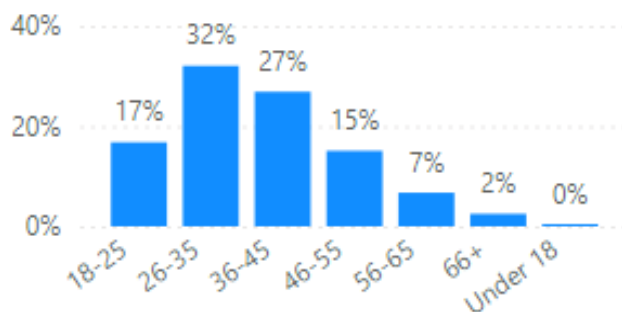
disability support needs (33%). Drug dependency and alcohol dependency, when taken together, make up the next highest support needs, at 17% (10% and 7% respectively).

Of the 3750 assessments January 2025 – March 2026, 353 were referrals into the Housing service from other agencies. Of these 353 referrals:

- 28 were from Hospital A&E or In-Patient (Duty to Refer)
- 26 were from Mental Health Community services (no Duty to Refer)
- 17 were from Mental Health service Acute In-Patient (Duty to Refer)
- 4 were Community based Health Service referrals (no Duty to Refer)
- 4 were GP referrals (no Duty to Refer)
- 25 were referrals from Children's Social Care (Duty to Refer)
- 12 were referrals from Adult Social Care (Duty to Refer)

The ages of the main applicant for the data period (January 2025 – mid-March 2026) recorded in assessments are presented below:

Age of the Main Applicant



Age of main applicant, (%) of 3750 assessments, January 2025 – March 2026.

(Data taken 17th March 2026).

Inequalities and intersectionality

We also looked at data about applicants' backgrounds, recorded under their support needs. It is important to note that the following data are *not* reasons for approaching the council for housing support; rather this background data may help us understand more about wider health inequalities issues and intersectionality of experience - that is, the multiple and

overlapping forms of disadvantage - that may have impacted someone's journey towards seeking housing support.

We found that, of the 3750 assessments January 2025 - March 2026:

- 29% (of 1603) women who had housing assessments in this period were at risk of, or had experienced, domestic abuse. 16% of all applicants were at risk of, or had experienced, domestic abuse.
- 8% of all applicants were at risk of, or had experienced, sexual abuse. Of those 67% were female, and 33% were male.
- A further 7% applicants had experienced Other types of abuse (e.g. bullying, harassment). Of those 52% were male, and 47% were female (1% unknown).
- We also found that 19 referrals of the 353 referrals made by other agencies to Housing service were from Refuge providers.

We found that 16% (868) of applicants had an offending history. Of these applicants, 84% were male and 62% (both male and female) of these applicants were between the ages of 26 and 45 years old. We also found that of the 353 referrals made from other agencies to the Housing service 81 (23%) were from the National Probation Service, and 7 referrals were from an Adult Secure Estate (prison).

We found that 9% (468) of applicants recorded as Former Asylum Seeker. Of these applicants, 71% were male, 29% were female, and 49% (of both male and female applicants) were aged 26-35. In terms of the applicant's household status, 16% were a family with one child, 8% were a family with two children.

1% (65 applicants) within the total 3750 assessments reported as a Victim of Modern Slavery.

We found that 17% applicants had a history of repeat homelessness, and 13% applicants had a history of rough sleeping. For male applicants, this figure was slightly higher at 19% with a history of repeat homelessness, and 16% with a history of rough sleeping.

It is important to note that not all data that is available has been reported here, due to variations in recording and/or reporting which mean that some data requires further analysis and/or verification, and/or because it is beyond the scope of this piece of work. It is important to recognise as well that wider challenges regarding reporting of homelessness (e.g. fear of adverse consequences by individuals) and inequalities issues (such as language, communication) may affect reported data (See Evidence challenges and research considerations below).

Evidence challenges and research considerations

The very poor health and health outcomes for people experiencing homelessness means it is crucial that patients experiencing homelessness are accurately captured in health service

data, and that this data is shared in a timely way, between providers (Fryer et al., 2024). This is important to improve understanding about the health needs of homeless patients, and to enhance the quality of care they receive. Timely and effective data sharing, and being able to access someone's recent history, avoids patients having to keep repeating their stories and is important for patients' safety (Fryer et al, 2024). For homeless patients, this can be especially important, as some people may move between places and need support from several services at the same time (Jackson et al 2024).

Identifying and making visible the needs of homeless patients within health service data and then sharing up-to-date information/data between relevant providers, however, can be very challenging. Some of these challenges relate to the issues around poor access to health services for people experiencing homelessness, meaning these patients go unrecorded (ONS, 2023). Some challenges also relate to lack of training for staff about how to ask the right questions, meaning that even when a homeless patient is seen and recorded, their care records may be limited, fragmented, and incomplete (Fryer et al, 2024). Data sharing meanwhile can be difficult because of the different patient record systems used by NHS organisations, plus a lack of interorganisational data sharing agreements across primary, secondary care and local authorities, because of different data governance arrangements and processes (Jackson et al., 2024). Lack of data sharing is, more widely, a major barrier to population-based approaches/population-health management.

For these reasons, there have been many improvements in recording of housing status within data held by health partners and in healthcare settings including, locally, by UHCW and the Anchor Centre, to improve visibility of people experiencing homelessness. However, this data is still held separately and not joined up.

Likewise, there is a need to continue to improve the visibility of health within housing data. Although some questions about health are asked by the council Housing service during assessments to determine support need(s), the information provided by people seeking housing support varies and may be limited (for example, people may not wish to disclose, forget to mention, or have other priorities at the time). The way information is asked about and recorded is also not standardised. This means that using this information to undertake further research of the relationship between health and homelessness is currently challenging. Furthermore, data collected by the Housing service generally only tells us about *scope of demand* for the housing service *not need* - because data is collected on approaches made to the council, therefore if an approach to council is not made it is not recorded.



Taken together, these issues mean that accurate and complete population-level data about people experiencing homelessness, and their health, is limited. There is therefore a need to consider and identify opportunities to improve sharing of data across systems and services, and the visibility of both health and housing status and needs, within respective datasets.

More widely, it is important to acknowledge the barriers that people experiencing homelessness face in terms of their participation and inclusion in health research. People

experiencing homelessness are often underrepresented and have been described as a hidden population (Crawley et al., 2013; D'Souza and Mirza 2022) within health research, because of the challenges for researchers reaching and accessing people experiencing homelessness. Moreover, certain groups are more likely to be among the 'hidden homeless' (such as women fleeing violence) (ONS, 2023). These individuals may be invisible to, or hidden from, researchers because they want to remain undetected, are dealing with their situation informally (e.g. staying with family/friends or 'sofa-surfing') and/or because of the generally transient and unsettled nature of homeless lives. People may also not come forward to take part in research because of mistrust and fear of stigmatisation. For these same reasons, people may also not approach statutory or support agencies because they fear adverse consequences and therefore miss out on receiving vital support.

Furthermore, the typical research methods used by researchers may not be appropriate for people experiencing homelessness. Conventional research methods that require predetermined and/or inflexible participation processes and follow-ups can be hard for people experiencing homelessness to engage with (D'Souza and Mirza, 2022). Asking for specific information from people experiencing homelessness - particularly during first contacts or encounters - can also be difficult and not necessarily appropriate. It can take time to build trust so that individuals feel safe and willing to disclose information, particularly if questioning is triggering or distressing for individuals. In addition, people may have other priorities or needs which take precedence for them and are their focus at the time. Training may be required to ensure questioning and information gathering is handled appropriately, because if it is not managed well, it can reduce trust and make people less willing to engage with services or research in the future.



There is a need for more innovative, flexible and inclusive research methods that are responsive to the circumstances of people experiencing homelessness and centralise their voices. In line with this, Coventry HDRC and the Housing and Homelessness team is committed to working with Coventry Public Voices Group and the Homelessness Forum to consider how researchers can undertake research with people experiencing homelessness in a way that is enriching for them and avoids further marginalisation.

Evidence gaps

The above challenges and issues mean that there continue to be gaps in the wider evidence about health and homelessness. Jackson et al. (2024) and the Homeless Link (2025) identify the following key areas that would benefit from further research. Some of these are discussed in Section 5 of this report, 'Identifying priorities for future research':

- Health needs of distinct groups experiencing or at risk of homelessness; including children in Temporary Accommodation and vulnerable families, people with neurodiversity (ADHD, Autism, learning disability), vulnerable migrants, and wider health inclusion groups, among others.

- Early intervention and prevention; especially how services such as primary care, mental health, and social care, can play a role in upstream prevention (e.g. through identification of risk factors for homelessness – such as mental health problems, neurodiversity, childhood trauma and abuse, and self-neglect).
- Effectiveness and cost effectiveness of different services and interventions. There is some emerging evidence about the effectiveness of specialist primary care (Crane et al., 2023), however there is a general need to improve the evidence base about specialist and mainstream models of healthcare provision for people experiencing homelessness including outreach programmes; also, the wider social and long-term costs of not providing effective or earlier interventions.
- Effective mental health interventions; including psychosocial and preventative interventions
- Effective implementation and impact of trauma-informed care and psychologically informed environments on health outcomes

Summary of findings

- National data shows that people experiencing homelessness are at least four times more likely to access urgent and emergency or acute healthcare services. Physical health problems/conditions (32%), self-harm/attempted suicide (18%), mental health problems/condition (14%), and accidents (10%) are the most common A&E attendance reasons nationally (Jackson et al, 2024).
- Locally, infections and Other physical conditions (such as existing long-term conditions, injuries or wounds) are the most common primary presentations for homeless patients attending UHCW. Alcohol withdrawal, substance misuse, and mental health, are by far the most common secondary presenting conditions.
- In September 2025 there were 571 registered adult patients (430 male, 141 female) at The Anchor Centre recorded as homeless (including roofless and vulnerably housed).
- 3750 unique assessments for housing support were undertaken by the Housing service between January 2025 and mid-March 2026. Of these applicants, 36% had mental health support needs, and 33% had physical ill-health or disability support needs. 17% had either alcohol or drug dependency needs. 13% had learning disability support needs.
- Data about applicant backgrounds in these assessments indicate wider health inequalities issues and intersectionalities that may have impacted people's journeys towards seeking housing support, including e.g.: domestic abuse (16%), sexual abuse (8%), history of offending (16%), former asylum seeker (9%), and history of rough sleeping (13%) or repeated homelessness (17%).

Recommendations

- There is a need to improve understanding about the primary healthcare needs of homeless individuals and patterns of primary care service utilisation among people experiencing homelessness in Coventry.
- Further evidence and analysis to understand outcomes for people attending UHCW would be helpful, as well as further evidence and analysis to understand the relationship between alcohol/drug misuse and/or withdrawal, mental health, and people's primary presenting conditions.
- It is important to continue to build on local efforts to improve the visibility of housing status within health data, and health within housing data, respectively.
- There is a need to identify opportunities to improve data-sharing to support population-health management approaches and develop better understanding about the size and health needs of the homeless population in Coventry.
- There is a need to improve the visibility and representation of people experiencing homelessness in health research more widely, and to develop more inclusive and flexible research methods to engage with people experiencing homelessness.

3. Stakeholder views

We engaged with stakeholders about what they saw as the main issues, challenges, and priorities regarding health and homelessness in Coventry. The author attended relevant meetings to share information about the project and hear views, and stakeholders were invited to contribute further through one-to-one follow up meetings and informal interviews. Stakeholders' views about the main health challenges, and barriers and enablers to improving the health of people experiencing homelessness in Coventry, are presented below.

Key Challenges

Increased complexity of healthcare needs

A key overriding theme during discussions with stakeholders was that there had been a perceived overall growth in the numbers of people needing support over the last two decades, and that people's health and support needs had drastically changed and become more complex.

Homelessness services felt that they were dealing with increasingly complex individuals, experiencing a combination of physical, mental health and substance misuse difficulties, and that there had been a rise especially in people needing support with neuro-divergent conditions (both diagnosed and undiagnosed). Respiratory and cardio-vascular conditions were described as especially prevalent among the people they were supporting. Certain aspects of healthcare, such as managing follow-ups, wound care, and conditions requiring long-term or routine treatment and management were described to be particularly challenging for people experiencing homelessness, and there was a lack of outreach support for these issues.

Stakeholders explained that the lack of outreach support, combined with people's unsettled lifestyles, mean that people experiencing homelessness often do not seek treatment or struggle to access health services until they are very unwell or in crisis, and their needs have become very complex. Services explained they therefore in turn struggled to support people with the complexity and severity of their health needs, and that this was made more difficult because services often face their own resourcing and capacity issues. Stakeholders explained there is a danger that some services may therefore be less inclined to work with complex cases, to protect their limited resources, leading to a vicious circle whereby the complexity of people's needs continues to increase, and these individuals are "bounced" between services. The adoption of multidisciplinary approaches across some service areas was viewed very positively as starting to help to address this, and there was enthusiasm for partnership-working and getting to know staff based in different services to jointly support complex individuals.

Availability and access to mental health specialist services

One of the most significant health needs of people experiencing homelessness discussed by stakeholders was mental health. Stakeholders explained there were many challenges in accessing appropriate mental health for people experiencing homelessness because of the limited availability of both specialist and generic mental health services. The homelessness mental health specialist team at CWPT was very widely used and highly valued by stakeholders, but severe capacity issues were noted within the two-person team. The team itself reported managing approximately 30 referrals each month with most referrals involving crisis work with individuals being supported in temporary accommodation. This was seen as a major issue because people's mental health needs meant that they were often deemed unsuitable for, or unable to stay in, temporary accommodation due to their needs, risks, and/or lack of appropriate support. However, there was a lack of alternatives for individuals, meaning that some individuals struggled to be accommodated and supported appropriately, which further impacted their mental health. Stakeholders meanwhile explained that there were barriers to accessing more general mental health services, including high service thresholds, long waiting lists, a lack of mental health outreach, and general limits in service capacity, contributing to increased demand on the specialist mental health team.

Stakeholders explained that mental health and substance misuse problems often co-occur and are deeply interlinked within the homeless population, with poor mental health often contributing to the development of substance misuse problems. But aside from the mental health specialist homeless team and work by CGL, lack of understanding and effective management of dual diagnosis (mental health and substance misuse problems co-occurring) was said to be a major challenge within the Trust and generic mental health services. Stakeholders reported that many people experiencing homelessness who had underlying mental health conditions were often wrongly diagnosed, or not diagnosed at all, because their presenting condition was attributed to substance misuse, or they were deemed unable to be assessed. Stakeholders emphasised that people experiencing homelessness therefore continue to self-medicate with drugs or alcohol to cope with their untreated mental health, and services are often unwilling or unable to effectively support people because of their substance misuse, leading to a negative spiral. This was seen to be a particular problem contributing to long-term homelessness.

In addition, it was felt that poor mental health, but more particularly unaddressed trauma, limited people's ability and/or willingness to engage with healthcare and other services and underpinned a tendency to self-neglect. Until this underlying trauma was addressed, it was felt that many people experiencing homelessness would continue to struggle to seek appropriate help and keep up with any treatment, leading to a worsening of their health and general situation over time, further compounding the cycle.

Other key issues discussed by stakeholders concerned adults with neurodivergent conditions who do not meet the learning disability criteria within current legislation, but who struggle to look after a tenancy. Greater understanding and appropriate assessment and support around neuro-divergency and its impact on people's mental health and housing outcomes was seen to be very important.

Access to primary care and limited primary care outreach

The Anchor Centre was seen as a major positive development in Coventry, providing specialist care and assistance for people experiencing homelessness. It was seen as reducing barriers for people by offering flexible appointments, working collaboratively and linking to other homelessness services in the city, and providing continuity of care, with well-trained and committed staff. However, it was felt that there was limited outreach and the need to travel to the Centre to attend appointments was a barrier for some patients. Some homelessness services supported people to access the Anchor Centre by providing transport, or means to travel, making appointments for people and/or accompanying them to the Centre, but not all services felt this was sustainable. Other primary care services in the city were seen as mixed in terms of how well they supported people experiencing homelessness.

Access to appropriate GP and primary care services was felt to be fundamental to addressing health needs for people experiencing homelessness, and key to facilitating earlier intervention and prevention. This view resonates with the findings of the NICE self-assessment undertaken by Coventry City Council in 2024 which found a clear need for better access to and use of primary care, and for GP and other community services to engage earlier with patients experiencing homelessness.

There is a longstanding debate in healthcare whether developing specialist services for people experiencing homelessness or improving mainstream services should be prioritised. It has been argued, for example, that mainstream services should become more accessible for people, and that a focus on specialisation can lead to greater marginalisation and segregation of people experiencing homelessness. However, wider evidence suggests that specialist services can increase uptake/engagement and lead to better patient experience due to better staff training and flexibility (Crane et al., 2023).

A recent comparative study (Crane et al., 2023), funded by the NIHR, evaluated models of care in primary health and their provisions for people experiencing homelessness. The study found that mainstream GP practices were generally not meeting the needs of single adults experiencing homelessness and that specialist services were able to provide better assistance and care, with higher satisfaction and confidence scores from their recipients. The mainstream GP practices ran differently with large patient lists, fixed appointments, no dedicated homelessness staff, lacked homelessness specific services, and were not linked with other existing homelessness services in the community. However, a few mainstream GP services did perform well for health screening and satisfaction scores, so the study suggests that if conditions are right, some mainstream GP practices can meet the needs of people experiencing homelessness.

A&E, acute and intermediate care challenges

Stakeholders described, in general terms, the multiple challenges for people experiencing homelessness in seeking out, accessing, and receiving acute care and treatment. These included intense fear and anxiety about going to hospital for some individuals, long wait times in A&E, issues with addiction withdrawal, and the stressful nature of the A&E

environment, which compounded people's anxiety and addiction withdrawal issues while waiting. These issues often meant that people avoided or severely delayed going to hospital for treatment, or self-discharged before treatment. This was seen to have many implications for individuals, including worsening of their conditions, prolonged pain, missing out important treatment, and/or subsequently requiring more intense treatment or an in-patient stay.

For example, a support worker explained a situation where one person experiencing homelessness had suffered a jaw fracture but was very reluctant and anxious about going to hospital and therefore did not go to A&E until four days after the fracture had occurred. During this time the person struggled to eat properly, stay hydrated, speak, and experienced significant pain, so their physical and mental health deteriorated. Support workers further explained that although they often escorted and stayed with people within A&E to support them to access treatment, homeless individuals - and support workers themselves - often encountered stigmatisation by staff and/or other patients. This increased the stress and anxiety of the situation, likelihood of self-discharging, and/or triggered frustration and behaviours that were perceived as challenging. Stakeholders therefore felt that providing additional support to people to attend hospital and address barriers particularly within A&E environments, including staff training, were important.

Similar challenges were described for some people requiring an in-patient stay, particularly rough sleepers and/or where people were managing substance withdrawal, as these issues could lead people to self-discharge, go off-ward, or experience additional distress if they anticipated they would not receive opioid withdrawal medication in hospital. The introduction of a Homelessness Pathways Lead at UHCW was therefore viewed by stakeholders as a very positive development to support people experiencing homelessness. The Pathways Lead was seen to support in-patient stays through more effective communication, information-sharing, patient advocacy, and general awareness-raising among hospital staff, and promote a trauma-informed approach. This was particularly important for patients who may go off the ward for a period, because of their nomadic living habits. The Pathways Lead was also able to support more personalised care-planning for homeless individuals and help the hospital fulfil its Duty to Refer responsibilities. It was agreed that the Pathways Lead had significantly improved discharge planning, communication and coordination between the hospital, housing/accommodation services, and adult social care, and there had been considerable improvements in coordinating follow-up care, for example with primary care services such as the Anchor Centre.

A continued wider challenge to safe and effective discharge however was said to be the general lack of available and appropriate discharge accommodation options, as it was felt that many patients would benefit from intermediate (step-down) and/or long-term care. Wider evidence has highlighted that specialist intermediate care services can have a range of positive outcomes for people experiencing homelessness, including better health outcomes, reduced delayed discharges, and improved follow-on care, and can be more cost-effective than standard discharge procedures and prevent unplanned reattendances and readmissions (Jackson et al., 2024). Intermediate care provision has also been included within the NICE Guideline for homelessness and was identified as an area for further focus in Coventry's NICE homelessness baseline assessment, mentioned in section

1 of the report. Outpatient and follow-on care were also described as continuing challenges for some patients, however some areas of developing good practice were highlighted by stakeholders, including some outreach services (such as the palliative care team) and improved multi-agency and multidisciplinary collaboration.

Public health challenges

From a public health perspective, TB was highlighted as a particular challenge locally for people experiencing homelessness. TB was said to be concerning as it was often asymptomatic for a considerable period and - combined with the issues experienced by people in seeking out and accessing treatment - meant that the disease was often already advanced when treatment was sought. Treatment itself was also seen as very difficult for people experiencing homelessness because it typically requires six months of intensive antibiotic treatment. The unsettled nature of homeless lives, mental health and substance misuse issues, often means that people experiencing homelessness struggle to engage with and sustain treatment. Direct observation – where healthcare professionals observe the patient taking the medication – can help to ensure treatment is sustained, however this can be experienced as intrusive and punitive by patients. Not sustaining treatment can also require - in the worst cases - an enforced quarantine, due to the severity of the disease, possibility of transmission, and risk of developing drug-resistant TB if antibiotic treatment is not completed. These treatment methods can therefore exacerbate the sense of stigma or lack of trust faced by people experiencing homelessness and make people less likely to engage with services in the future.

There have been improvements in outreach to manage and support homeless individuals with treatment for TB, as well as awareness raising, targeted communication, and improved screening, but early detection and treatment is still challenging. Screening for other blood-borne viruses including Hepatitis and HIV has also been improved at UHCW for people experiencing homelessness, and awareness raising is also being promoted within the community. Infectious disease transmission generally remains a challenge however among people experiencing homelessness due to behaviours/activities that increase risks (such as survival sex-work, needle use), close-living in accommodation, and challenges with hygiene.

Access to dental services and poor oral health

Dental care and access to dentistry was described to be very challenging for people experiencing homelessness. Dental practices often did not have appropriately trained staff to provide care for homeless patients, and the fixed locations and lack of outreach for dental services was seen to be a major barrier. There was also said to be a lot of confusion about who pays for dental treatment, and limits to how much care can be provided within primary care contracts for dentists. In addition, many people experiencing homelessness also have phobias and/or high anxiety about dental care (which may be linked to other mental health issues), so seeking treatment can be very difficult. People experiencing homelessness also struggle to look after their teeth because they may lack facilities or

easy/sustained access to facilities. Self-neglect, mental health and substance misuse issues, can also contribute to poor oral health and the lack of an oral care routine. Tooth decay and dental pain can therefore be very common for people experiencing homelessness. Furthermore, people may not have the means to eat a healthy diet and rely on cheaper, more easily accessible or donated sugary and 'fast foods', meaning people's overall diet is very poor, further contributing to oral health and general health problems (see also Jackson et al., 2024).

Stakeholders felt there was a clear need for more outreach, flexible appointments, and training for dental staff to improve support and treatment for people experiencing homelessness. By not being able to access regular or preventative treatment people experiencing homelessness often seek help for oral health problems via GP and A&E services, who are not able to effectively help them. The Oral Health Improvement Project has been commissioned and is committed to improving dental care for people experiencing homelessness by offering more flexible appointments for patients and improved staff training. The project has also taken training out to local homelessness services, as well as other dental teams, to help improve self-care and engagement with dental health services. However, access and availability to dental care and treatment for people experiencing homelessness generally remains poor.

Adult Social Care challenges

Due to the complex health needs of people experiencing homelessness many people have care and support needs that require input from adult social care. Assessments and organisation of social care support for people experiencing homelessness take place both in the community and at UHCW/in hospital settings (for patients medically ready to be discharged).

The introduction of the Homelessness Pathways Lead at UHCW was said to have greatly helped the process from an adult social care perspective by expediting referrals for housing support, thereby removing barriers to being able to organise (short-term) social care support, and therefore reducing delayed discharges, because of lack of address. Communication and coordination for patients was much more effective and had greatly reduced the need for additional meetings to address discharge for complex individuals. However, staff described some continued challenges relating to adult social care assessment and provision in general for people experiencing homelessness.

For people in hospital, stakeholders explained that care act assessments can sometimes focus on peoples' apparent capabilities while on the acute hospital ward, failing to consider their likely living situation post-discharge. The result is that people can be assessed as having no care needs as they are able to function on the ward, leading to no or inadequate support after their discharge from hospital. On the other hand, once in the community, the transient nature of living situations for people experiencing homelessness on discharge means that people's addresses or wider circumstances can change relatively quickly, presenting challenges for social care support planning and delivery. Some staff also felt that many individuals in the community did not want to engage with social care support, and/or that substance misuse issues meant that many individuals were unable to be effectively

assessed and/or meet thresholds/conditions for social care support. Staff also expressed there were difficulties and delays where people were awaiting temporary accommodation, or where they did not stay in temporary accommodation long (as a result for example of severe mental health issues/needs that were unable to be appropriately supported), making it challenging to arrange support such as Occupational Therapy and equipment etc.

The wider literature has meanwhile highlighted safeguarding as a key area of adult social care practice that would benefit from further exploration in relation to homelessness (Manthorpe et al., 2015; Harris et al., 2023). Safeguarding aims to protect the health and wellbeing of at-risk adults by making sure they have the care and support they need, and are safe from abuse and neglect, including self-neglect. As people experiencing homelessness can often be in vulnerable circumstances and often experience self-neglect - which can be associated with mental health and/or substance misuse issues - they are considered high-risk groups (Harris et al., 2023). Research has shown for example that the most common of all Safeguarding Adult Reviews (SARs) including cases from inclusion health groups is self-neglect, which makes up 45% of all SAR cases (Jackson et al, 2024).

This wider research has indicated that multidisciplinary working with experienced social work staff for people who self-neglect and are experiencing homelessness can be effective, and that SARs can help spread learning. However, there are challenges around interpretation and implementation of safeguarding in relation to self-neglect under the Care Act (2014). Wider evidence about SARs (Martineau et al., 2019) found that failures are often due to practitioners' lack of understanding of self-neglect as a safeguarding risk, sometimes because an assumption has been made that a person is making 'lifestyle choices', and/or because their main need is interpreted to be housing. Stakeholders and social care professionals we spoke to also suggested that substance misuse issues can be a major barrier to assessing and providing social care support for people experiencing homelessness, as well as where people are considered to have capacity, which makes intervening difficult. Our stakeholder engagement as well as wider research suggest that social workers and professionals would benefit from more policy or system-level clarity about their safeguarding responsibilities in relation to homelessness and self-neglect.

Wider barriers

Stakeholders also referred to wider trends and pressures that exacerbated the local challenges around health and homelessness and made it more difficult to improve support and access for people experiencing homelessness. Stakeholders talked in general terms about pressures on NHS resources meaning that services are generally pressured to operate less flexibly, with higher service thresholds, longer waiting lists, and less capacity to manage complex cases. It was noted that certain groups experiencing homelessness also face additional barriers due to wider national government policies that were felt to be at odds with inclusion health principles. For example, migrants in vulnerable circumstances face particular issues where government policy restricts access to free healthcare for people with insecure immigration status or other restrictions on entitlement to support. This makes existing health inequalities worse for this group due to challenges with language and literacy and a poor understanding of how to navigate the UK health system.

Other key issues included stretched capacity, workforce retention (e.g. in social care) and a nationally challenging financial context for local authorities making local planning and delivery more difficult. Finally, the availability and affordability of housing nationally was seen as a barrier, with issues such as rising rents, changes to housing benefits, and increased costs of living, all having reduced the affordability of renting. There was also said to be a general lack of sufficient or available social and affordable housing. These issues have all led to an increase in homelessness risk or actual homelessness.

Key Enablers

Inclusive, flexible ways of working and trauma-informed care



“Somebody listened to me. Somebody actually wanted to hear what I had to say, rather than telling me what I needed to hear” - A stakeholder’s view of trauma-informed care.

One of the biggest enablers of improving healthcare for people experiencing homelessness was working in a more trauma-informed, compassionate way and making services more flexible and inclusive. It was noted that some healthcare staff may find it difficult to deal with what are perceived as difficult or challenging behaviours from people experiencing homelessness (such as unwillingness to wait to be seen, agitation, or ward absence for long periods). While many stakeholders recognised that these behaviours often arose from complex trauma, deep or repressed anger, and/or from individuals’ feeling triggered by their environment, stakeholders felt that the wider untrained health workforce would not necessarily be aware of this, leading to increased stigmatisation and negative attitudes towards people experiencing homelessness. It was also felt that language such as ‘did not engage’ typically used within a healthcare context could be judgmental and dismissive and did not account for the complexity of individuals’ situations and circumstances.

Stakeholders also felt that rigid appointment booking processes for some healthcare services were unhelpful and that some services were too quick to take patients off their caseload if appointments were missed. Growing use of digital technology and digital processes, such as the use of QR codes or online booking systems to make appointments and/or other information, were also cited as barriers to access for people experiencing homelessness.

Stakeholders recognised the challenges for healthcare providers in making services more flexible because of pressures on services – such as high demand and staff capacity issues - meaning that many services are having to operate inflexibly with stretched resources. However, it was felt that training and raising staff awareness, alongside other local developments already underway, could lead to enhanced flexibility in practice over time. Creating psychologically safe environments and trauma-informed care were also seen as

integral aspects of good healthcare that would make services more inclusive and benefit all patients.

Finally, it is important to note that some stakeholders felt that being trauma-informed was in danger of becoming a 'trend' or 'buzz phrase' and becoming less meaningful over time. Stakeholders pointed out there were broader questions about what being truly trauma-informed meant, and the types of approaches needed. Stakeholders therefore stressed that being trauma-informed required genuine compassion, authentic listening, and continual reflexivity about the person and their circumstances/challenges, to provide a personalised, sensitive response to individuals' needs.

Multidisciplinary approaches

Stakeholders shared the view that the complexity of people's needs required effective collaboration between services and sectors. It was agreed that promoting recovery, stability, and lasting positive outcomes for people required housing, health, mental health and social care to work together, and that no one sector or agency could support people alone. Taking a multidisciplinary approach towards supporting individuals was therefore seen as vital and as the most effective way to improve access, streamline pathways for people, and ensure a holistic approach towards addressing people's support needs. Stakeholders felt that a lot of progress had been made towards multidisciplinary working in recent years, with developments such as the Vulnerable Persons Forum, Homelessness Pathways Lead at UHCW, and establishment of a Health and Homelessness Strategy Group, all helping to embed and develop a multidisciplinary culture of support. The proposed move towards Integrated Neighbourhood Teams (INTs) at UHCW was further seen as a significant opportunity to grow specialist multidisciplinary expertise for people experiencing homelessness across Coventry and further improve outreach and inclusive provision.

When asked what good multidisciplinary care would look like for people experiencing homelessness, stakeholders shared that key elements would include being compassionate and trauma-informed, providing outreach, flexibility, and having good local connections and networks to coordinate care and encourage appropriate multi-service responses. The palliative care team were cited by many stakeholders as being a model of good practice in this regard, as they incorporated many of these principles. Stakeholders also shared that they felt that it was important to build good communication channels, protocols and processes into the system to embed multidisciplinary working and avoid any homeless individual "dropping off the radar" if key professionals/staff who would normally facilitate or advocate for that individual were not available. Many stakeholders further felt that specialist multidisciplinary teams could help with establishing and maintaining trusting relationships with people experiencing homelessness and encourage them to access and sustain their engagement with services longer-term.

Identifying opportunities for earlier intervention and prevention

Given the direct impact of homelessness on health as well as people's ability to access and engage with services, stakeholders agreed there is a need to understand more about the

role that health and social care services can play in the prevention of homelessness for vulnerable groups and at-risk populations. There have been significant developments already in Coventry through, for example, the introduction of the Homelessness Pathways Lead at UHCW to support implementation of Duties to Refer responsibilities, and the work of the specialist Anchor Centre primary care service. However, developments such as these are often limited by their nature to forms of tertiary prevention - that is, the prevention of chronic (worsening) homelessness, for people who are already homeless. There is a need to understand more about the role that health services such as primary care and mental health services, as well as social care services, can play in more upstream (primary and secondary) prevention through the earlier identification of risk factors for homelessness: e.g. mental health problems, various forms of neurodiversity, childhood trauma, abuse, neglect. Pathway and Crisis research (Jackson et al., 2024) has also showed that more evidence is needed on the causal chains that lead people into homelessness in order to identify the best opportunities and approaches for health and social care services to engage in upstream prevention.

Early intervention and prevention is a key principle within Coventry's Homelessness and Rough Sleeping Strategy 2025-2029, and stakeholders agreed this was an important opportunity to build on existing partnerships with local health and social care services to drive early identification and support for people at immediate (secondary prevention), and future (primary prevention) risk of homelessness. Stakeholders agreed it was also important to identify and make better use of available data and evidence to drive a prevention strategy. A few stakeholders also felt that an opportunity to top-slice budget for prevention had been missed.

Finally, it was agreed that children, young people and vulnerable families would likely benefit the most from primary prevention strategies – that is, upstream preventative support for people at future risk of homelessness. Work is already going on through, for example, Early Help to identify and understand housing needs among these groups; however it was felt that more could be done to use available data from children's and young people's services to drive prevention strategies, and more evidence was needed about the health needs of children and families in Temporary Accommodation.

Summary of findings

- Mental health is agreed to be one of the largest challenges for people experiencing homelessness and is often strongly related to substance misuse issues. The development of a specialist mental health team at CWPT has been a very positive development but stakeholders note it has limited capacity. Lack of availability and access to mental health services is a major barrier.
- The introduction of a Homelessness Pathways Lead at UHCW has been a positive development to support inpatient stays, discharge processes and Duty to Refer responsibilities for people experiencing homelessness. Challenges remain around provision of intermediate care, appropriate discharge accommodation options, and follow-up care for patients.
- The Anchor Centre has been a positive development to improve access and patient experiences and engagement with primary care but there is limited outreach provision.
- There have been efforts to raise awareness of the relationship between oral health, nutrition and overall health, but access to dental services overall remains poor for people experiencing homelessness due to fixed locations and payment issues.
- There are challenges in identifying and treating people experiencing homelessness for infectious diseases including, but not limited to, TB. It is important to build on existing efforts to raise awareness, improve screening, and outreach.

Recommendations

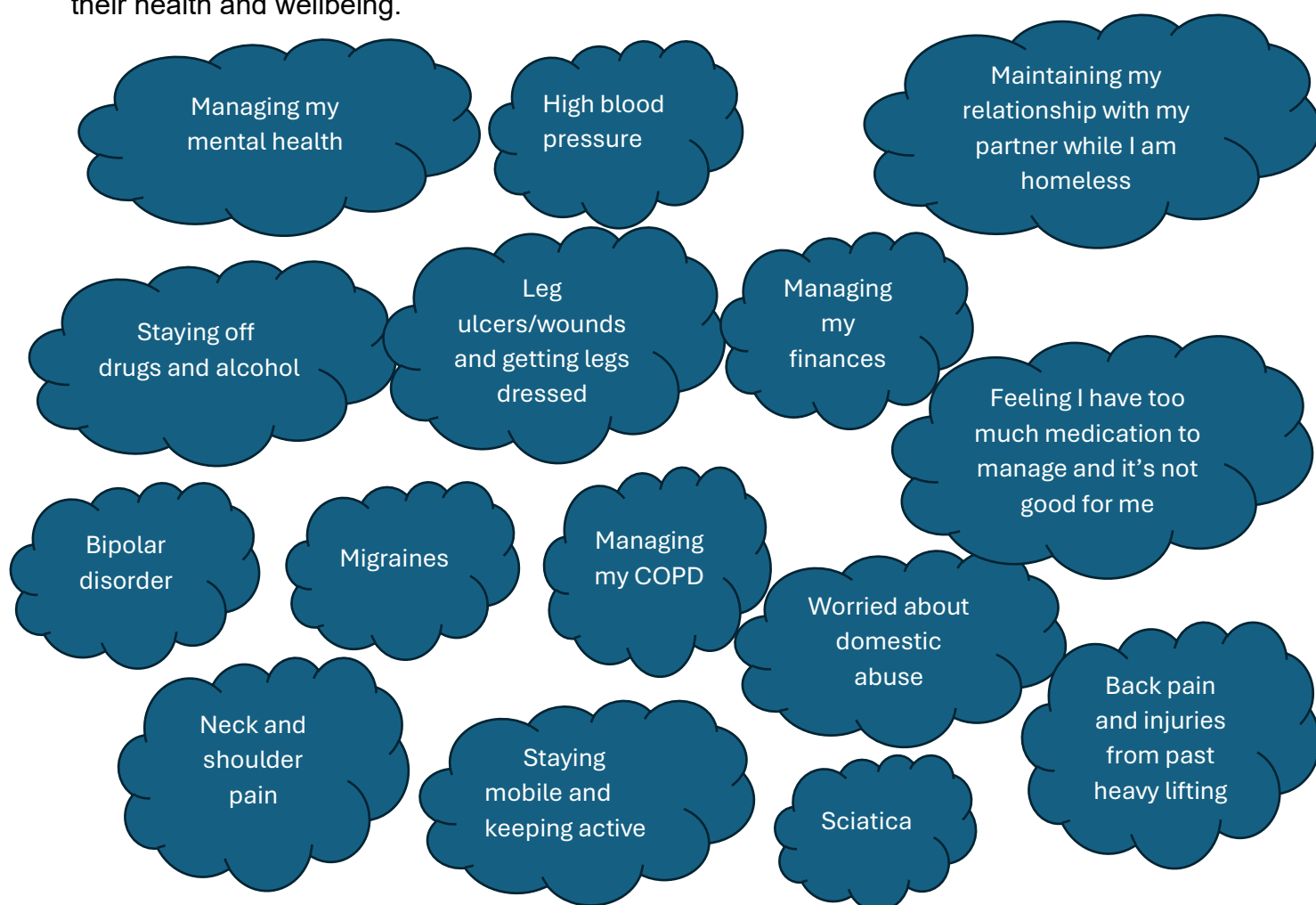
- There is a need to raise awareness and improve training among health and social care staff to provide effective and authentic trauma-informed care, to encourage and support engagement with services.
- There is a general need for improved health outreach within primary and secondary care, and to build on existing examples of good practice of multidisciplinary working and compassionate care.
- There is a need to ensure access to appropriate mental health support for individuals experiencing homelessness.
- Wider research has highlighted the valuable role of adult social care in supporting people experiencing homelessness. There is a need to further develop practice and guidance around safeguarding and self-neglect, and how issues such as substance misuse and lack of address can affect assessments, eligibility, and feasibility of providing social care support to people experiencing homelessness.
- It is important to acknowledge, and continue to grow, the role of health and social care services in preventing homelessness, through for example, Duty to Refer responsibilities and identifying and working with those at risk.
- Much homelessness prevention tends to be focused on tertiary prevention (preventing worsening homelessness, for those already homeless). There is a need to understand more about, and develop, primary and secondary prevention strategies for those at future and immediate risk of homelessness, particularly children, young people and vulnerable families, and to understand more about their current and future health and housing needs.

4. Lived Experience voices

We engaged with people with lived experience of homelessness about their experiences of using healthcare and other support services, and what was important to them about their health. We asked people if they had any current concerns about their health, what worked well about current services they used, what did not work well, and what could be improved. We also asked people how much say they felt they had about local services, and whether and how they would like to have more say about local services in the future. We engaged with 17 individuals in total. Key themes from the conversations and feedback are presented below qualitatively (rather than quantitatively) because the feedback given was qualitative in nature, and not all individuals answered all questions.

What people told us was important to them about their health and wellbeing:

We asked people what their priorities were in terms of their health and wellbeing and if they had any current concerns about their health. Health and wellbeing were interpreted broadly by people during the feedback, and we invited and encouraged people to reflect on what was most important to them and what they felt would make most difference to improving their health and wellbeing.



What people told us they liked about current services:

We asked people what they found helpful about current healthcare services they accessed, and what worked well about their current healthcare. People also told us what they found helpful about the homelessness support they received, where it was related to or impacted their health.

- People valued the support they received to arrange, manage and attend healthcare appointments from their homelessness support worker/support staff, and many individuals explained they would struggle to attend healthcare appointments without this support.
- People appreciated outreach appointments and visits from healthcare staff e.g. to have leg wounds/ulcers dressed, because it was much easier for them to attend outreach appointments/visits, and made them more likely to engage or keep up with treatment.
- Some people expressed that the healthcare professionals they had seen for particular health conditions had been very helpful, for example the COPD outpatient clinic at UHCW; and many individuals also expressed they were happy with the primary care support they received from the Anchor Centre.
- Importantly, many individuals expressed how happy they were to know that help with their health was available and to receive help when they actively sought it out, and particularly for the ongoing support they received from local homelessness support services.

"Without the help I get I dread to think how my life would be, because one of the symptoms of my mental health issues was I used to bury my head in the sand and ignore my problems in my life. But I know inside that any problems won't go away by ignoring them"

"I am extremely grateful for all the help I receive; it puts my faith back into human nature..."

"It is good that there are people/services that will help you any way they can if you seek out the help"

What people told us they did not like about current services:

We asked people what they found challenging about current healthcare services.

- Many individuals felt frustrated by the use of online booking systems, online health information, and electronic prescriptions by local healthcare services, because these were hard to manage and access without having personal access to the internet or smart phones. The use of digital/online information and processes compounded people's struggles to keep up with and engage with their appointments and manage information.
- People struggled with long-waiting times to be seen at healthcare appointments, or in A&E, because it increased anxiety, gave "too much time to think", and made people feel unimportant.
- People similarly struggled with referrals taking longer than expected, or when appointments were changed/delayed; some individuals described feeling misled or "lied to" in these situations.
- Some people were reluctant to go to hospital because of previous bad experiences, e.g. needing unexpected treatment/surgery, feeling a loss of control, or feeling they were not treated well in the past by staff.
- Some people described difficulty getting to health services and felt that the journey - involving two buses and a walk - was off-putting; however, some individuals explained they enjoyed the same journey as it gave time out from their 'everyday' and a change of scene.
- People described feeling frustrated if they experienced poor communication from healthcare professionals about treatment, or medication changes and updates. This was a particular issue for people on drug withdrawal medication or mental health prescriptions, as this caused additional anxiety and added to their stress about e.g. going into hospital.
- People said they sometimes didn't feel listened to and/or felt "dismissed" by healthcare professionals and occasionally council staff, and a few people said they did not feel confident or comfortable talking about their health or personal issues to them as they feared judgement or adverse consequences.

While some of these experiences may also be common for other members of the public, it is important to remember that people experiencing homelessness are likely to have a much lower tolerance of these issues because of trauma, poor mental health, or other circumstances associated with their homelessness.

What people told us would help them:

- More mental health support; currently people don't feel they get enough help with their mental health, which makes them feel like they want to use drugs or alcohol
- To feel "listened to" by healthcare staff e.g. when they went to hospital, but also more generally by others in their life. Some individuals described feeling "invisible".
- Help with managing and keeping their appointments, and with managing finances. Many people described feeling overwhelmed by their challenges.
- More drop-in services and flexible appointments, as these were easier to manage and less anxiety-inducing for people.
- Access to transport, or a travel/bus pass, to be able to get to healthcare services
- "Workers who stay with us, they hand us over to other workers constantly"
- Easier access to information: about e.g. benefits, housing and support, and healthcare, but also about local clubs and activities that might help people feel better
- Opportunities to connect with other people who were not experiencing homelessness and/or not using drugs/alcohol. Some people described feeling "trapped", and explained that being around other people who were using drugs or alcohol made it more difficult for them to abstain and move forward with their lives.

How people would like to have a say in the future about services:

- One-to-one conversations was a popular idea, because people would be able to more openly share their thoughts and feelings
- Questionnaires with easy tick boxes
- Some people expressed they wouldn't feel comfortable talking to healthcare professionals or council officers, but would feel comfortable talking to their support worker/support staff
- Having opportunities to meet and provide feedback through e.g. activities, groups, would allow people to talk about things more informally in a relaxed environment. Many of the activities that people currently accessed at current support services (such as bingo or sports days) were very popular and these could be used to facilitate further conversations/feedback.

Summary of findings

- People experiencing homelessness described a range of health concerns, including mental health, managing drug and alcohol issues, long-term health conditions, pain from previous injuries, and maintaining overall wellbeing. People also shared that worries about their situation and wider challenges they faced drastically impacted their sense of wellbeing (e.g. concerns about finances, maintaining relationships).
- People expressed that the support they received from homelessness services was vital to their sense of being able to cope with their situation. People also expressed that being able to recognise when they needed help, and taking steps towards actively seeking help, were important milestones in their individual journey towards recovery.
- Experiences of health services were mixed. Some people described positive experiences of care, while others described experiences of feeling stigmatised, not listened to, and confused by communication (or lack of communication) from health professionals. Anxiety about attending appointments or seeking treatment was a major barrier for these individuals.
- An overriding theme was that people very often felt overwhelmed with their situation and many people described feeling trapped. This was particularly the case for people experiencing drug and alcohol issues, who found being around others who also had addiction issues, or being in environments where they were exposed to this, very challenging.
- Mental health was also a major challenge and people felt they required more support with their mental health, to stop them wanting to turn to drugs and alcohol.

Recommendations

- There is a need for wider training and awareness-raising around homelessness and trauma-informed care for health professionals.
- The move towards online appointment processes and digital communication was a significant barrier for many people experiencing homelessness. Many people relied on their support worker to both manage and attend medical appointments. There is a need to consider alternative ways to manage appointments for people experiencing homelessness and other groups who are likely to be digitally excluded.
- There is a need to ensure access to appropriate mental health support for individuals experiencing homelessness.
- People felt that outreach and flexible services, such as drop-ins, were much more suitable for them in the context of their daily lives/challenges and easier for them to access and engage with. Further consideration and evaluation of alternative models of care based on outreach approaches would be helpful.
- People expressed a desire to understand more about other sources of support, help, and activities that would help them feel better about themselves and take steps to improve their situation. It is important to build on existing opportunities and improve communication about wider sources of support for people experiencing homelessness.

5. Establishing priorities for future research: Areas of Research Interest workshop

We held a workshop with approximately 45 colleagues from housing, health, social care, the voluntary and community sectors, Coventry HDRC, and Coventry Public Voices Group to share emerging findings from the work and to establish priorities for future research - 'Areas of Research Interest'. Areas of Research Interest (ARI) (French and Hawkins, 2024) are public expressions of research priorities and evidence needs. Coventry HDRC is facilitating the development of ARI in relation to identified priority wider determinants of health, including homelessness. We presented emerging findings from the project and then invited initial feedback from delegates about the issues they felt were most important to research further locally in relation to health and homelessness, drawing also from their own experience. Their reflections are presented below:



Identifying Areas of Research Interest: break-out group discussions

We then asked delegates to discuss what they felt should be priorities for research in small break-out groups. We asked each group to identify and agree up to three top priorities to feed back to the room. The priorities identified in the break-out groups were:

Break-out group 1:

- Improve the evidence-base to allow wider bureaucracies to understand the impact of their decisions and actions on outcomes for people, including how their processes can sometimes cause adverse consequences for people or result in 'failures'.
- Understand the appropriateness of services that people are referred to and whether services have been right for them.

Break-out group 2:

- Mental health: Understand what is working well and successful interventions; Understand underlying reasons for mental health; Understand and improve dual diagnosis.
- Temporary accommodation for families: Understanding the distinct needs of families, such as Special Education Needs (SEND) and how quality of accommodation impacts health.
- Training for staff and researchers to improve representation and inclusiveness of people experiencing homelessness, to - in turn - improve access to and engagement with services.

Break-out group 3:

- Understanding the impact of early intervention and improving data collection (who is being asked what?). There is a need for better integration of data, and early identification of individuals, to understand and address need, and support prevention.
- The experiences and views of healthcare professionals supporting homeless patients.
- Improve understanding about effective pathways and the impact of partnership working.

Break-out group 4:

- Understand effective partnerships and systems working.
- Understand data linkages and how we use data to improve health – e.g. is there an agreed data matrix for partnerships (including e.g. public health, mental health)? Also identify opportunities to improve data, e.g. establish a working group.
- Understand the interaction between and impact of mental health, neurodiversity and substance misuse, and improve dual diagnosis practice.
- Understand the impact of services through evaluation.

Break-out group 5:

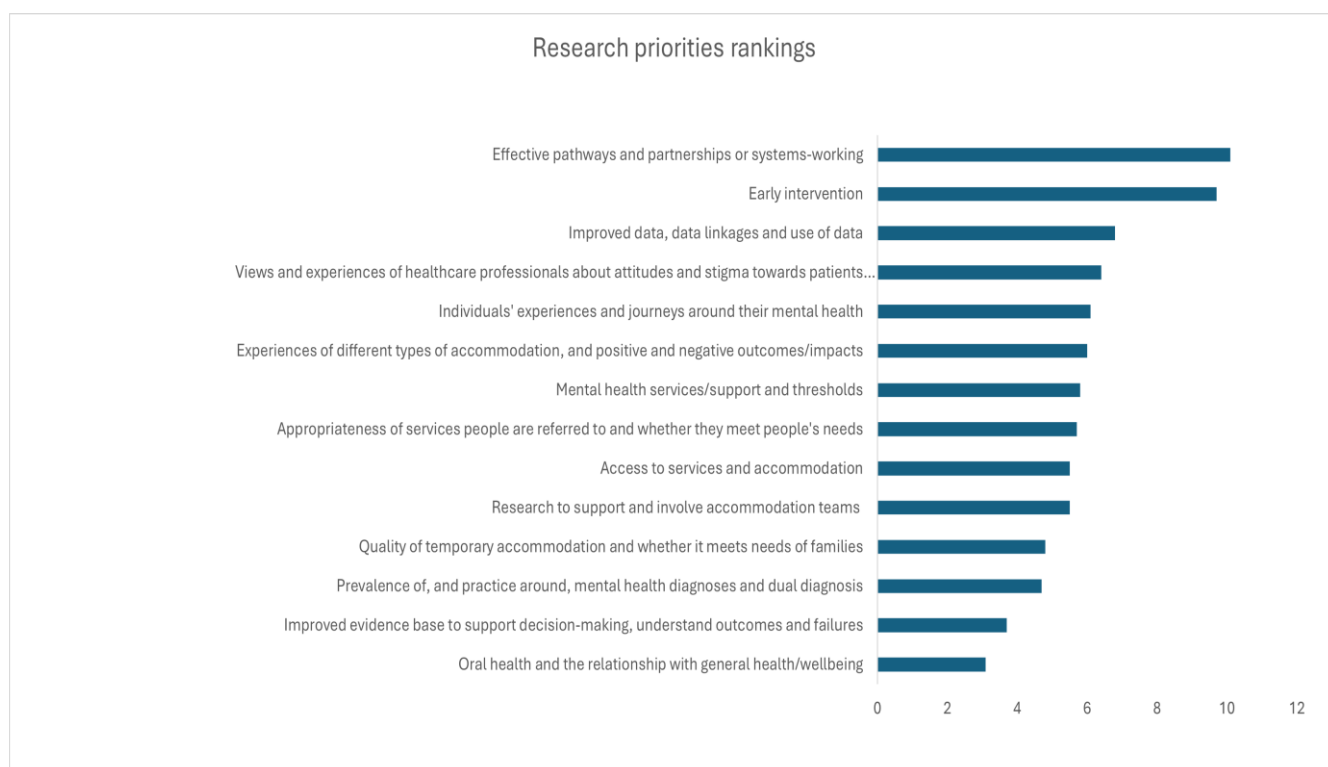
- Understand the impact of mobile outreach interventions for rough sleepers and partnership working for people with complex needs.
- Improve understanding of oral health and the relationship between oral health and general health. Also improve our understanding of how poor oral health can be a sign of self-neglect and prompt action.
- Understanding and improving access to services and what will help people engage.



Ranking the identified Areas of Research Interest

We then summarised the research priorities (areas of research interest) identified by the break-out groups and asked delegates to rank them in order of importance. We then invited delegates to explain their rankings and discuss the implications of researching - or not researching - certain areas. The summarised priority areas, ranked in order of importance, were as follows:

1. Effective pathways and partnerships or systems-working
2. Early intervention
3. Improved data, data linkages and use of data
4. Views and experiences of healthcare professionals about attitudes and stigma towards patients experiencing homelessness
5. Individuals' experiences and journeys around their mental health
6. Experiences of different types of accommodation, and positive and negative outcomes/impacts
7. Mental health services/support and thresholds
8. Appropriateness of services people are referred to and whether they meet people's needs
9. Access to services and accommodation
10. Research that supports and involves accommodation teams
11. Quality of temporary accommodation and whether it meets needs of families
12. Prevalence of, and practice around, mental health diagnoses and dual diagnosis
13. Improved evidence-base to support decision-making, understand outcomes and failures
14. Oral health and the relationship with general health/wellbeing.



The top three areas where it was felt that further research and evidence could have the most impact were:

1. Effective pathways, partnerships or systems-working
2. Early intervention
3. Improved data, data linkages and how we use data

There was very little difference in mean rankings between the priorities Views and experiences of healthcare professionals about attitudes and stigma towards patients experiencing homelessness, Individuals' experiences and journeys around their mental health, and Experiences of different types of accommodation and positive and negative outcomes/impacts.

The fact that mental health experiences, interventions/services, and practice, is the focus of three priorities suggests that mental health is an area that would benefit from further research activity.

Similarly access to, experiences of, and differences between accommodation types and their impacts, appear in four priorities. This suggests this is also an area that would benefit from further research activity.

Oral health was ranked the lowest priority for further research, however feedback from the room suggested that this was because there was already a good evidence base for the relationship between oral health, nutrition, and general health, rather than because people felt that oral health was not important.

Indeed, it is important to remember that all the areas were identified as priorities by delegates, and that rankings reflect order of importance. Additionally, many delegates said they found it hard to separate out or treat issues as exclusive, because they recognised that many issues were linked and impacted each other.

There was a general consensus that the rankings reflected where people felt that a stronger evidence base could help support their work and improve outcomes for people experiencing homelessness.

Summary

- Areas of Research Interest (ARI) are public expressions of research priorities and evidence needs.
- Coventry HDRC is facilitating the development of ARI in relation to identified priority wider determinants of health, including housing and homelessness.
- The top three areas where it was felt that further research and evidence could have the most impact in relation to health and homelessness were:
 - Understanding effective pathways, partnerships or systems-working
 - Early intervention
 - Improved data, data linkages and how we use data.

Recommendations

- Agreed Areas of Research Interest for Coventry HDRC on health and homelessness, based on workshop findings, are Understanding effective pathways, partnerships or systems-working; Early intervention; and Improved data, data linkages and data-use.
- Views, experiences and attitudes of healthcare professionals about patients experiencing homelessness, and impacts of different accommodation types, were also high priority areas, suggesting these would also benefit from further research in the future.
- Mental health experiences, interventions/services, and diagnosis practice, similarly featured across three priorities, suggesting that mental health is an area that would benefit from further research activity in the future.

6. Next steps and recommendations

After further discussion and feedback with colleagues the three top priority areas for health and homelessness research identified at the workshop were further refined as:

ARI 1: Understanding the impact of multidisciplinary and partnership working

ARI 2: Early intervention and prevention

ARI 3: Strengthening population-level data, and improving data, data-sharing and use, to inform health and homelessness strategy and service development.

ARI 1: Understanding the impact of multidisciplinary working and partnership working

This priority will focus on understanding the impact of multidisciplinary working and partnership working for people experiencing homelessness. Our project and wider existing evidence suggests that the complexity of needs and challenges faced by people experiencing homelessness (particularly multiple exclusion homelessness) is not able to be addressed by one sector or service alone, and requires coordination between multiple agencies to improve outcomes for individuals. This priority incorporates and reflects partnership working and coordination at the different levels that were identified at our workshop, including pathways for individuals, between services, and across systems.

ARI 2: Early intervention and prevention

This priority will focus on evidencing the importance and effectiveness of early intervention and prevention. The importance of early intervention and prevention is generally well accepted and intuitively understood locally, and within national policy, however the evidence base regarding early intervention and prevention remains underdeveloped. Additionally, what existing evidence there is tends to focus on tertiary prevention (that is, preventing worsening of homelessness for people already experiencing homelessness), while evidence about effective primary and secondary prevention for those at future or more immediate risk is less. This priority will focus on understanding early intervention and prevention at all three levels, and for vulnerable groups who are understood to be at greater risk of homelessness.

ARI 3: Strengthening population-level data, and improving data, data-sharing, and use, to inform local strategy and service development.

This priority will focus on identifying opportunities to improve data collection, data-sharing, analysis and use within the council and with partners in relation to health and homelessness. This includes strengthening evidence about the size and nature of the local homeless population, the healthcare needs of individuals and families experiencing homelessness, and patterns of service utilisation. This is important to improve services and develop local approaches to improve outcomes for people experiencing or at risk of homelessness.

These three research priorities will form ongoing Areas of Research Interest (ARI) in relation to health and homelessness. We will also consider how these ARI can be applied across a number of relevant service areas, to address local health inequalities and support health inequalities research, as cross-cutting core research themes, within Coventry HDRC.

Our work has also indicated that the following areas would benefit from further local research and strengthened evidence in the future:

- Mental health experiences, interventions, and services for people experiencing homelessness, including dual diagnosis practice
- Views, experiences and training needs of healthcare professionals regarding people experiencing homelessness, and the implementation and impact of trauma-informed training on health outcomes
- The appropriateness and impact of different accommodation types for individuals and families
- Primary healthcare needs of people experiencing homelessness
- Effective intermediate and follow-up care for people experiencing homelessness
- Health needs of specific health inclusion groups and other individuals identified as likely to be at particular risk of homelessness, including (but not limited to) care leavers, prison-leavers and/or those in contact with the criminal justice system, vulnerable migrants, and vulnerable children, women and families (including in temporary accommodation).

The existing evidence reviewed in this report, and our stakeholder and lived experience engagement, suggests that flexible and compassionate healthcare, that includes outreach and incorporates multidisciplinary working, is likely to be effective for people experiencing homelessness, and potentially more cost-effective in the long term. Evaluative work of models of healthcare based on these approaches is emerging internationally and nationally (see e.g. Dorney Smith et al., 2016; Cornes et al., 2018; Jago et al., 2018) and would also be welcome locally.

To progress our three identified Areas of Research Interest in relation to health and homelessness, in the near future, we will:

- Establish a working group comprising Coventry City Council Housing performance and Public Health analysts, Coventry HDRC and UHCW, to identify opportunities to improve data-sharing across systems and services, consider population-level data, strengthen existing data collection and analysis, and identify opportunities to improve data use and application (ARI 3).
- We will review the existing evidence regarding early intervention and prevention, particularly the role of health and social care services in identifying and supporting early intervention and prevention to improve health of people experiencing homelessness (ARI 2).
- We will undertake evaluative work of new multidisciplinary and service approaches to understand their impact for people experiencing homelessness (ARI 1).

- We will also continue to engage with people with lived experience of homelessness and work with Coventry Public Voices Group to develop our research and ensure it continues to reflect local people's priorities. We will also continue to seek feedback on the most effective and meaningful ways to involve people experiencing and at risk of homelessness.
- We will share learning with other HDRCs who are working on similar issues to further develop good practice and enhance our research.
- We will also continue to identify opportunities to strengthen the general evidence base around health and homelessness and the other priority areas identified through our workshop and wider work, to improve outcomes for people experiencing homelessness in Coventry.

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Useful Resources

Further reading

Jackson et al. 2024, [Always at the Bottom of the Pile: The Homeless and Inclusion Health Barometer 2024](#) Pathway and Crisis.

The Kings Fund, 2020 [Delivering health and care for people who sleep rough 2020](#)

Homeless Link, 2025 [Unhealthy State of Homelessness: Findings from the Homeless Health Needs Audit](#)

Fryer et al., 2024 [The unseen struggle: the invisibility of homelessness in NHS data](#) Pathway Report

Local Government Association, 2017 [The Impact of Homelessness on Health: A Guide for Local Authorities](#)

The Faculty for Homeless and Inclusion Health, 2018 [Homeless and Inclusion Health standards for commissioners and service providers](#)

NICE (National Institute for Health and Care Excellence) Homelessness Guideline 2022, [Integrated health and social care for people experiencing homelessness](#)

NHS England, 2023 [A national framework for NHS – action on inclusion health](#)

Public Health England, 2021 *Homelessness: applying All Our Health* <https://www.gov.uk/government/publications/homelessness-applying-all-our-health>

HM Government (2025) [A national plan to end homelessness: policy paper](#)

Local strategies and policy documents

[ICB Health Inequalities Strategic Plan](#)

[Coventry Health and Wellbeing Strategy \(2023-2026\)](#)

[Coventry Partnership Rough Sleeping Strategy \(2019-24\)](#)

[Coventry Homelessness and Rough Sleeping Strategy 2025-2029](#)

Resources to support further research and analysis

- **Coventry HDRC Data catalogue**
<https://www.coventry.gov.uk/healthdeterminantsresearchcollaboration/research-projects/information-pack-1-housing-homelessness>
The Data Catalogue produced by Coventry HDRC suggests available sources of data about Housing and homelessness which could be used to further support research.
- **SPOTLIGHT – Improving health inclusion outcomes**
<https://analytics.phe.gov.uk/apps/spotlight/> (go to glossary and search homeless).
Spotlight is an analytical tool developed by the Office for Health Improvement and Disparities (OHID) that shares key public statistics on inclusion health groups. Spotlight draws upon a range of existing data sources, including healthcare datasets, statutory homelessness data and survey research. Further detail on these sources is given as they appear in the text. (See Appendix B for a complete list of data sources presented in Spotlight.)
- **Department of Health and Social Care - Fingertips | Public Health Profiles - Homeless**
<https://fingertips.phe.org.uk/profiles> (search homeless)
These profiles provide collections of indicators covering a range of public health topics. They have been developed to show local area data alongside relevant comparators. Homelessness is not included as a discrete indicator, but data on homelessness can be retrieved by using the search function and searching for 'homeless'.
- **HDR UK Phenotype Library – Homelessness**
<https://phenotypes.healthdatagateway.org/phenotypes/PH344/version/688/detail/>
The HDR UK Phenotype library can facilitate the study of multiple conditions (phenotypes) within homeless populations. The platform does not store data, but provides access to algorithms, metadata and tools to support researchers to undertake analysis and mapping.
- **GOV.UK** <https://www.gov.uk/government/collections/homelessness-statistics>
This collection includes the latest statistics and management information on homelessness and rough sleeping in England. (From Ministry of Housing, Communities and Local Government, Ministry of Housing, Communities & Local Government (2018 to 2021), and Department for Levelling Up, Housing and Communities).
- **GOV.UK** <https://www.gov.uk/government/publications/statutory-homelessness-ad-hoc-analyses>
Additional statistical analyses on statutory homelessness from the case level data collection. From Ministry of Housing, Communities and Local Government. (December 2025).