

Executive Summary

Health and Homelessness in Coventry



Foreword

This report presents summary findings of a project facilitated and funded by the NIHR (National Institute for 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 further research (areas of research interest).

This summary 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 can be read alongside the full report produced from this project, which also includes a list of useful resources to support future research and analysis.

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.

1. Introduction

The relationship between health and homelessness

It is now well established that homelessness is both a cause and consequence of poor health¹. People experiencing homelessness have some of the poorest health outcomes and worst health inequalities in the UK.² The average age at death for people rough sleeping is approximately 43 years for women and 45 years for men,³ more than 30 years below the national average for life expectancy.⁴

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.⁵ 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.⁶⁻⁹ A recent report by the Homeless Link¹⁰ 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 misuse¹¹ and substance misuse issues often worsen or become a way for many people to cope with their feelings about their homelessness.¹²

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.^{13, 14} For other people, these issues may have arisen more directly or recently, and/or worsened, because of their homelessness.¹⁵ 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.¹⁶ 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. The recent Homeless Link report¹⁰ finds that people experiencing homelessness use A&E services on average four more times more frequently than the general population.

For all these reasons, people experiencing homelessness have been established as a national priority health inclusion group^{17, 5} and reducing the impact of homelessness is a

key priority within the recent 2020 Marmot review of health inequalities.² 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.

2. Existing Evidence

We reviewed some key sources of existing national and local data regarding health and homelessness to understand the healthcare needs and experiences of people experiencing homelessness. We also sought to identify limitations and challenges with current data and evidence, suggest where evidence needs to be strengthened, and highlight wider considerations for researchers.

- Many sources of national and international evidence^{18, 10, 1} confirm that people experiencing homelessness are intensive users of accident and emergency services (A&E). Exact figures vary, but they are at least four more times more likely than the general population to use A&E for healthcare¹⁰ and are also more likely to experience delayed discharge and more frequent re-admittance to care.¹⁸ 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.¹⁹ This is very serious and distressing for the individual and costly to the public purse.
- 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. A recent report¹⁰ which summarises the most recent HHNA data collection wave (2022-25) finds that: 81% (587) of respondents reported having at least one physical health condition, 77% (560) of respondents reported at least one mental health condition, and almost half (49% (344)) of respondents reported self-medicating with drugs or alcohol to help them cope with their mental health. Of those receiving mental health support, only 32% felt their needs were met.
- Respiratory conditions were the most common *diagnosed* physical health condition: asthma (21% (142 respondents)), followed by chronic breathing problems including bronchitis, and emphysema, obstructive airways disease (19% (132 respondents)).¹⁰

- 'Dental/ teeth problems' are now the most common *reported* physical health condition, affecting 48% (339) of respondents. Only 37% of respondents were registered with a dental practice.¹⁰
- Barriers to accessing primary healthcare, mental health, and substance misuse services are known to contribute to higher rates of utilisation of emergency healthcare (A&E) by people experiencing homelessness.^{20,21}
- Locally, 195 patient admissions were recorded as homeless and seen by the Homelessness Pathways Lead at UHCW (University Hospitals Coventry and Warwickshire) between January 2025 and July 2025. Infections and Other physical conditions (such as existing long-term conditions, injuries or wounds) were the most common primary presentations for these homeless patients. Alcohol withdrawal, substance misuse, and mental health, were by far the most common secondary presenting conditions among these patients. Further analysis to understand the relationship between these secondary issues and people's primary presenting conditions would be helpful, as well as outcomes for homeless patients.
- In September 2025 there were 571 registered adult patients at The Anchor Centre (specialist primary care service) (430 male, 141 female) recorded as homeless (including people who are rough sleeping and vulnerably housed e.g. in temporary or emergency accommodation, sofa surfing, or staying with friends/family/acquaintances). There is a need for further research and analysis to improve understanding about the primary healthcare needs of these individuals, and patterns of primary care service utilisation of people experiencing homelessness in Coventry.
- 3750 unique assessments for housing support were undertaken by Coventry's 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.
- Housing service data about these applicants' backgrounds indicate wider health inequalities issues and intersectionalities that may have impacted people's journey towards seeking housing support, including, but not limited to: domestic abuse (16%), sexual abuse (8%), history of offending (16%), former asylum seeker (9%), history of rough sleeping (13%) or repeated homelessness (17%).
- 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, to support understanding about health and support needs of those experiencing homelessness.
- More widely, there are major challenges in identifying and making visible the needs of people experiencing homelessness, because people may be dealing with their

situation informally, and/or not make themselves known to services because of mistrust or fear of adverse consequences. People experiencing homelessness are therefore very likely to be underrepresented in existing datasets and research,^{22,23} and there is a need to improve understanding about the “hidden homeless”²⁴ population which often comprises the most vulnerable groups.

- Related to this, there is a need to identify opportunities to improve data-sharing across systems and services, to support population-health management approaches, and develop better understanding about the size, health needs and healthcare service utilisation of the homeless population in Coventry.
- There is also a need more generally to develop more inclusive and flexible research methods to engage with people experiencing homelessness, to enhance their visibility within health research, and to enrich their experience of research participation.

3. Stakeholder Views

We engaged with stakeholders across the housing, health and social care sectors about what they saw as the main issues regarding health and homelessness in Coventry, and key barriers and enablers to improving the health of people experiencing homelessness in Coventry. A summary of their views and recommendations is presented below.

- 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 Coventry and Warwickshire Partnership NHS Trust (CWPT) is viewed as a very positive development, but stakeholders noted it has limited capacity. Lack of wider availability and access to mental health services and lack of wider understanding (beyond the specialist team) regarding dual diagnosis, are agreed to be major barriers towards improving the (mental) health of people experiencing homelessness.
- The introduction of a Homelessness Pathways Lead at UHCW has been a very positive development to support inpatient stays, discharge processes and Duty to Refer responsibilities for people experiencing homelessness. The role is seen to have brought leadership, coordination, and improved communication regarding homeless patients across services and among stakeholders. Significant challenges remain however around provision of intermediate care, appropriate discharge accommodation options, and follow-up care for homeless patients.
- Access to primary care and preventative treatment/programmes is agreed by stakeholders to be key to improving the health of people experiencing homelessness. The Anchor Centre has been a significant development which has

improved access and patient experience and engagement, with well-trained staff and co-location of some services. However, there is limited outreach provision, and this is continued barrier for individuals who struggle to prioritise and manage their health and attend appointments.

- There have been valued efforts to raise awareness of dental hygiene and the relationship between oral health, nutrition and overall health by the Oral Health Improvement Project. But access to dental services overall remains challenging for people experiencing homelessness due to fixed locations and payment issues.
- In terms of public health there are major challenges in identifying and treating people experiencing homelessness for infectious diseases including, but not limited to, TB. TB is seen as a particular challenge because of the intensive and prolonged nature of treatment. It is important to build on existing local efforts to raise awareness, improve screening, and outreach.
- Issues such as substance misuse and lack of address or stable accommodation can affect assessments, eligibility, and feasibility of providing social care support for people experiencing homelessness. Wider research has highlighted the valuable role of adult social care in supporting people experiencing homelessness, particularly in relation to safeguarding and self-neglect.^{25,26} There is a need to further develop practice and national guidance in this area.
- Stakeholders agree there is a general need to raise awareness and improve training among the wider health and care workforce to provide effective and authentic trauma-informed care to people experiencing homelessness, to encourage and support engagement with services.
- There is a general need for improved health outreach which is easier for people to access, and to build on existing examples of good practice of multi-disciplinary working and compassionate care, such as the palliative care team.
- 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 of homelessness (e.g. individuals experiencing domestic violence).
- Much homelessness prevention work tends to be focused on tertiary prevention (that is preventing worsening of 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 for 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 17 people with lived experience of homelessness about their experiences of using healthcare, homelessness support services, and what was important to them about their health. Key themes from the conversations and feedback are presented below.

- 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 from homelessness.
- 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. This suggests there is a need for wider workforce training and awareness-raising around homelessness and trauma-informed care, and support for individuals to engage with services.
- 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.
- 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.
- 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 a major challenge and people felt they required more support with their mental health, to stop them wanting to turn to drugs and alcohol.

- 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 available and improve communication about wider sources of support for people experiencing homelessness.

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

We wanted to understand where people felt that improved or additional evidence to fill knowledge gaps could have the most impact in addressing health and homelessness. A workshop was held in September 2025 with approximately 45 stakeholders from the housing, health, social care, voluntary and community sectors, and Coventry Public Voices Group, to seek views on research priorities – ‘areas of research interest’ – for health and homelessness. Areas of Research Interest (ARI) are public expressions of research priorities and evidence needs.²⁷ Coventry HDRC is facilitating the development of ARI in relation to identified priority wider determinants of health, including housing/homelessness.

Through break-out discussions, delegates identified the following 14 areas for further research or research activity (areas of research interest). Delegates were then asked to place these areas in order of priority, using an online voting platform. The areas identified by delegates, in order of priority, were:

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 of research interest identified by workshop delegates were: 1. Effective pathways, partnerships or systems-working; 2. Early intervention; and 3. Improved data, data linkages and how we use data.
- There was very little difference in mean rankings between priorities [4] Views and experiences of healthcare professionals about attitudes and stigma towards patients experiencing homelessness, [5] Individuals' experiences and journeys around their mental health, and [6] 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 [priorities 5, 7, 12] suggests that mental health is also 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 [priorities 6, 9, 10, 11]. This suggests that this is also an area that would benefit from further research activity.
- Oral health was ranked the lowest importance 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 it was not an important issue.
- Indeed, it is important to remember that the 14 areas were all identified as research priorities, and that subsequent ranking determined their order of importance.
- Finally, some 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.

6. Next steps and recommendations

After further discussion and feedback with colleagues the three top Areas of Research Interest identified at the workshop were 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-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 more limited. 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 healthcare 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 nationally²⁸⁻³⁰ 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 evidence 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 service approaches and pathways 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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