

The
Kerslake Commission
on Homelessness and
Rough Sleeping

**A new way
of working:
ending rough
sleeping
together**

Final report
September 2021



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Foreword

Street homelessness, or 'rough sleeping' as it is commonly called, is deeply damaging to those experiencing it and to society at large. The health consequences of prolonged street homelessness are known to be severe and the costs of treatment and support escalate sharply the longer people are on the streets. For homeless young women, the risks of exploitation are high.

There is a shared and laudable ambition across the political parties to end rough sleeping and homelessness for good.

The Covid-19 pandemic might have been a reason for that ambition to have faltered. That it did not was in good part due to the success of the Everyone In campaign, which had one simple but powerful aim – to help people sleeping rough off the streets and into Covid-secure accommodation to allow them to protect themselves from the virus.

Everyone In was an emergency response to a health crisis. Enormous credit goes to the Government and Dame (now Baroness) Louise Casey for leading the initiative, and to local government, health and homelessness charities and providers for the way that they responded.

By almost any measure, the initiative was a resounding success. Some 37,000 people were brought in off the streets according to Government estimates. An article in *The Lancet* calculated that at least 260 deaths had been avoided. So why did it succeed when other pandemic initiatives clearly did not? And how can that success be embedded in the future?

As we move into a new phase of responding to the pandemic, however, the key question is how can we learn the lessons of Everyone In and harness them to find permanent solutions to rough sleeping. This is the question that the independent Commission I have chaired has sought to address and the conclusions of which are set out in this Final Report. This report also covers the recommendations that we made in my interim report on the longer term funding that will be needed to make the solutions a reality.

Perhaps inevitably, there is not one single answer but a series of actions covering prevention, early response, and new provision. Taken together, they add up to a substantial system change from the way things have been done up until now. All are practical and deliverable. At its heart is stronger cross-government planning and coordination, sufficient funding, and embedding a new level of collaboration and partnership across local government, health, and housing and homelessness providers.

The starting point must be responding rapidly to the individual needs of those who are rough sleeping or at risk of doing so. We must not let the institutional barriers that so rapidly came down during the pandemic creep up again.

A crucial insight from the work of the Commission is that rough sleeping and homelessness must be seen as **both** a housing **and** a health issue. Poor health is both a cause and a consequence of homelessness. Early action can prevent much greater health issues later on.

Another key issue that came through was the importance of recognising the different and specific needs of people who are homeless, particularly women, young people and those without confirmed settled status in the UK and who have no recourse to public funds.

There are tricky and sometimes conflicting issues for everyone involved. We have worked hard through the Commission, and with its 21-member Advisory Board, to find the points of common ground whilst at the same time not shying away from those issues where radical change is needed. I thank all members for their insight, expertise and willingness to think about their own contributions, as well as those of others. There are challenges in delivering the recommendations for all parties, not just Government. But I'm convinced that without clear and positive action on these recommendations, the goal of ending rough sleeping will not be met and we will lose the gains that have been achieved.

Whilst the report is in my name, it is the product of a huge amount of work by others. I owe a huge debt of gratitude to all those who submitted evidence and participated in the Advisory Board and bilateral meetings. We received in excess of 100 submissions of evidence and had meetings, focus groups and workshops with organisations across the country. I hope that the Final Report does justice to your contributions. My particular thanks go to the St Mungo's team who have provided absolutely terrific support throughout the review. St Mungo's is very fortunate to have them!

There is a choice now for Government and all those involved in preventing and tackling rough sleeping. We can build on the success of Everyone In and use it as a spur to change and improve or we can slip backwards and miss the opportunity. This, in my view, would be a dereliction of duty to protect some of society's most vulnerable people.

Chairing this Commission has been a great privilege for me. I have seen for myself the passion and commitment of those who are working on these challenging and complex issues. It is only right that the last word is saved for the people who had the most profound effect on me and the Commission; those with direct experience of sleeping on the streets. We are honoured and grateful that they chose and felt able to share their stories with us and their experiences alone should give us all the determination to not let this pivotal moment pass.

**Lord Bob Kerslake,
Chair of the Kerslake Commission**



Executive summary

In its 2019 General Election manifesto, the Conservative Party committed to ending rough sleeping by 2024. The monumental effort during the pandemic to get ‘everyone in’ has shown that this is possible and has redefined what can be achieved when all partners work together towards a singular shared goal. It is pivotal that the good work during this period is embedded into the system, so that this is not confined to a crisis response, but creates long term lasting change.

According to Government estimates, 37,000 individuals were brought inside during the emergency response, with more than 26,000 already moved on into longer-term accommodation. The response saved at least 226 lives, prevented 21,092 infections, and avoided 1,164 hospital and 338 Intensive Care Unit admissions.

In many cases, the response also connected people sleeping rough to the care, support and treatment they desperately need. This is a result of a burgeoning recognition that rough sleeping is not just a housing problem, but a whole system problem, and therefore needs a fully collaborative response between every part of the supporting framework, from housing to health to welfare to the criminal justice system.

However, the virus has not gone away and continues to damage lives, with those sleeping rough disproportionately at risk. A transition from the pandemic emergency response and the reduction and withdrawal of some emergency measures must not mean an increased flow of people onto the streets. A response to this immediate issue must be maintained, alongside a long-term and sustainable plan for recovery.

Addressing rough sleeping is vital, not just for the human toll – which is vast – but also the financial cost. The cost of a single person sleeping rough in the UK for 12 months is estimated at £20,128. Rough sleeping has a huge cost on health care systems, including mental health services and emergency services at hospitals; on criminal justice systems; and on social care services, to name but a few. As a whole systems problem, it has a whole systems cost, with the ripple effect felt throughout

public expenditure. The cost of intervening early on to prevent people from sleeping rough in the first place, saves far more expensive interventions further along the line.

The Kerslake Commission Interim Report

The Kerslake Commission Interim Report gave an authoritative overview of what had happened during this incredible public health emergency response to rough sleeping, and what lessons can be learnt. It also set out a series of recommendations targeted at the forthcoming Spending Review.

Positives

The Interim Report summarised that the clear messaging and hands on support from the Ministry of Housing, Communities and Local Government (MHCLG), since renamed as the Department for Levelling Up, Housing and Communities, helped galvanise local authorities in the early stages of the pandemic; and crucially was held up through existing and additional funding, and the investment in long term accommodation which supported sustainable recovery. At the heart of the response was clear direction to local authorities – at least initially – to help ‘everyone’ at risk of rough sleeping, effectively derogating rules on priority need, local connection and No Recourse to Public Funds. This improved knowledge of, engagement with and outcomes among groups that had previously fallen through the gaps of support.

By treating rough sleeping as a public health issue, rather than just a housing issue, the response also saw a substantial and increased engagement from

the health sector with rough sleeping. Clinical cohorting of clients by health needs shone a light on clinical vulnerabilities and allowed for a better understanding and treatment of clients. The public health approach also led to an increase in innovation and creativity, which was solution focused and facilitated the delivery of person-centred support.

Crucially, the provision of food and good quality, self-contained accommodation was key in encouraging people to come inside and facilitated the in-reach of multi-agency services, particularly health. By providing nutrition and a safe and comfortable environment, it gave clients the headspace to improve their health and housing situation.

These changes were also underpinned by preventative measures taken by the Government in the form of welfare changes which raised income and increased housing options. This makes both humanitarian and financial sense. These changes should be continued to stop people from ever sleeping rough in the first place. Ending them will threaten any progress made in terms of preventing rough sleeping during the last 18 months. Although the primary focus of the Kerslake Commission is on rough sleeping – the most visible and dangerous form of homelessness – there is a body of work that must be looked on preventing the wider problem of homelessness. Homelessness in any form is hugely damaging to the individual and to wider society.

Limitations

There were also limitations in the pandemic response. The short-term and piecemeal nature of funding was highlighted as a crucial issue, as it caused anxiety among clients about when offers of support would end and hampered local authorities’ ability to commission effectively, strategically plan or revise existing initiatives. It also created additional difficulties for frontline providers, as services would face a rapid turnover of staff towards the contract end and struggle to retain skilled workers.

Some services moved online, making them harder to access for those who experience digital exclusion. The emergency response was less effective at meeting the needs of women and young people, where the lack of

tailored provision meant these groups did not come inside or were placed at risk in mixed environments. There was also a significant degree of local variation in response: first, areas without pooled resources and connections struggled to meet the mark; second, when the Government reminded local authorities in May 2020 that there were legal restrictions on offering support to those who had no recourse to public funds, this created confusion as to whom was eligible for support.

The Kerslake Commission Final Report

The Kerslake Commission’s Final Report has examined what system change is needed to embed the lessons learnt from the emergency response to rough sleeping, addressing both the positives and the problems exacerbated by the pandemic. Importantly, the report also highlights recommendations called for prior to the pandemic, which remain fundamental to the goal of ending rough sleeping. In many ways, the pandemic has acted as a platform to take forward lessons previously learnt. These must not be forgotten.

Vision

Crucially, to end rough sleeping by 2024, the system has to prevent people from arriving at a crisis point. When rough sleeping does occur, it should be brief and with a sustained and long-term recovery.

The approach must be person-centred, and the services and systems which support a person to prevent or recover from rough sleeping must be co-designed. Prevention, not cure, must be the driving force. It requires a whole systems approach, with all agencies and bodies working together in a fully integrated way. The core service offer must be trauma-informed and psychologically informed, with a workforce which is trained to respond to the needs of the individual.

When people do reach crisis point, there needs to be help for them to recover quickly and be equipped with the tools to maintain their recovery. This requires appropriate accommodation, which is good quality and gives the person dignity, alongside the right level of support. There must be an increase in tailored

provision for people who face additional distinct barriers. There will be additional costs involved, but preventing rough sleeping and homelessness, and responding to it quickly and effectively when it does occur, is a moral imperative and will bring with it substantial savings in the future.

Better strategy, policy and delivery

The Everyone In initiative was an emergency response and a longer-term strategy is vital to ensure any gains made and lessons learnt, during this period, are not lost. One of the core aspects of this Rough Sleeping Strategy must be partnership working across central, regional and local government and its various delivery agencies.

Delivery and implementation of this strategy is also key. However, prior to the pandemic, and during the emergency response, there has been significant local variation between local authorities which stems from issues surrounding capacity and resources and the ability of local authorities or their partners to prevent and address homelessness and rough sleeping. This difference in provision, as well as funding limitations, can then result in authorities which do offer a service having to ration provision to prevent being overwhelmed.

The aspiration should be that gatekeeping policies become less relevant, by reducing the number of people coming onto the street in the first place and ensuring all areas have the capacity to respond to the needs of the people sleeping rough in their local communities.

Accurate monitoring and data recording is essential to achieving this, alongside understanding and measuring the scale of the problem and what resources are needed. However, currently there is incoherence in what data is captured across the country, making it difficult to measure activity and impact and share information.

Commissioning is key and currently all too often hinders partnership working. For commissioners, pressure on budgets prompts strict and rigid service access criteria, and focus on narrow outcomes as opposed to addressing the wider set of issues which contribute to rough sleeping. For providers, competing budget constraints

caused by having separate funding pots can create incentives to reduce provision and push people onto other service caseloads. Current practice, where people are identified as having a 'primary presenting need' and pushed into rigid single focus pathways, can compound these problems. As discussed in the Interim Report, partnership working has been the defining characteristic of the pandemic response and can – and should – be maintained through joined up commissioning processes.

With limited capacity and funding, local authorities have also been understandably reluctant to commission more tailored services – for those with extreme clinical vulnerability for example – if there is only a small number of individuals who require it within their area. In addition to increased capacity and funding, this could also be addressed through changes in commissioning to look further at pan-regional and sub-regional models. The pandemic further demonstrated this model through the hotel provision, where people could be referred into these from any local authority, with the referral based on need rather than geographical location.

Roles of accommodation and service models

The right accommodation with the right support at the right time plays a huge part in both preventing homelessness and supporting an individual to recover from it. The fundamental challenge of the availability and quality of housing and support continues to have a huge impact on what any service can do.

The Everyone In initiative demonstrated that it is possible to implement targeted interventions on a national scale to prevent people at the sharp end of homelessness from sleeping rough. These interventions can provide a final safety net for those people who have not been helped earlier. The next step is to maintain these targeted interventions at a crucial point before they sleep rough.

However, a significant barrier to delivering rough sleeping prevention is the need for verification – the requirement for people to be seen and recorded as rough sleeping by outreach workers in order to access the many services and accommodation. As highlighted in the Interim Report, during the Everyone

In initiative some local authorities effectively derogated rules on verification, allowing local authorities and frontline services to quickly provide shelter at the point of need and without having to check eligibility. This helped improve engagement and outcomes among groups that had previously fallen through the gaps of support. Going forward, verification should be a part of the assessment, rather than a requirement for accessing help.

Assertive outreach – which played a key role during in Everyone In – is also vital in any approach to ending rough sleeping. However, due to the lack of embedded mental health or drug and alcohol support in outreach teams, (a result of funding constraints due to decreases in the public health grant¹), outreach workers are left to fulfil too many specialist roles which they are not equipped or trained to do.

In regards to accommodation, there was a broad agreement within the evidence submissions that emergency accommodation should only ever be for short term use, to offer immediate protection from the dangers of sleeping rough. In instances outside of emergency assessments, dormitory style accommodation was criticised for not being psychologically informed, for eroding dignity and wellbeing, and for being a public health risk. Yet many local authorities are reliant on communal night shelters, particularly during severe weather protocols, and lack long term preventative planning.

There are also issues in the quality of homelessness accommodation, including exempt accommodation, which varies dramatically. It is important that over time the sector works with the Government and local authorities so that the overall balance of provision is shifted away from short term accommodation, such as hostels, towards longer term alternatives.

Housing First is one such longer term alternative which provides a tenancy as a platform for change, with intensive and flexible support to help clients address their needs at their pace. What came through strongly in the Commission's evidence submissions was that Housing First, and the principles that put the individual and the support they want and need at the forefront, should be a key component in the approach to ending rough sleeping. This will require investment from Government, as well

as an adequate supply of social housing. A starting point would be to extend the Housing First pilots.

Social housing is often the best route for those with a history of rough sleeping. Unfortunately for those in desperate need, social housing has become scarce due to a decline in new supply and a depletion of existing stock. Local authorities therefore ration their social housing by restricting who can qualify to go onto housing waiting lists. The restrictions have a disproportionate impact on people with experience of homelessness and rough sleeping. There is a further challenge of housing associations – which own 60% of social housing – having understandable concerns about their own expertise in supporting tenants with high or complex needs. This could be assisted by greater dialogue between housing associations and local authorities. However, the core of the problem is insufficient suitable homes. A crucial step in ending rough sleeping is therefore increasing the supply of social housing.

As highlighted in evidence submissions, the private rented sector (PRS) is housing an increasing number of people who are moving on from rough sleeping. The main challenges associated with PRS include: high rental costs, insecurity of tenure, low quality of accommodation, and the reluctance of landlords to let to individuals on benefits and/or with a homeless history. The PRS has a role to play in supporting people's recovery from homelessness, but the Government must urgently bring in its proposed reforms to ensure that tenants are protected from the risk of homelessness.

Addressing unfairness and inequalities

Since single white men who are UK nationals are the most represented in homelessness services, support is generally geared to meet their needs.

One particular group who need tailored support are non-UK nationals who may, due to their immigration status, have no or limited access to public funds. Resolving immigration matters is difficult technically and almost always requires professional support, yet independent immigration advice has been cut following the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO).² For some individuals, having restricted access to support



causes destitution, which was exacerbated during the pandemic despite emergency accommodation being made available for those sleeping rough.

It is important that people who are homeless are not treated as one homogenous group. Rather, a tailored, informed and inclusive offer of support is needed to address homelessness. Being young, LGBTQ+, BAME, or a woman, for example, all shape someone's experience of homelessness. Many women or young people are hidden homeless, meaning they are hidden from help, missing from homelessness services and rendered statistically invisible.

The Government is now following a policy response of 'living with Covid-19'. This raises significant concerns around the impact this will have on a population who are generally more clinically vulnerable, with lower rates of vaccination, in comparison with the general population. Given the potential for further outbreaks, it is critical that steps are taken to prevent Covid-19 from becoming a permanent health crisis for people who are experiencing homelessness, and exacerbating health inequalities further.

The criminal justice system also has a significant relationship with homelessness and rough sleeping, as spending time in prison increases the risk of homelessness, and a lack of stable accommodation then increases the risk of (re-)offending. Despite this, ex-offenders and those leaving prison do not always receive the support they need, with some people provided with no more than tents and sleeping bags on release from prison.

The self-perpetuating cycle of homelessness and experience of the criminal justice system is further exacerbated by the criminalisation of rough sleeping. This is through both the existence of the Vagrancy Act 1824, as well as the potential impact of the recent changes to the immigration rules which introduce rough sleeping as a new basis on which the Home Office can refuse or cancel permission to stay in the UK.

Headline recommendations:

Everyone has a responsibility to adopt a consistent and collaborative approach to support people in need to live their best life. Preventing, addressing and supporting recovery from homelessness and rough sleeping should be a shared ambition that cuts across all agencies, and cannot fall on one sector. When we work together it is remarkable what can be achieved.

This is very much a collective effort. Although the following recommendations name specific actors, this is to highlight a leading role, not an exclusive one. Every one of these recommendations requires supporting actors to fully engage as ending rough sleeping requires an integrated, system-wide approach.

The full list of recommendations can be found on page 66 of the report.

Central government

The Everyone In initiative showed the difference it makes when central government embraces its leadership role and provides clear direction to delivery partners. The Government must continue to take ownership of rough sleeping and homelessness.

- A longer term rough sleeping strategy is needed if the Government is to achieve and sustain its goal to end rough sleeping by 2024. Building on the success of Everyone In and the lessons learnt, the new Inter-Ministerial Group on rough sleeping, led by the Department for Levelling Up, Housing and Communities (DLUHC), should set out the overarching vision of the Government, publishing a cross-Government national strategy with clear expectations and strategic engagement with key agencies, and an explicit focus on prevention. The strategy should be accompanied by a published annual review of performance, no later than three months after the annual count. This annual performance review should be carried out by DLUHC, working with regional and local government, and be used to analyse national trends and identify gaps in provision and strategy. A key responsibility for the Inter-Ministerial Group in its terms of reference must be to push for cross government investment to enable delivery of the strategy.
- To support a whole systems approach to street homelessness, the Government should extend the Homelessness Reduction Act's Duty to Refer³ to a Duty to Collaborate with relevant public agencies to both prevent and respond to homelessness. This should include the Department of Health and Care (DHSC) and health services, Department of Work and Pensions and its agencies, the Home Office, the Ministry of Justice and its agencies and other government agencies with an involvement in homelessness and rough sleeping services. An example of this collaboration would be the sharing of data within Caldicott Principles.
- The challenge of local variation, where this leads to differences in performance, can be addressed through the Government commissioning tripartite reviews of performance in homelessness services, including prevention and long term provision and support. Driving this system requires joined up performance management involving (1) local authorities, (2) local delivery partners, and (3) cross Governmental departments and bodies, namely DLUHC, DHSC, the NHS and the Office for Health Improvement and Disparities. The aim should be to find what has and has not worked for partner agencies, where there are issues of resourcing, and support improvement using examples of good practice. This should build on the successful DLUHC advisers model and be supplemented by direct offers of support, including the option of peer review. The Local Government Association has a role in supporting the development of good practice.

- To prevent an increased flow of people onto the streets, the Government must retain the welfare changes that have kept people afloat during the pandemic, whereby Local Housing Allowance rates were raised to the 30th percentile of local rents and Universal Credit received an uplift of £20 per week. In addition, the Government should review the benefit cap and seek to increase it in areas with high affordability pressure, and provide a financial package of support for people in arrears due to the pandemic.
- The Government must establish a clear policy position that limiting access to benefits for non-UK nationals should stop short of causing destitution. Destitution can be prevented through investing in good quality independent immigration and welfare advice and employment support, clear guidance on access to benefits for non-UK nationals whose status is yet to be determined and simpler and faster processes to clarify people's immigration status. Local authorities should be provided with guidance on what it means to 'exhaust all options within the law'⁴ to support those who are sleeping rough and are not eligible for statutory homelessness assistance, due to their immigration status. Local authorities should be provided with financial compensation where all other options have been exhausted to prevent destitution. Further, local authorities with a high number of non-UK nationals with unclear immigration status on the streets should look to funding immigration advice as part of their rough sleeping and homelessness prevention services. Collecting data on the number of individuals with no or limited access to public funds experiencing destitution will help to identify what resources are needed to assist this group out of homelessness.
- Everyone In should continue to be financed through the Rough Sleeping Initiative (RSI), delivered through a minimum three year funding settlement and with an annual spend of £335.5m. The RSI spend should have a focus on rough sleeping prevention, outreach, accommodation and support, and should pay for an increased supply of self-contained, good quality emergency accommodation, with tailored options for women and young people.
- The Rough Sleeping Accommodation Programme should be continued for the duration of the Rough Sleeping Initiative. The viability of this model can be improved, and take up increased, by aligning capital and revenue funding, allowing capital funding to roll over into subsequent years and drawing on continuous market engagement approaches. Strategic partnership working should be built into the programme and there should be flexibility to increase the maximum length of stay beyond two years.

Local authorities

- To prevent homelessness, and respond to it quickly where it does occur, local authorities should be expected to produce long term, integrated homelessness and health strategies, and rapid rehousing plans. This work should require a local assessment of need, conducted using local homelessness partnerships and based on a standardised methodology set by DLUHC. This assessment of need would aim to quantify the level of central government funding needed to ensure the most appropriate accommodation is available for the individual, and that there are sustainable long term recovery options, with wraparound support where needed.
- Winter comes around every year but preparedness for its implications on rough sleeping varies amongst local authorities. Local authorities, in partnership with homelessness organisations, should conduct long term, strategic planning for peaks in weather, including extreme cold or severe heat, and other contingencies. This strategy should be grounded in prevention, to ensure that people supported through severe weather emergency protocol (SWEPEP) are kept to a minimum, and should be supported through long-term funding. The aim should be to reduce reliance on communal night shelters.

Homelessness organisations

- Staff in the homelessness sector support very vulnerable people, often with complex needs, and it is essential that they have the right competencies to do this job. To recognise the challenging job that they do, it is recommended that Homeless Link convene a consultation on professional accreditation. This should cover all areas of the workforce and include understanding the integration of specialist support, such as mental health and immigration advice.

Housing providers

- Housing associations are not public bodies, and therefore do not have a legal duty to address homelessness. However, housing associations do have a social responsibility, and an important role to play in the provision of secure and safe accommodation and support for people who are homeless or at risk of homelessness. The Commission recommends that the National Housing Federation, working with Homes for Cathy, continues to promote the positive work done by housing associations and drives forward this commitment to collaborate with their members to prevent and relieve homelessness. The Commission also recommends that the LGA continues to promote the benefits of local authorities and housing associations working together to develop solutions and longer-term strategies. To incentivise housing associations to prevent and contribute to homelessness solutions, the Regulator of Social Housing should monitor performance in this area.

Health organisations

- The forthcoming integrated care systems will play a crucial role in embedding health within local delivery agencies. Guidance for the integrated care systems should stipulate that Integrated Care Boards, Integrated Care Partnerships and Health and Wellbeing Boards have a dedicated focus on tackling health inequalities for inclusion health populations, including people experiencing homelessness and rough sleeping, and ensure that both mainstream and inclusion health services deliver trauma informed and psychologically informed services for this cohort, who may struggle to engage. This focus must also be shared by the new Office on Health Promotion. There should be an assessment of need and capacity within inclusion health services to ensure that people are able to access care and support. As part of the Care Quality Commission's (CQC) system review framework, there should be a specific focus on whether integrated care systems explicitly reference homelessness and rough sleeping as part of their health inequality strategy. This should be used as a litmus test for the quality of integrated care systems' population health plans.

Introduction

The Kerslake Commission was created to examine the lessons from the unprecedented public emergency response to rough sleeping, which has become known as the Everyone In initiative.

At the outset of the Covid-19 pandemic, the Government sought to ensure that anyone at risk of rough sleeping was immediately provided with safe and secure accommodation. By common consensus, the Everyone In initiative saw a remarkable increase in partnership working, with the overarching objective to save lives leading to a step change collaboration.

The ‘preservation of life’ principle also prompted an increase in innovation and creativity in approach, which was solution-focused and facilitated the delivery of person-centred support.

Fundamentally, the provision of food and good quality, self-contained accommodation was key to encouraging people to come inside and improving people’s housing situation and their health. It also allowed partner agencies to take their support offer directly to those in need, further removing potential barriers.

But the sharp focus also exposed the cracks in the system; the sheer number of those who were sleeping rough or in unsafe emergency accommodation, the limited resettlement options for people with restricted, or no, access to public funds which locks them out of many services and the lack of provision for people who have complex needs or require tailored provision. All too often these are the people who fall through those gaps in provision and support.

These are issues the system was already grappling with, but which have come to a head during the last 18 months. What’s more, there is wide-spread concern that without the impetus provided by the public health crisis, the significant progress made will begin to slip back. The Kerslake Commission’s mission was to understand the lessons from the emergency response, and what systemic changes are needed to embed them in the long term.

In July, the Kerslake Commission released its Interim Report, which provided an authoritative overview of the lessons learnt from the emergency response and made recommendations, targeted at the 2021 Comprehensive Spending Review, advising what should be the priorities and approaches to achieve the Conservative Government’s 2019 General Election manifesto commitment to end rough sleeping.

The key recommendation of the Interim Report was that rough sleeping must continue to be treated as a public health priority. It called on the Government to maintain the investment in rough sleeping that was seen during the pandemic, but with longer-term, joined up funding, and crucially investment in prevention, particularly in welfare support and affordable housing.

However, funding on its own is not sufficient to embed the important learning and success from the last 18 months. There is also a requirement for the different way of working, exemplified by all parties during this period, to become the norm.



The purpose of this final report is to examine the systematic changes that are needed to embed this way of working, bringing forward both new recommendations developed as a result of lessons learnt during the pandemic, as well as reiterating recommendations developed prior to the pandemic which remain vital to ending rough sleeping.

As can be seen in the recommendations for change, everyone has a role to play. From the Government’s need to have an integrated, centrally shared strategic plan, to the core challenge for local authorities to exemplify the best and tackle local variation in provision and performance, to the need for homelessness to be embedded in all health policies – taking advantage of the new integrated care systems across England – and the need for the housing and homelessness sector to ensure that their services meet the needs of those they are trying to help, and to collaborate with other services to ensure that the universal approach puts the individual at its heart.

Although the Kerslake Commission’s primary focus is on rough sleeping, it is vital that decision makers and actors across the system look to the wider body of work on preventing homelessness more broadly. Homelessness in any form is hugely damaging to the individual and to wider society. Not having a safe and reliable place to call home prevents people building a better life for themselves, and does long term damage to physical and mental health and wellbeing.

Chapter 1 summarises the findings and recommendations, particularly on funding, from the Kerslake Commission’s Interim Report.

Chapter 2 sets out the vision of what an effective system to end rough sleeping should look like, incorporating the crucial lessons learnt during the pandemic and building on the knowledge and experience that came before.

Chapter 3 then looks at what is needed to deliver this system: a long-term, joined up strategy, complete alignment of policy across different institutions, effective delivery of services and support and a constructive monitoring system to ensure that all of these aspects are working as they should.

The focus of **Chapter 4** is the various types of accommodation and service models at different points in a person’s recovery journey, and the barriers to effective delivery.

The **final chapter** addresses the unfairness and inequalities faced by different groups – such as non-UK nationals, women, people who are LGBTQ+, people with a BAME background and young people – all of whom have distinct experiences of homelessness, often requiring different support.

Evidence gathering

The Kerslake Commission's evidence gathering has been approached through a major call for submissions of evidence. In total, 112 organisations and individuals contributed through surveys, focus groups and bi-laterals. In addition, there were two literature reviews conducted by Crisis and the London School of Economics and Political Science (LSE).

This final report has been drawn from the Commission's initial evidence gathering, which has then been further refined and tested at 21 bilateral meetings that took place between July and September 2021. Bilateral contributors included representatives from health, housing, homelessness, criminal justice, local authorities

and crucially, those with personal experience of homelessness and rough sleeping. The full list of bilateral contributors can be found in Appendix B.

A 21-member Advisory Board was tasked with providing expert advice to the Commission, particularly with regards to the analysis and recommendations, and met four times over the course of the Commission. These meetings were used as opportunities to provide feedback and to develop a consensus, wherever possible.

All conclusions and recommendations are those of the Commission's chair, Lord Kerslake.

Chapter 1: The findings from the Interim Report

The Kerslake Commission Interim Report gave an authoritative overview of what had happened during this incredible response to the public health emergency to help rough sleepers and what lessons could be learnt. It also set out a series of recommendations targeted at the forthcoming Spending Review.

Positives

It summarised that the clear messaging and hands-on support from the Department for Levelling Up, Housing and Communities (DLUHC) helped galvanise local authorities in the early stages of the pandemic and crucially was held up through existing and additional funding, and the investment in long term accommodation. The Government also demonstrated a continued investment in homelessness and rough sleeping through a 60% increase in revenue funding in 2021-22, compared to the 2020-21 Spending Review base budget.⁵

At the heart of the response was clearly directing local authorities – at least initially – to help 'everyone' at risk of rough sleeping, effectively derogating rules on priority need, local connection and No Recourse to Public Funds. This improved knowledge, engagement and outcomes among groups that had previously fallen through the gaps of support.

By treating rough sleeping as a public health issue, rather than just a housing issue, the response also saw a substantial and increased engagement from the health sector with rough sleeping. Cohorting of clients by health needs shone a light on clinical vulnerabilities and allowed for a better understanding and treatment of clients. The public health approach also led to an increase in innovation and creativity in approach, which was solution focused and facilitated the delivery of person-centred support. Examples included: key services being delivered on-site or easily reached, swift and accessible assessment processes, and easier and more flexible access to drug treatment prescriptions.

Crucially, the provision of food and good quality, self-contained accommodation was key to encouraging people to come inside and facilitated the in-reach of multi-agency services, particularly health. By providing nutrition and a safe and comfortable environment, it gave clients the headspace to improve their health and housing situation.

These changes were also underpinned by preventative measures taken by the Government in the form of welfare changes which raised income and increased housing options. This makes both humanitarian and financial sense. These changes should be continued to stop people from ever sleeping rough in the first place.

Limitations

There were also limitations in the response. Some services moved online made them harder to access for those who experience digital exclusion. The emergency response was less effective at meeting the needs of women and young people, where the lack of tailored provision meant these groups did not come inside or were placed at risk in mixed environments. There was also a significant degree of local variation in response: first, as areas without pooled resources and connections struggled to meet the mark; second when the Government reminded local authorities in May 2020 that there were legal restrictions on offering support to those who had no recourse to public funds, which created confusion as to whom was eligible for support.



The short-term funding was also highlighted as a crucial difficulty. Services and local authorities found constant bidding for different funding, and the multiple and lengthy monitoring requirements attached to them, were resource intensive and prevented strategic service delivery. Services struggled to retain skilled workers and relied on agency staff. In total, 13 different governmental funding sources were allocated to rough sleeping during the pandemic. The Next Steps Accommodation Programme (NSAP) and Rough Sleeping Accommodation Programme (RSAP), which provide funding for longer term accommodation and support, were welcomed but this report has concluded that they would be more viable funding models if there was greater flexibility over when the capital funding needed to be spent, and better alignment between the capital and revenue funds.

	2020-21	2021-22 (planned spend)	2022-23 –2024-25 (recom- mended annual spend)
Rough Sleeping Initiative	£112m	£254m	£335.5
Additional expenditure on rough sleeping due to Covid-19, used to provide accommodation and support	£223.5m		
Total	£335.5	£254	£335.5

Recommendations:

Spending Review 2021

- To deliver the sector recommended target of building 90,000 social rented homes a year, the Government must increase grant funding delivered through the Affordable Homes Programme. The Government should increase the supply of supported housing through the continuation of the Affordable Homes Programme, but ensure capital funding is linked to multi-year revenue funding for support services.
- Everyone In should continue to be financed through the Rough Sleeping Initiative (RSI), delivered through a minimum three-year funding settlement and with an annual spend of £335.5m. The RSI spend should focus on rough sleeping prevention, outreach, accommodation and support, and should pay for an increased supply of self-contained, good quality emergency accommodation, with tailored options for women and young people.
- The Rough Sleeping Accommodation Programme should be continued for the duration of the Rough Sleeping Initiative. The viability of this model can be improved, and take up increased, by aligning capital and revenue funding, allowing capital funding to roll over into subsequent years and drawing on continuous market engagement approaches. Strategic partnership working should be built into the programme and there should be flexibility to increase the maximum length of stay beyond two years.
- The Department of Health and Social Care (DHSC) should reverse the disinvestment in drug treatment and wider recovery services, increasing funding by up to £552 million annually over the next five years, on top of the baseline annual expenditure from the public health grant, as recommended in the Dame Carol Black Review.⁶

Chapter 2: Our vision

During the pandemic, the Government rightly recognised the significant threat to health posed by sleeping on the streets and in communal shelters. Through focusing on getting ‘everyone in’ and providing safe accommodation, many lives were saved. Furthermore, it connected people sleeping rough to the health, care, support and treatment they desperately need. The Kerslake Commission Interim Report highlighted the many lessons to learn from the success of the Everyone In initiative. However, many of those who submitted evidence stressed that Everyone In was a success in spite of the system, not because of it. This Commission’s final report sets a vision for what this system should look like, at best to prevent, or help people recover from, sleeping rough, incorporating the lessons learnt during the pandemic. Crucially, the system has to prevent people from reaching this crisis point, and, where rough sleeping does occur, it should be brief and with a sustained and long-term recovery.

The system that does this best is one which has the individual, whom it is designed to support, at the centre. Sleeping rough is a state not a trait: all parts of the system which support people need to recognise this to help them recover effectively. An important step change, therefore, is for person-centred care and for services to be co-designed by those with lived experience, to ensure that they are accessible and inclusive.

Further, what has been made clear during the Commission’s evidence gathering, is that prevention has to be the driving force behind strategy and delivery. Prevention has both a human and financial cost saving. Stopping someone from sleeping rough in the first place means many of the potential consequences – poor physical health; increased substance use;⁷ deteriorated mental health and wellbeing;⁸ an increased engagement with the criminal justice system⁹ – are pre-empted, or at least lessened, resulting in savings for the taxpayer.¹⁰ Rough sleeping prevention is an aim that crosses Government departments, bringing with it social and financial returns outside of DLUHC’s remit. In the 2015 Hard Edges report, the costs of rough sleeping to the public purse were calculated to be between £14,300 and £21,200 per person

per year. This is three to four times the average cost to public services of an average adult (approximately £4,600).¹¹ When designing a system to meet its commitment to end rough sleeping by 2024, the Government must therefore lead the way with looking to prevent, rather than cure.

“We need to recognise that prevention needs to be intentional and perpetual, part of business as usual. We need a Housing and Wellbeing Strategy, not just an Ending Rough Sleeping ambition.” (Homelessness/S17)

Key to upstream prevention are general housing policy (supply, access and affordability), and the welfare system (including the availability and level of benefits and employment protection). During the pandemic, the Government put in place preventative measures such as the £20 uplift in Universal Credit, changes to the Local Housing Allowance, and exemptions to the Shared Accommodation Rate for those under 25. In the Interim Report the Commission strongly recommended that these preventative changes be maintained. Unfortunately the current Government position is that the Universal Credit uplift will be rescinded, and that Local

Housing Allowance will be frozen at the same level in cash terms for 2021-22, which the Commission fears will undermine the prospect to end rough sleeping by 2024. In addition to housing policy and welfare support, addressing long standing issues, such as the supply of genuinely affordable homes, and the approach of landlords to supporting residential tenants and avoiding evictions are equally important, as is employment support. These steps would look to prevent rough sleeping, but also the broader problem of homelessness.

Stopping people from falling into homelessness and sleeping rough, and responding quickly where it does occur, requires a whole systems approach, where all agencies and bodies work together in a fully integrated way. A person’s problems are not siloed: they experience them in an overlapping and often mutually enforcing way. It is the responsibility of the Government to create a strategy which encourages and enables an integrated response that reflects this experience.

There are multiple aspects to integrated working. First, it needs a fully coherent and joined-up Government approach. Central leadership must involve all the relevant departments in its plans – supported by one funding stream and a shared set of data – so that homelessness is not seen as solely the responsibility of one department, but as a shared mission in which each department fully understands and commits to the joint vision. This is not just at a ministerial level but must be reflected at civil service level. This can be done through the creation of a joint unit.

“Increasing national leadership through a detailed call to action with a long term, cross departmental strategy in place to bring together the departments with dependencies identified across each area...” (Homelessness/S54)

This principle should flow down to local systems, with local authorities and the health and care sector – through the new integrated care systems in England – empowered to

deliver an integrated approach which best meets the needs of people sleeping rough in their area, working in close partnership with the commissioned services. Local leadership is vital to crafting an approach that is relevant to a local population. Providers of all services which help a person recover from homelessness, from housing, to health, to welfare, should be encouraged to see their roles as helping the person as a whole, and sharing information and practice which helps other agencies to meet co-occurring needs.

Whilst services in different areas will be tailored to local needs, there should be a core service offer available nationally. The framework for all agencies involved in delivering these care and support services must be person-centred, trauma-informed and psychologically informed. These should form the base principles for all services – be they housing, health, or welfare – underpinning a multiagency, multidisciplinary workforce that fully understands and adopts common ways of working to respond to the needs of the individual.

Another part of a whole systems preventative approach is the central role of health in homelessness. Poor health is both a cause and consequence of homelessness, and those experiencing homelessness have some of the highest health inequalities in the population. As highlighted in the Kerslake Commission Interim Report, the Everyone In initiative has shown that treating rough sleeping as a public health issue, rather than just a housing issue saves lives and also supports people to recover from homelessness. What is needed is a system with fully joined up working between health and homelessness, both in terms of vision and delivery. It is part of a population health approach, moving “away from a system just focused on diagnosing and treating illness towards one that is based on promoting wellbeing and preventing ill health.”¹²

“A recognition that a health led/informed response to homelessness is needed.” (Local Authority/ S53)

“National recognition of responsibility of health and social care to this cohort with resourcing, capacity and (possibly statutory) guidance developed, to drive multiple systems change.”
(Local Authority/S68)

Where people do reach crisis point, there needs to be help for them to quickly recover and be equipped with the tools to maintain their recovery. This requires appropriate accommodation alongside the right level of support. Where emergency or temporary accommodation is used, it must be brief, with the primary purpose being to move someone off the street and ensure their safety and health whilst more sustainable options are found.

To ensure there are affordable, longer-term options available, there needs to be a greater supply of social housing allocated to people with experience, or at risk, of homelessness.¹³ For the private rented sector to be an appropriate part of the system, it must be reformed to address problems such as high rental costs,^{14, 15} insecurity of tenure,^{16, 17} low quality,^{18, 19} and the reluctance of landlords to let to individuals on benefits and/or with a homeless history.^{20, 21}

“We will not solve homelessness without truly affordable homes or enough long-term funded support to help people keep them.” (Homelessness/S57)

Irrespective of the type of accommodation, it must be good quality, suitable for an individual's needs at that point in their recovery journey, whether health or care related, and it must allow the person dignity. Many of those provided with hotel accommodation during the Everyone In initiative said that the dignity they felt as a result of having their own front door was important to their wellbeing.

Although all support and accommodation should meet this standard, the system must include tailored options for groups who face additional distinct barriers and therefore require a different type of service. There should be provision suitable for all needs, be it accommodation and support for those who are highly clinically vulnerable, who have extremely complex needs, who need it to be gender-informed, or LGBTQ+-informed.

Depending on the causes of a person's homelessness, prevention and recovery may also require employment advice and training; tenancy sustainment support; welfare advice; or specialised immigration advice. The system must be able to adequately provide these at an early stage to ensure that recovery is sustainable and long-term. Specialist employment and immigration advice is a vital tool to help those with unclear immigration status who otherwise find it very difficult to move on from homelessness. Regardless of immigration status, no one should have to face destitution, yet in our current system, this is an increasing reality for far too many.

“A bold long-term shift in approach is needed between services, local and national government to support people who currently face NRPF, so many of whom face destitution and will continue to fall through the cracks of the system.”
(Complex Needs/S39)

The following chapters examine how we can work together to embed this real system change and fulfil the Government's commitment to ending rough sleeping by 2024.

Chapter 3: Better strategy, policy and delivery

To deliver the system necessary – namely, one which prevents people from becoming homeless, and quickly and effectively supports those who do experience it to recover – it requires a long-term, joined up strategy, complete alignment of policy across different institutions, effective delivery of services and support and a constructive monitoring system to ensure that all of these aspects are working as they should.

Rough Sleeping Strategy

As set out in the Kerslake Commission's Interim Report, the Everyone In initiative was commendable in both aim and often in execution. However, this was an emergency response, pulled together rapidly during a public health emergency. A longer term strategy should draw on the vital lessons learnt from this crisis, and the knowledge and experience developed previously, to meet the Government goal to end rough sleeping by 2024.

In early 2020, the Prime Minister appointed Dame Louise Casey (now Baroness Casey) to lead a review into rough sleeping, which would renew and adapt the Rough Sleeping Initiative and other pilots and programmes initiated as part of the 2018 Rough Sleeping Strategy. However, in mid-March her role changed to focus on the emergency response and the Government has not yet demonstrated a renewed commitment to review and renew its Rough Sleeping Strategy.

One of the core aspects of the Rough Sleeping Strategy must be partnership working across central, regional and local government and its various delivery agencies. This was a key theme which emerged in the submissions to the Kerslake Commission.

“It is vital that somehow we maintain the partnership working across agencies.”
(Homeless/S14)

The Government should own the national strategy and provide centralised strategic thinking and support to deliver it. The funding that flows from the national strategy must be long term, joined up and flexible, so that it is applicable to different individual and local circumstances.

For this to be effective, government departments must work seamlessly together. It is not simply a housing problem within the remit of the DLUHC. It is also a health problem, with poor health being both a cause and consequence of homelessness. Dame Carol Black's independent report into drugs, for example, demonstrated the interwoven nature of drug use and homelessness that many experience,²² and recommended joint work between DLUHC and the Department for Health and Social Care (DHSC). Similarly, immigration policies under the Home Office have a significant impact on people becoming homeless and their ability to end it (as will be further explained on pages 50-53); as do welfare policies sitting in the Department for Work and Pensions (DWP). Ministers across government need to be able to offer solutions, and be held accountable for the Government's goal to end rough sleeping by 2024.

In addition to integrated working in central government, the only way to effectively develop and deliver the Government's Rough Sleeping Strategy is to work in partnership with regional and local government and delivery agencies. There should be ownership at different levels, involving key delivery partners who are responsible for the delivery of strategy in their local area.

“A recognition that public services at a local and regional level have the insight and capability to work effectively where they have the permission and resource to do so – leading to de-centralising decisions and increasing the length and control over funding settlements.”
(Local Authority/S53)

A shared ownership of the strategy also goes some way towards recognising different localities and capacities across local authorities. Local leadership is vital to crafting an approach that is relevant to a local place and population.



Rough Sleeping Strategy Group

Tackling rough sleeping in London is a priority for national government, the Mayor of London, London local authorities, the NHS, and a wide range of voluntary and community sector charities and service providers. While partners share a common aim and work together in a spirit of positive collaboration, responsibilities, governance and activity can sometimes overlap or appear disjointed.

A Rough Sleeping Strategy Group for London was established in response to the Covid-19 outbreak to bring together key partners to ensure the safety of rough sleepers during the pandemic. Its role subsequently evolved to provide a space for partners to come together to join up conversations, drive activity to end rough sleeping and monitor risks, issues, and outcomes. The Rough Sleeping Strategy Group is a system leadership body, which facilitates partnership working, problem solving and information sharing. It is not a formal commissioning body, and it does not have formal control or accountability with such responsibilities sitting with other

formally constituted, often democratically accountable, groups.

The key actors involved in the work to end rough sleeping in the capital are reviewing the role of the Rough Sleeping Strategy Group – alongside that of other important bodies like the Mayor's Life OffThe Streets Task Force. The intention being to consider the wider structures, oversight arrangements and shared initiatives around rough sleeping and bring governance and shared programmes under a single leadership structure with clearly defined roles and responsibilities for all involved.

The changes to governance should provide a welcome opportunity to review and reset London's strategic work programme to end rough sleeping as we move out of the pandemic, and a new Rough Sleeping Programme Director role (based within London Councils) has been established and recruited to so as to make sure that the programme is delivered, focus is maintained, and shared work remains properly co-ordinated.

Recommendations:

- A longer term rough sleeping strategy is needed if the Government is to achieve and sustain its goal to end rough sleeping by 2024. Building on the success of Everyone In and the lessons learnt, a new Inter-Ministerial Group on rough sleeping, led by the Department for Levelling Up, Housing and Communities (DLUHC), should set out the overarching vision of the Government, publishing a cross-Government national strategy with clear expectations and strategic engagement with key agencies, and an explicit focus on prevention. The strategy should be accompanied by a published annual review of performance, no later than three months after the annual count. This annual performance review should be carried out by DLUHC, working with regional and local government, and be used to analyse national trends, and identify gaps in provision and strategy. A key responsibility for the Inter-Ministerial group in its terms of reference must be to push for cross government investment, to enable delivery of the strategy.
- A joint Health and Homelessness Unit, akin to the Joint Work and Health Unit,²³ should be established to ensure that cross-departmental working is carried through at a civil service level. The unit should have joint priorities and shared data to support the removal of barriers to effective working.
- To support a whole systems approach to street homelessness, the Government should extend the Homelessness Reduction Act's Duty to Refer,²⁴ to a Duty to Collaborate with relevant public agencies to both prevent and respond to homelessness. This should include health services; Department of Work and Pensions and its agencies; the Home Office; and Ministry of Justice and its agencies; and other government agencies with an involvement in homelessness and rough sleeping services. An example of this would be the sharing of data.

Delivery and implementation

During the Everyone In initiative, there was widespread engagement from local authorities in responding to rough sleeping. This was largely due to the presence – but importantly not intervention – of central leadership, allowing areas to tailor responses to suit their population.

Throughout this report are examples and case studies of where local authorities and commissioners have exemplified the best of local government in its response.

However, as discussed in the Interim Report, there was local variation in response.²⁵ The degree of success that areas had in mobilising and meeting the needs of their rough sleeping populations was largely determined by pre-existing services and infrastructure; areas without these pooled resources and connections struggled.

Success was also affected by the funding that was available for local government. This stems from the current situation where rough sleeping provision is concentrated in major cities, whereas in other areas authorities may not offer a service, due to a lack of available funding, the perception that rough sleeping does not exist in the area, prioritising other policy, or concerns that providing a service will attract or keep rough sleeping in the areas. This disparity in provision then results in authorities which do offer a service gatekeeping to prevent being overwhelmed²⁶ – for example through verification and rules on local connection.

Verification is the requirement for people to be seen and recorded as rough sleeping by outreach workers to enable access many services and accommodation. The 'local connection' test looks at an individual's residency, employment, and family connections in the area to determine whether they are eligible for support. Both of these create an additional barrier for people sleeping rough to access help

at an earlier point. The Commission was told by homelessness organisations that the requirement to be verified has led to people being advised by some of their local authority partners to sleep rough to access support.

The aspiration ought to be that local connection and verification become less relevant, by reducing the number of people coming on to the street in the first place and ensuring all areas have capacity to respond to the needs of the people sleeping rough in their local communities. A 'no wrong door' approach would ensure that everyone who is in need is able to access help quickly and effectively.

Though there should be different provisions and joint working arrangements to reflect local areas, there needs to be a minimum standard of service for people at risk or who are experiencing rough sleeping.

There is currently a LGA sector-led improvement (SLI) programme on homelessness for local authorities, which aims to support and improve performance, where needed, through support and challenge from peers; benchmarking performance; using comparable data and sharing good practice. An independent evaluation of the SLI found a high level of satisfaction with this model, and found a significant majority of respondents saying that it "had a positive impact on their council to a great or significant extent."²⁷

However, local authorities do not work in isolation, and the lack of engagement from partner agencies creates significant barriers in preventing and addressing homelessness and rough sleeping. Evidence submissions to the Commission emphasised that local agencies have a significant role to play in supporting the local authority with delivery and implementation of the Rough Sleeping Strategy.

**“There must be firm involvement from mental health services in tackling disadvantage and ensuring mental health services are fundamental to local partnerships. Agencies such as police, probation and courts, as well as prisons and the secure estate and voluntary sector organisations need to be key partners in shaping local responses.”
(Complex Needs/S39)**

Lewisham health and homelessness partnership working

Prior to the pandemic, Lewisham had a number of contracts in place to support the healthcare of the homeless population. Before the South East London CCGs merged, Lewisham CCG had commissioned GP in-reach contracts and there was also a Health Inclusion Team (HIT), which went into the larger hostels, as well as the 999 Day Centre.

A priority for Lewisham was shared living, including hostels. There were concerns about the spread of infection, depleted workforce through self-isolation and clients with very high support needs having to self-isolate in self-contained accommodation, without the 24-hour support of a hostel. As part of this response, a Lewisham public health consultant reviewed risk assessments for each building and commissioners worked with providers to put risk management strategies in place.

The Council and the CCG worked with GPs, the Health Inclusion Team (HIT) and the Lewisham Public Health team to develop plans to deliver a self-isolation service in a 24 self-contained hostel managed by St Mungo's. This service would offer ongoing support to the vulnerable cohort in a self-contained setting who would not otherwise manage in unsupported temporary accommodation. There was a recognition that the good practice in the 'Covid Care Hotels' could be replicated in hostels and so the HIT team did temperature checks, and supported new residents with self-assessments, to ensure that the risk to others was minimised as much as possible.

Having access to the pan-London Find and Treat service also led to incredible results – it enabled the council to pick up any outbreaks via testing in large hostels, and had good take up and provided specialised support.

The protocols developed with health partners, including clinicians, the CCG and Public Health, helped to establish excellent working relationships which has benefited the vaccine rollout. Health colleagues have gone into services to work with clients on vaccine hesitancy to understand their concerns and what else could be done. Lewisham Council also developed vaccination passes

for those sleeping rough or in supported accommodation – people are able to ring up on the day and be vaccinated anywhere with availability, including at a number of pop-up clinics in the area. At the time of writing (July 2021), there was a 57% vaccination take up amongst vulnerable adults.

Funding from DLUHC's RSI programme and co-production with DLUHC advisors also proved invaluable when approaching winter provision. As night shelters were not a viable option, Lewisham worked with two 'non-commissioned' providers in the borough and set up a rough sleeping supported housing pathway, based on single rooms rather than shared sleep sites. This provision was funded through housing benefit and top-up funding from Lewisham Council (via Rough Sleeping Initiative 4). The service offered accommodation via high quality properties and was cheaper than night shelter provision. Supported housing services were also further supported by the Lewisham public health team who developed local guidance for managing shared services, supported providers to implement 'bubbles' in shared services, attended residents' house meetings via Zoom to clarify guidance and risks directly with service users and offered one-to-one support for services to ensure any suspected cases were responded to swiftly.

A longer term outcome of the health partnerships developed is that a strategic group has now been set up to oversee the approach to rough sleeping in Lewisham. This is attended by those commissioning health, mental health, drug and alcohol, housing, rough sleeping and community safety services and sets and reviews the strategic direction for the borough's approach. Alongside this, Lewisham received funding through the RSI 4 grant for health inclusion nurses – helping to ensure that they are at the centre of service delivery. Nurses are now firmly embedded in the outreach team, helping to increase engagement with services amongst those sleeping rough and offering them an opportunity for support with their health needs on the street.

Recommendations:

- The challenge of local variation, where this leads to differences in performance, can be addressed through the Government commissioning tripartite reviews of performance in homelessness services, including prevention and long term provision and support. Driving this system requires joined up performance management involving (1) local authorities, (2) local delivery partners, and (3) cross Governmental departments and bodies, namely the Department for Levelling Up, Housing and Communities (DLUHC), Department for Health and Social Care (DHSC), the NHS and the Office for Health Improvement and Disparities. The aim should be to find what has and has not worked for partner agencies, where there are issues of resourcing, and support improvement using examples of good practice. This should build on the successful DLUHC advisers model and be supplemented by direct offers of support, including the option of peer review. The Local Government Association has a role in supporting the development of good practice.
- To prevent homelessness, and respond to it quickly where it does occur, local authorities should be expected to produce long term, integrated homelessness and health strategies, and rapid rehousing plans. This work should require a local assessment of need, conducted using local homelessness partnerships and based on a standardised methodology set by DLUHC. This assessment of need would aim to quantify the level of central Government funding needed to ensure the most appropriate accommodation is available for the individual, and there are sustainable long term recovery options, with wraparound support where needed.
- Housing associations are not public bodies, and therefore do not have a legal duty to address homelessness. However, housing associations do have a social responsibility, and an important role to play in the provision of secure and safe accommodation, and support for people who are homeless or at risk of homelessness. The Commission recommends that the National Housing Federation, working with Homes for Cathy, continues to promote the positive work done by housing associations and drives forward this commitment to collaborate with their members to prevent and relieve homelessness. The Commission also recommends that the LGA continues to promote the benefits of local authorities and housing associations working together to develop solutions and longer-term strategies. To incentivise housing associations to prevent and contribute to homelessness solutions, the Regulator of Social Housing should monitor performance in this area.
- It is crucial that the healthcare organisations at a local and neighbourhood level prioritise the needs of people experiencing homelessness and rough sleeping. NHS England has released service requirements asking Primary Care Networks (PCNs) to “work from October 2021 to identify and engage a population experiencing health inequalities within their area, and to co-design an intervention to address the unmet needs of this population. Delivery of this intervention will commence from March 2022.”²⁸ As people experiencing homelessness and rough sleeping experience some of the worst health inequalities in society, PCNs should identify them as a population to engage with as part of these service requirements.
- Health organisations should ensure that mainstream services are accessible to people experiencing homelessness and rough sleeping. This can be improved upon by providing flexible appointment times and training for staff to increase understanding of issues related to homelessness.

Monitoring and data

Accurate monitoring and data recording is central to ensuring that all aspects of the strategy and its delivery are functioning effectively, and to understand and measure the scale of the problem and what resources are needed.

The purpose of capturing data should be to help an area identify the gaps in the system to make sure they have the most effective pathways to ending rough sleeping. Evidence submissions raised concerns that there is a lack of data on the support needs of people helped during Everyone In, stressing that this data would have been beneficial in helping understand the level of need and plan responses accordingly. One homelessness provider said that Everyone In meant that they were able to review and revise data to tell a better story of the barriers in move-on.

An independent review of Greater Manchester’s A Bed Every Night programme²⁹ highlighted that an improvement would be to refine data collection on the immediate triggers of rough sleeping to develop preventative methods.³⁰ A homelessness service provider told the Commission that ensuring all areas capture the different cohorts of people sleeping rough – for example people newly sleeping rough and people living on the streets – would be beneficial as a person who is newly sleeping rough requires different interventions and solutions to someone who has been living on the streets.

The problems expand to the recording of health service support for people experiencing homelessness. One submission called attention to the fact that there is “no systematic way to record interventions for inclusion health populations that are recognised as such.” (Health/S22)

The second problem raised in evidence submissions was the incoherence of what data is captured across the country.

“Data collection in relation to health and homelessness is fragmented. It uses many different definitions, data is often not collected at all and there is a lack of accurate and consistent data on all forms of homelessness.”³¹

The flaws in data recording have made it difficult to fully analyse the impact of Everyone In, with evidence submissions pointing to a lack of central recording systems earlier on in the pandemic, resulting in large variations in measuring activity and impact.

A comprehensive data set on rough sleeping is the Combined Homelessness and Information Network (CHAIN) dataset in London, funded by the GLA and managed by St Mungo’s.³² This database is able to collect trends of people sleeping rough, rather than snapshot annual counts. It was raised in one submission that it would be beneficial to have a country wide joined up CHAIN database:

“Developing a national CHAIN database will support far more effective working across the country and provide a more seamless approach to supporting people.” (Homeless/S54)

In wider consultation with the homelessness sector, there was agreement that this would take too long for every area to complete, would not reflect the different circumstances of each area and would have data protection implications. However, comparable data sets would be beneficial in larger cities, and collaboration on data sets between major cities would be hugely valuable for measuring activity and impact.

Shared definitions, and the shared principles which come with them, are an essential piece of data architecture that are currently missing. Most parts of the system are not aligned in what ‘cohorts’ of people should be monitored, and how to define them. Providers said that different terminology is often used across the country and do not necessarily overlap, so it is difficult to compare what is happening in different areas. For example, in the London CHAIN database, the terms ‘flow’ (people newly sleeping rough who have not been seen

before), 'stock' (people seen across a minimum of two consecutive years) and 'returner' (those who have had a gap in their rough sleeping histories) are used to delineate between the cohort of people sleeping rough, to achieve a more granular picture. These terms are not used in other areas, or where they are used they can have a slightly different meaning, making it difficult to build a coherent picture to design the best solutions. It also creates barriers to sharing information if an individual moves area.

The integration of data is another issue. As the Greater Manchester Homelessness Strategy stated, there is the "need to balance privacy with telling your story just once to trusted people."³³ This means data collection in itself needs to support integrated working by ensuring that all partners are collecting and sharing data in a collaborative way, leading to an increase in positive outcomes.

"There is no system in place that effectively shares information across services to better support people and provide a multi-agency response. One is needed to provide a more joined up response and reduce duplication of presentations to services."
(Local Authority/S77)

As noted in a report on data released by the NHS Strategy Unit, having coherent provision requires "integrated systems for data capture and sharing."³⁴

An example of good practice which emerged during the pandemic was the Covid-19 Homeless Rapid Integrated Screening Protocol (CHRISP).³⁵ This was a health

needs assessment tool, used to screen the health and social care needs of people who were street homeless, accommodated in Greater London Authority (GLA) hotels. A modified Mini-CHRISP PLUS tool was also developed in July 2020 to allow non-clinical outreach workers to quickly identify those at increased risk of Covid-19 who needed to be shielded in appropriate accommodation. This both recognised and acted on the high level of vulnerability faced by those experiencing homelessness. It also encouraged communication between the health and housing teams and a local multidisciplinary team process to ensure that health needs fed in to individuals' move on plans.

A data and monitoring system which faces difficulties due to a lack of integration is Streetlink. Streetlink is a website, app and phone line system which allows people to alert the relevant services in their local area that there is someone sleeping rough, to assist local services to make contact with them. In discussions with homelessness service providers, however, it was highlighted that the service is only fully functioning and effective in London. Although outreach service providers in London stressed that it is an integral part of their service delivery – for example StreetLink alerts are used by commissioned street outreach services to plan and organise their shifts – the experience outside of London is much more mixed. Amongst other issues – such as the lack of team capacity to filter alerts – a predominant reason is the lack of well-established working relationships with services operating outside the London area. This means that the feedback loops that lead to joined-up working and continuous improvement for Streetlink in London do not exist elsewhere.

Recommendations:

- There should be a national review of how an individual's needs, strengths and aspirations are assessed and what data is collected. This should use an outcomes-based approach, and work with people with experience of homelessness, providers, and commissioners. This will ensure assessments and data collection have a clear purpose. This will be crucial in helping identify what action, support and resources are required to end rough sleeping, and enable successful outcomes to be measured by genuinely useful data.
- Improving consistency and comparability of datasets will improve integrated working between local authorities and their delivery partners. Local authorities should collaborate with their partners, to maximise the potential of what data is collected and how it is then used.
- To effectively meet people's health and housing needs, there must be robust and effective cross sector data sharing. NHS England should put support and guidance in place to enable local systems to share data successfully, including vaccination uptake amongst people experiencing rough sleeping and homelessness. This should include providing examples of good practice, for example, the sample Data Protection Impact Assessments (DPIAs) and Data Sharing Agreements (DSAs) that have been developed to support data linkage around homelessness. This should then be supported at the local level through the duty to collaborate.
- Members of the public have a role to play in ending rough sleeping and have been able to help by using StreetLink, an innovative and effective referral mechanism that connects people sleeping rough with the local services that can support them. This system should be recommissioned at a national level.

Commissioning

Addressing homelessness requires all agencies to work together. However, the systems supporting people experiencing homelessness are designed and funded as if people fit into one box, rather than the reality that people's problems are complex and interwoven and need to be approached holistically.

These problems can be broadly delineated into two groups. On the commissioners' side, a pressure on budgets leads to setting strict criteria as to who can access a service – restricting entitlement or not recognising practical challenges (for instance, the practical difficulties of transport or timekeeping for someone who is sleeping rough).³⁶ Evidence submissions also pointed to the tendency for commissioners to focus on narrow outcomes rather than on the wider set of issues that contribute to rough sleeping.

Second, as set out in the Commission's consultation with providers, the competing budget constraints caused by providers having separate funding sources can create incentives to reduce provision and push people onto other service caseloads. This can spiral into a

race-to-the-bottom, where services erect their own barriers, which is met in kind by similar responses from other services. Current practice, where people are identified as having a 'primary presenting need' and pushed into rigid single focus pathways, can compound these problems.

"Competitive tendering for short term contracts does not facilitate supportive relationships between organisations who are required to work closely together."
Health/S70

As discussed in the Interim Report, there was a significant increase in partnership working during the Everyone In initiative, largely driven by the central Government directive, the funding to match, and the shared overarching objective of saving lives. Fitzpatrick et al. notes in its examination of the response that collaboration between sectors and organisations has been a defining characteristic of the crisis response, particularly at the local level.³⁷ This increased sense of shared responsibility and impetus to act (supported by additional funding³⁸) meant that complex needs organisations saw agencies take responsibility for people beyond their remit, with fewer services gatekeeping in order to protect

oversubscribed caseloads. This coordinated approach meant that stakeholders were more effective at responding to need, and people were supported from the streets without delays through bureaucracy or process. Evidence submissions did stress though that this was largely in spite of, rather than because of, the system.

An important way to enact an integrated approach through system change is joint commissioning: bringing all the parts of the system around the table to discuss the desired

outcome, and collaborating and sharing responsibility for achieving it. This builds strong relationships across different parts of the local 'system' and ensures that commissioners are well-placed to help improve service pathways, making sure that they are person-centred and not focused on trying to address a single problem. However, as limited service criteria and siloed thinking is often a feature of systems with inbuilt scarcity of resources, appropriate resourcing will be required to support it.

Changing Futures in Bristol

After a successful bid to Government, Bristol secured a £3.3 million grant to help adults in the city facing disadvantages such as homelessness, mental health problems, substance issues, domestic abuse and being in the criminal justice system.

Building on a shared appetite to tackle multiple disadvantage, commissioners from Adult Social Care, Children and Young People's services collaborated with key partners in Golden Key, lived experience representatives and the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) to develop the successful bid. The team drew on local evidence of what was needed, what worked and successful models elsewhere, and worked at pace to involve as many voices and agencies as possible.

It was envisaged that the grant would support development of the partnership's 'My Team Around Me' multi-agency team concept, to provide long-term wraparound support to a person with multiple needs to ensure consistent relationships and better, sustainable outcomes.

Hugh Evans, Executive Director for People commented that the National Lottery and DLUHC funding they received would further enable them to meet their vision – to ensure people with multiple disadvantages are valued and empowered, and that they inspire and are inspired to have a life beyond service.

Working directly with people with lived experience was, and would continue to be, at the heart of Bristol's approach. The bid

had been co-designed with lived experience groups and included deep listening exercises to fully understand the system change needed.

The team selected three main groups to work with in Bristol with the view that learning from these would be applied to wider populations with multiple disadvantages. The cohorts included:

- young people from minority ethnic communities experiencing multiple disadvantages compounded by discrimination
- women experiencing domestic abuse
- people experiencing complex/compound trauma, behavioural challenges and chronic homelessness

In the spirit of reflective practice the bid team fed back that trust was paramount to the whole process; creating the right environment to challenge one another, to be creative and innovative was crucial. On a more practical basis working collaboratively was helped by having the right IT in place to update documents and communicate in real time, something which the pandemic paved the way for. The team also welcomed the opportunity to focus on something positive and inspirational whilst continuing to deal with the impact of the pandemic.

Katherine Williams, Strategic Commissioning Manager – Mental Health said: *"Having a positive opportunity on the horizon is a marvellous motivator and we are looking forward to evolving our existing partnerships and governance structures to give the programme the multi-agency focus that is needed."*

Although there is a need to join up the interconnected services which contribute to relieving homelessness through joint commissioning, the new integrated care systems³⁹ – set out as a key component of the NHS Long Term Plan – provide a specific opportunity to join up health and homelessness further. This is crucial, both due to the poor health faced by this group, but also the barriers faced in accessing timely healthcare, which then exacerbates health problems further. Groundswell's 'More than a Statistic' research revealed that one of the key barriers that people who are homeless face to accessing healthcare is registering and making use of a GP practice.⁴⁰ This is very important as primary care is a gateway to other health services, as well as a preventative measure to avert increased A&E visits. A persisting problem with GP registration is that people are refused on the grounds of

lacking ID, having no fixed address or not being able to prove their immigration status. This is despite NHS guidelines.⁴¹ This demonstrates the lack of understanding of complex needs in mainstream services, and the need to join up health and homelessness further to ensure that health services are not creating further barriers to access. Research by SOLACE has highlighted the value of partnership working between the NHS and local authorities.⁴²

The two primary aims for integrated care systems are, first, to push forward integration across health and social care, alongside other partner agencies; second, using this to achieve improvements in population health and a reduction in inequalities. However, they do not currently have an explicit focus on inclusion health populations such as those experiencing homelessness and rough sleeping.⁴³

Recommendations:

- To encourage partnership working, local authorities and integrated care systems should put in place joint processes for commissioning services. This should include exploring longer contracts to give time to build practice and a culture of integrated working, where needed, whilst maintaining the ability to test and pilot initiatives to respond to changing circumstances. This must be supported through longer-term funding settlements.
- The forthcoming integrated care systems will play a crucial role in embedding health within local delivery agencies. Guidance for the integrated care systems (ICS) should stipulate that Integrated Care Boards, Integrated Care Partnerships and Health and Wellbeing Boards have a dedicated focus on tackling health inequalities for inclusion health populations, including people experiencing homelessness and rough sleeping, and ensure that both mainstream and inclusion health services deliver trauma informed and psychologically informed services for this cohort, who may struggle to engage. This focus must also be shared by the new Office on Health Promotion. There should be an assessment of need and capacity within inclusion health services, to ensure that people are able to access care and support. As part of the Care Quality Commission's (CQC) system review framework, there should be a specific focus on whether ICSs explicitly reference homelessness and rough sleeping as part of their health inequality strategy. This should be used as a litmus test for the quality of integrated care systems' population health plans.
- The existing specialist rough sleeping programme within NHS England⁴⁴ and Improvement should continue to be delivered. The wider Long Term Plan mental health transformation must be inclusive of people experiencing rough sleeping and homelessness in line with the NHS Mental Health Implementation Plan.⁴⁵ This should have a continued focus on reducing barriers to access and quality of care. Future expansion of existing programmes should be funded beyond the Long Term Plan so that services can reach people in every part of the country.



Chapter 4: Roles of accommodation and service models

The right accommodation with the right support at the right time plays a huge part in both preventing homelessness and supporting an individual to recover from it. It is far broader than simply a roof over someone's head. It can help improve health outcomes, enhance wellbeing, and support someone to sustain a job and contribute to the community, which in turn creates a positive feedback loop.⁴⁷

The fundamental challenge of the availability and quality of housing and support continues to have a huge impact on what any service can do.

As recommended in one evidence submission, the Government has an opportunity to *“reimagine the homelessness system and should build on Everyone In by working with local authorities and the third sector to provide and commission a range of accommodation and support to both prevent homelessness and address it quickly when it occurs.”* (Housing/S26)

This chapter examines the various types of accommodation and service models at different points along a person's recovery journey. It brings together the different views from across the sector on the efficacy of various service and accommodation types and how to overcome barriers to effective delivery.

Prevention services

The first step should always be preventing people from rough sleeping in the first place. Every case of rough sleeping is an emergency. People who sleep on the streets are at immediate serious risk of assault. The average age of death of someone who dies while sleeping rough or in emergency accommodation is only 45.9 years for men, and even lower for women.⁴⁸ The longer

people spend on the streets the more they are exposed to the risk of assault, violence, and physical and mental health problems.⁴⁹ The human and social costs of rough sleeping are extensive, and much of it borne out in the health and criminal justice system, and within communities. Furthermore, it makes financial sense by preventing even larger costs associated with rough sleeping to public services – A&E visits for example⁵⁰ – as well as the wider economic costs. Analysis of public spending has shown that the average cost for quickly resolving an episode of rough sleeping is just £1,426, but would rise to £20,128 if rough sleeping were to persist for 12 months.⁵¹ Research by SOLACE showed a “conservative estimated annual cost to the public purse of £1 million” in Doncaster, based on 57 people with complex needs. When scaled to the estimated 4,200 people experiencing complex needs in Doncaster this was estimated to be £50 million a year in reactive cost.⁵²

Many experiences of rough sleeping have their roots much further back in someone's life than the immediate trigger. Adverse childhood experiences (ACEs) are bound up with poverty and complex trauma, and make individuals less equipped to cope when housing problems emerge. In a similar way, more general housing insecurity and unaffordability will be experienced before an individual is at risk of rough sleeping.

Geographical commissioning

More specialist services are also needed. These should provide a more individualised approach and create the ability to cohort people by clinical vulnerability, or by specific need – for instance women-only accommodation.

All services must provide a baseline of person-centred, trauma-informed and psychologically informed support and accommodation.⁴⁶ However, in addition to that, some individuals face additional barriers such as high clinical vulnerability or specific trauma which means that they need a specialist type of accommodation and support.

“Local commissioners should ensure they commission a mix of safe accommodation...including wholly funded places available for women with no recourse to public funds and funding allocations for immigration support and intensive resettlement support as provided in the emergency refuge.” (Women/S34)

However, with limited capacity and funding, local authorities will be understandably reluctant to commission separate services if there are only a small number of individuals who require it within their area.

There are, however, examples of alternative models. During the pandemic there was a pan-London response through the hotel provision. GLA categorised hotels based on health needs, distinguished as: the Covid-19 Care hotels (people with Covid-19); Covid-19 Protect hotels (people with underlying health conditions) and then the more generic hotel provision. People could be referred into these from any Local Authority, with the referral based on need rather than geographical location.

The pan-London and sub-region models outlined here would also address issues with standardising pathways, whereby many individuals experience difficulties of fragmentation, and improve communication across local authorities.

It was made clear during consultation with the homelessness sector that regional and sub-regional offers must ensure that risk assessments are undertaken so that people are not moved from support networks, with the individual's personal risk and wellbeing at the forefront.

Recommendations:

- To ensure that an appropriate offer of support is always available, local authorities should make greater use of pan-regional commissioning of specialised services.

Evidence submissions to the Commission highlighted the significant value of tenancy sustainment in preventing homelessness and rough sleeping. This can include a range of support, such as practical help with money management; submitting benefits claims; securing suitable work; or intensive support with complex problems such as hoarding. A crucial part of tenancy sustainment is equipping people with life skills and building on their personal strengths and confidence to stop problems from reoccurring or escalating. A lived experience organisation advised the Commission that training and guidance whilst someone is in a homeless accommodation setting, such as a hostel, is imperative in preventing homelessness once they are in longer term accommodation. This can be as practical as teaching someone to cook. Some people may also struggle with moving away from the street because they lack other support networks, are unable to occupy their time, or do not want to spend extended periods of time in their new accommodation. Employment, volunteering, peer support networks, and courses or activities can all play a valuable role in supporting people to recover.

However, once an individual is at risk of homelessness or sleeping rough, they should be able to go to their local authority and obtain a high level of support which addresses their housing problems and other relevant support needs. This is a critical stage.

There is already a greater focus on prevention than before (thanks to new and amended duties in the Homelessness Reduction Act 2017 which recognised that there is a role for local authorities to act in a preventative way), and initiatives exist to support people off the streets (such as the Rough Sleeping Initiative). Yet people who are at immediate risk of sleeping rough remain vulnerable. Current gaps in the protections provided by homelessness legislation – for example priority need or intentionality criteria – still leaves many single homeless people at risk of rough sleeping. These gaps are highlighted in a survey by Crisis which found that nearly four in ten respondents' housing circumstances either

stayed the same or worsened after presenting at a housing options service since the Act came into force, with some people going from being housed to sleeping rough or sofa surfing.⁵³ In addition, there is the wider context of resourcing difficulties for local authorities to support preventative measures.

In some areas, the Everyone In initiative meant those at immediate risk of sleeping rough with nowhere safe to stay – not just those who were already sleeping rough – were provided with suitable emergency accommodation. The Everyone In initiative demonstrated that it is possible to implement targeted interventions on a national scale to prevent people at the sharp end of homelessness from sleeping rough. These interventions can provide a final safety net for those people who have not been helped earlier. The next step is to maintain these targeted interventions at a crucial point before they sleep rough.

A small number of the Somewhere Safe to Stay (SStS) services, funded by central government and local authorities, are already focussed on this tipping point. These were at first proposed by the Government's Rough Sleeping Advisory Panel as a way of preventing rough sleeping for people at immediate risk of doing so, by offering a safe place to stay, a rapid assessment of their needs and support to find a longer-term solution to their homelessness.⁵⁴

Rapid assessment is key, as this determines the appropriate pathway. A poor assessment may result in people being offered interventions which are inadequate for their needs, resulting in a revolving door of homelessness and rough sleeping. The SStS services are important in this, as they have the specialist knowledge to help someone with their particular needs – for example, knowing the steps needed to support someone who is a non-UK migrant and has limited access to public funds. A national survey of street outreach professionals carried out by St Mungo's in 2018 showed that 70% of areas which had avoided an increase in numbers had a rough sleeping prevention service in their locality.⁵⁵

However, a significant barrier to delivering rough sleeping prevention is the need for verification. As highlighted in the Kerslake Commission's Interim Report, during the Everyone In initiative, some local authorities effectively derogated rules on verification, allowing them and frontline services to quickly provide shelter at the point of need and without having to check eligibility. This helped improve engagement and outcomes among groups that had previously fallen through the gaps of support.

“If someone is statutorily homeless they should be offered support, the initial stages of Everyone In offered support unconditionally and this really helped people. In contrast, the normal pre-pandemic verification rules associated with initiatives...such as Streetlink can often make the offer of support harder. We think the criteria needs to be much less strict to ensure a more effective response. During the pandemic, we had instances where verification could not happen for several days due to bank holiday periods...” (S44)

Preventing homelessness through early intervention – Porchlight, Kent

Live Well Kent and Medway, a network of voluntary sector services supporting people with a range of mental health needs, from mental wellbeing through to severe mental illness and focussing on early intervention and prevention, as well as longer term recovery.

Live Well Kent and Medway's services targeted the most socially and economically deprived areas of Kent where risks around mental health issues are higher.

The services provided a mix of practical and emotional support and advice that is focused on the individual and often meets a range of complex needs all in one place. It might be answering questions about benefits or housing, help with paperwork or form-filling finding education or work opportunities, or connecting people with others or with specialist services so that they can address any problems early, stay well and better manage their own lives.

A number of services within the network provide support around the social factors impacting on mental health, providing direct advice and support as well as referrals to specialist help when it's needed.

An independent evaluation of Live Well Kent found that:

- 71.9% of people who accessed the service said their mental health and wellbeing had improved
- 78% of clients were from the most socially and economically deprived areas of Kent.

Porchlight is one of two strategic partners delivering as well as managing Live Well Kent & Medway on behalf of Kent County Council and Kent & Medway Clinical Commissioning Group.

Porchlight's Community Housing service works with individuals whose mental health is impacting on their housing such as Mike who was struggling with his mental health following the death of his partner. He was desperate to move from his local authority property which held too many painful memories and his finances were being impacted by the bedroom tax.

The death of his partner had also affected Mike's income, leaving him without enough money to live on. He didn't know how to navigate the benefits system and because he was grieving, didn't feel strong enough to deal with his financial situation. Mike was struggling to buy food and other basic necessities and was falling into debt.

Mike's support worker helped him to apply for the correct benefits and to create a profile on a housing exchange website and the local housing register. They connected him with professional mental health support and helped him to access foodbanks and temporary financial support. A grant from the Tenant Welfare Fund helped to pay for removal of some items of rubbish in Mike's garden which were becoming a health hazard.

Mike was eventually offered a move to a one-bedroom flat with a housing association, escaping the financial burden of the bedroom tax and gaining the fresh start he needed following the loss of his partner.

Case study provided in partnership with Homeless Link

Recommendations:

- To prevent an increased flow of people onto the streets, the Government must retain the welfare changes that have kept people afloat during the pandemic, whereby Local Housing Allowance rates were raised to the 30th percentile of local rents and Universal Credit received an uplift of £20 per week. In addition, the Government should review the benefit cap and seek to increase it in areas with high affordability pressure, and provide a financial package of support for people in arrears due to the pandemic.
- There should be a cross-departmental focus on homelessness prevention. By investing in preventative measures – such as arrears/debt recovery, employment support, training on budgeting and knowledge of tenancy rights and responsibilities – the resilience of families and individuals will improve. This should be supported by a similar approach to early mental health support which would further underpin a prevention culture and would result in fewer households in crisis. These measures would reduce the number of people rough sleeping in the future.
- Local authorities must ensure that all commissioning, services and support – from health, to housing, to benefits advice – are person centred, trauma informed and psychologically informed, where the individual is supported to make their own choices and supported to identify what is important to them.

Street outreach and emergency accommodation

Prior to the pandemic, London CHAIN statistics for April 2019-March 2020 showed a 21% increase compared to the number of people seen sleeping rough in 2018-19, and followed an 18% increase between 2017-18 and 2018-19. It was 170% higher than 2010-11. Though the package of financial support brought in by the Government during the pandemic did help to stem the tide of homelessness, it did not succeed in preventing a rise in cases, particularly among single, young men.⁵⁶ Towards the second wave of the pandemic, there were bigger increases in people experiencing homelessness for the first time, including people who had been furloughed or become newly unemployed.⁵⁷ For many of these individuals, street outreach and emergency accommodation were vital tools in addressing rough sleeping.

Street outreach

Evidence from the frontline strongly backed that assertive outreach is vital in any approach to ending rough sleeping. Street outreach models involve teams going out late at night

and in the early hours of the morning to identify those who find themselves rough sleeping and provide urgent assistance.

The models will vary but the principle remains the same: no one should be left to sleep rough and through a persistent and determined approach any individual can be supported off the street.

A core component of outreach is going to people where they are, and establishing trusting relationships, rather than waiting for them to approach traditional place-based services. This is important as many of the individuals for whom this model is designed for have historically experienced a distinct lack of trusting relationships, causing a suspicion of services and institutions.⁵⁸

Outreach played a crucial role during Everyone In. A literature review by Crisis noted that *“the need for agility and quick responsiveness was identified as key to successful outcomes.”*⁵⁹ Evidence submitted to the Commission showed that the extent to which an area invested in outreach and had strong partnerships in place, influenced how effectively people could come off the street. Vaccination delivery was also dependent on effective outreach delivery.

“Outreach teams were effective at building on their relationships with rough sleepers, this highlights how often the best relationship that a rough sleeper forms is with the first professional that encountered them and built trust hence they were essential to enable people to settle into hotels.” Homelessness/S7

A problem highlighted with outreach as it currently stands is that due to fewer specialist workers able to engage with people where they are, teams are left to fulfil too many specialist roles which they are not equipped or trained to do. In St Mungo’s national survey of street outreach professionals in 2018, 70% of respondents said that access to mental health support for people sleeping rough had become harder in their area during the last five years, and 42% said the same for alcohol and drugs services. In the survey only a minority of respondents said important mental health services were in practice available to people sleeping rough in their area.⁶⁰ The Independent Review of Drugs highlights that significant cuts have been made to drug and alcohol outreach.⁶¹ This was exacerbated during the pandemic, as difficulties in accessing some services, due to them closing or moving online, meant that there was an even greater burden placed on outreach workers to deliver this support.⁶² Yet outreach is not currently accredited or effectively audited. Many workers do not have clinical or specialist knowledge around mental health or drug and alcohol use but are expected to manage complex cases where people are experiencing drug problems, rough sleeping and mental ill health. It has been recommended to the Commission that there should be either be

generic teams with embedded specialist workers (such as drug and alcohol and mental health workers); and/or accreditation for outreach workers who might specialise in specific areas. This would align with the model of outreach as a specialised service that works with a distinct and targeted cohort.

Another difficulty for outreach, as with prevention, is the way that verification currently works. Needing to be verified by outreach teams as sleeping rough before being able to access many types of support means that far more people require intervention via outreach. Frontline providers highlighted to the Commission that outreach should not be a gatekeeping service, but rather a targeted intervention for a specific cohort of people who cannot or will not come off streets, or who are unable to seek help elsewhere; everyone else should be signposted to places of safety rather than helped on the street. This is where the crucial step of prevention – in this context, particularly the crisis prevention through emergency assessment hubs – is key. Verification should be a part of the assessment, rather than a requirement to accessing help.

For any type of outreach to succeed, however, it must be matched with available accommodation, personal budgets and guaranteed support.⁶³ The Commission was told that the main problem currently is the lack of viable offers and pathways. Due to the generic nature of provision, there are many individuals whose needs cannot be adequately met, meaning they remain on the street, compounding their support needs.

Recommendations:

- Requiring verification that a person is sleeping rough before they can access a service, inhibits efforts to prevent rough sleeping. Local authorities should remove verification as a necessary step for accessing services, and instead incorporate it as part of the assessment process, in order to determine the appropriate offer of support and pathway.
- Staff in the homelessness sector support very vulnerable people, often with complex needs, and it essential that they have the right competencies to do this job. To recognise the challenging job that they do, it is recommended that Homeless Link convene a consultation on professional accreditation. This should cover all areas of the workforce and include understanding the integration of specialist support, such as mental health and immigration advice.

Continued over...

- To maximise resources, capacity and expertise in outreach services, local authorities should either embed specialist workers – such as drug and alcohol and mental health workers – in generic outreach teams; and/or develop specific accreditation for outreach workers who might specialise in particular areas. This should include working with the new integrated care systems in England to commission and coordinate effective specialist services, which are embedded into outreach teams. This may require additional and designated resourcing from public health grants.

Emergency accommodation

Once someone sleeping rough has been approached by an outreach team, the most common next step is an assessment hub and emergency accommodation.

Some people remain in emergency accommodation until resettlement in more permanent accommodation, while others may be referred to interim accommodation or specialist schemes.⁶⁴ There was a broad agreement within the evidence submissions that emergency accommodation should only ever be for short term use, to offer immediate protection from the dangers of sleeping rough.

One example of an emergency accommodation and assessment model pre-pandemic was the No Second Night Out (NSNO) service commissioned by the GLA. This helped move people newly sleeping rough off the streets as quickly as possible often using a single service offer.⁶⁵ The aim was that no one sleeping rough should spend more than 72 hours at a NSNO hub, where they could access emergency accommodation along with washing facilities and food. Outreach services, to help identify people on the streets, was one of the key elements of the approach. DLUHC has rolled out NSNO across England since 2011⁶⁶ with examples of the service in Greater Manchester⁶⁷ and Oxford.⁶⁸

Communal sleeping spaces – alternatively known as ‘night shelters’ – are a common form of emergency accommodation which aim to provide a safe place away from the street. These are usually provided and managed by faith groups, or by national or local charities.⁶⁹ Just over half of local authorities (52%) in England reported at least some dormitory-style homelessness accommodation in their area pre-pandemic.⁷⁰ Prior to Covid-19, communal space was the main delivery mechanism for Severe Weather Emergency Protocol (SWEP), enabling lifesaving interventions for individuals rough sleeping during extreme weather.

Providers in the homelessness sector highlighted to the Kerslake Commission that communal spaces can have a role to play during short period emergency assessments, to allow staff to observe behaviour and assess needs. Further, providers highlight that they are on the whole far more cost effective to run.

“The shelter model, with free space provided by churches, would allow for a greater number of people to find support than a model that relies on single-rooms. Our data shows that with wrap-around support, shelters can be effective, safe, humane forms of accommodation that can act as a springboard out of homelessness. We believe a mixed model that provides safe environments and allows people to move from shelter to hostels to independence, all buttressed with crucial support from trained support workers, would be the right combination moving forward.” (Homelessness/S30)

In instances outside of emergency assessments, however, dormitory style accommodation was criticised for not being psychologically informed: contributors from the homelessness sector raised concerns that communal spaces are stressful environments with limited privacy for people who have experienced rough sleeping, many of whom have trauma-induced mental health and substance use which can be exacerbated by these conditions.⁷¹ They are also a public health risk, putting people at high risk of contracting Covid-19. In one study, it was found that the mortality rate from Covid-19 for people staying in homeless shelters in New York City was 61% higher than the rate among the general population.⁷²

Independent research commissioned by Housing Justice found that:

‘Almost everyone interviewed – guests, volunteers, coordinators and partners including local authorities – strongly believed that 24-hour access, self-contained or single room accommodation was more desirable than the communal, night-time-only model. It provided privacy and stability for guests, and made it easier for them to access support and employment. It was also more accessible for women. Even where 24-hour site access was not possible – for example, in some pod accommodation – the privacy afforded was considered beneficial compared with communal sleeping spaces.’⁷³

Research also shows that the provision of self-contained accommodation during Everyone In and the dignity people felt from having their own front door was a strong force for good in improving wellbeing. Further, the vulnerability that many felt when using shared spaces in night shelters was eased.⁷⁴ Homelessness providers gave evidence to the Commission that many individuals who had previously rejected shared sleeping spaces have accessed, sustained and successfully moved on from hotel accommodation. In the City of London, one hotel manager said that they had long-term clients come into the hotel who, cumulatively, had been sleeping rough for 200 years.⁷⁵

On 16 August 2021 the Government published its updated Operating Principles for Commissioners and Providers of Night Shelter Projects.⁷⁶ The guidance encourages the use of self-contained models but falls short of specifically discouraging or ruling out shared sleeping models. It emphasises that final decisions need to be taken locally with public health and local authorities.

Health experts at the Healthy London Partnership (a partnership of health bodies, GLA and local government to improve health) have stressed that single room accommodation is the safest option: *“communal night shelter accommodation in the context of a poorly vaccinated population remains a high risk.”⁷⁷* The lack of clear direction from Government guidance has resulted in confusion amongst both providers and people sleeping rough, with both parties telling the Commission of dual worries for this winter that people may be left stranded outside – and concurrently that there may be large outbreaks amongst vulnerable populations if night shelters are to open. Currently, many night shelters are uncertain whether or not they will open, which will have implications – particularly during winter – for people with no, or limited, access to public funds and those whom the council have determined do not have priority need. Night shelters are generally the last safety net for these groups.

It is essential that all emergency accommodation protects people from sleeping rough and the huge health risks that it poses, as well as the significant health threats which Covid-19 poses to a vulnerable cohort.

Research has found that some local authorities intend to make a decisive shift away from communal accommodation. However, other areas worry that financial and legal constraints make the use of this accommodation unavoidable, particularly during winter.⁷⁸ For areas to move away from communal accommodation outside of emergency assessments, the Government must therefore recognise that self-contained accommodation is more expensive, and provide adequate funding to make it feasible, particularly during periods of greater need such as winter:

Recommendations:

- Homelessness service providers, charities and agencies have a responsibility to make sure that any accommodation model is safe and Covid secure using the following principles:
 - a. Operated from buildings that can be made Covid secure, for example can be well ventilated and are able to test temperature on entry.
 - b. If communal spaces, they are part of an established pathway that allows for people to be given self-contained emergency accommodation if they need to isolate or test Covid positive.
 - c. If providing a shelter or communal space, the accommodation must have in place a testing regime where people are tested on entry and then are regularly tested when in the building.
 - d. Have a continuity plan that allows for managing an outbreak and decanting the space.
 - e. Where shelters are not reopening, ways of harnessing the community response to homelessness and other forms of disadvantage should be considered; these range from floating support to large-scale food provision to smaller contributions.
 - f. Regardless of shelter models, space to store possessions and access to showers should be provided where possible.
- Winter comes round every year but preparedness for its implications on rough sleeping amongst local authorities varies. Local authorities, in partnership with homelessness organisations, should conduct long term, strategic planning for peaks in weather, including extreme cold or severe heat, and other contingencies. This strategy should be grounded in prevention, to ensure that people supported through severe weather emergency protocol (SWEP) are kept to a minimum, and supported through long-term funding. The aim should be to reduce reliance on communal night shelters.

Supported housing

Supported housing is any housing scheme where housing, support and sometimes care services are provided as an integrated package.⁷⁹ Some schemes are long-term, designed for people who need ongoing support to live independently due to complex needs, others are short-term – for example some hostels. The way accommodation and support services are delivered also varies between schemes; some organisations own properties, some provide support, and some do both. Housing associations deliver over 70% of England's supported housing.⁸⁰

The combination of secure housing and high-quality support can transform lives, helping people settle into a new home, maintain tenancies and improve life chances. For many, the only viable alternative to supported housing

would be residential care, hospital or another secure institution. This is a poor use of limited hospital resources and is detrimental to the individual who could live independently with the right support. Supported housing helps ease the pressure on the NHS and care services with the National Housing Federation (NHF) estimating that it saves the public purse around £940 per resident per year.⁸¹

However, the supply of supported housing is decreasing while need is increasing. Research in 2015 calculated that by 2024-25, there will be a national shortfall of 46,771 supported, sheltered and extra care housing places.⁸² A recent report found that long-term uncertainty over capital investment, revenue funding for support, and funding for housing costs through the Housing Benefit system have all been barriers to housing associations developing new supported housing schemes.⁸³

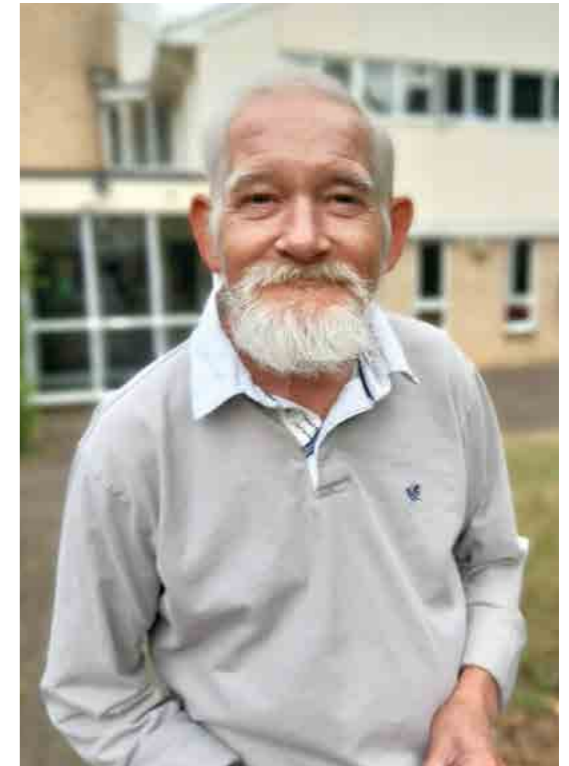
Hostels are one type of supported accommodation. For some people experiencing homelessness, hostels can act as a meaningful and appropriate pathway to permanent accommodation after the immediate emergency has been dealt with. However, for others, hostels have been a place without adequate support, too many rules and restrictions, and difficult to move on from.

More than 90% of all homeless accommodation projects in England consist of temporary accommodation, including hostels, with a maximum two year stay.⁸⁴ The term 'hostel' can cover a spectrum of accommodation options. Some take hostel to include emergency settings without support, whilst others in the homelessness sector look to hostels as the longer-term generic provisions and specialised services offering tailored support to specific cohorts. Services vary in the size of accommodation, as well as the level and nature of support offered. The absence of an agreed definition of a hostel causes some difficulties amongst the sector.

There are then issues surrounding the level of quality of hostels, which varies dramatically.^{85, 86} A report into the experiences of single people experiencing homelessness with mental health needs in the London Borough of Hackney found that 'Many said their hostel accommodation made them feel "unsafe" and "highly anxious".'⁸⁷ With some, although they purported to have staff onsite at all hours, lack of funding can mean this is just security staff who are not appropriately trained to ensure the welfare of residents, creating dangerous environments for residents' health and wellbeing.⁸⁸ Further, as discussed in Chapter 4, there is a lack of specialist accommodation available.

It was reported to the Commission that this lack of oversight on what hostels are and what their purpose is, makes it difficult to assess their effectiveness and hold them to account.⁸⁹

Contributors made the case that if there was a defined set of standards which all provision should meet, irrespective of whether it would fall under the definition of hostel or emergency accommodation, this would hold hostels to account.



People accessing hostels also face significant structural barriers in moving on to more permanent accommodation options. The Homeless Link 2019 survey showed that 24% of those in hostels were ready to move on but were unable to. Of this, 36% had been waiting six months or longer. Respondents identified the lack of accommodation available at the Local Housing Allowance rate (72%) and being excluded from housing providers due to 'previous debt, or rent arrears' (70%) as significant barriers.⁹⁰

There is evidence that the right type of hostel can bring positive outcomes for residents and can support people to progress towards independent living, as well as protecting residents from many of the risks and health impacts associated with sleeping on the street.⁹¹ Hostels should maintain their role as interim accommodation and support, helping people improve their health and wellbeing and move towards independence and permanent accommodation. To do this however, the baseline level of accommodation and service delivery must be improved.⁹²

Wherever possible, the solution to homelessness should focus on providing permanent homes rather than temporary accommodation. It is also important that over time the sector works with Government so that the overall balance of provision is shifted away from short-term accommodation, such as hostels, towards longer-term alternatives – particularly for people who have high complex needs and therefore much of the current short-term offer is not suitable for them. It is important that temporary means temporary, and people are not stuck in the hostel system, or caught in a cycle of returning to sleeping rough. To do so, an increase in availability of longer-term accommodation is needed, but as highlighted in the Interim Report, a better alignment between the capital and revenue funds is also key.

Much like with hostels, the quality of provision in other supported housing is also inconsistent, particularly for 'exempt accommodation.' 'Exempt accommodation' – non-commissioned leased supported housing – is supported accommodation provided by non-profit making organisations where the rules that normally limit the amount of rent covered by a benefit award – such as the benefit cap – do not apply. It was introduced to account for the higher operating costs of providing certain types of supported or supervised accommodation.⁹³ However, there is little regulation of care, support or supervision provided, merely a requirement for it to be 'more than minimal'.⁹⁴ In recent years, it has come to light that this has been abused by some providers who can claim high rental yields in exchange for, sometimes, relatively minimal input.⁹⁵ There is a high concentration of this issue in Birmingham.⁹⁶

This can be hugely detrimental to those stuck in substandard exempt accommodation. This is a very vulnerable group with few other options, who have often come to exempt accommodation through mental health trusts, care, or the criminal justice system. Some are young people.⁹⁷ Research published by Commonweal, Spring Housing Association and the Housing and Communities Research Group found they then have "common experiences of isolation, insecurity and lack of privacy for residents, and the corresponding negative effects

on mental health and wellbeing."⁹⁸ This ties into the challenges with non-commissioned services more generally, and the need to ensure that all homelessness accommodation meets a good standard. There is a role for all the actors – local authorities, housing associations, homelessness organisations, etc. in understanding and managing the local market, including need, quality, and funding.

In October 2020, DLUHC launched five pilots to try and improve oversight in supported housing. The purpose was to test new approaches to drive up standards, including strengthening enforcement in the sector, such as accommodation inspections,⁹⁹ and gather findings to inform future national policy. Four of them – in Birmingham, Hull, Blackpool and Blackburn – have been extended and will run until September 2021.

Outside of these pilot areas, there are concerns across housing associations, local authorities and the homelessness sector that there is a dearth of regulation in this sector. The National Housing Federation, for instance, has stated that from September it will remove membership from exempt accommodation providers if they do not meet new requirements being written into the organisation's new membership policy.¹⁰⁰ There is a need for a national standard of expectations alongside the outcome of the pilots. Whilst there is a transition to a better offer of self-contained accommodation, it is also important that supply is maintained to ensure that needs are adequately met.

In addition to the wider need for improved quality of both support and accommodation, there is also a specific point on the relationship between homeless organisations and drug and alcohol support teams. Despite there being a strong reciprocal relationship between rough sleeping and drug and alcohol problems (footnote with knocked back research), the Commission has been advised that there is a lack of clinical governance experience in homelessness providers. There is a need for homelessness organisations to have stronger partnerships with voluntary sector providers around single clinical governance frameworks to ensure that people experiencing homelessness get the right level of clinical safety.

Recommendations:

- Quality accommodation, provided with the right levels of support, has a material impact upon a person's recovery journey. Poor accommodation, and inadequate support has the opposite impact. The Government should introduce a quality assurance framework for homelessness accommodation, with a national register that requires evidence that providers are meeting minimum standards set by the framework as a condition of registration. This is to ensure that accommodation is safe, decent and appropriate, and creates a better definition of the standard of care, support and supervision required. The work to regulate must be supported by funding for local authority teams to enforce homelessness standards.
- Meaningful employment can play a crucial role in a person's recovery from rough sleeping, but only if it does not destabilise other parts of it. The Department of Work and Pensions should allow people living in supported housing to experience the positive effects of work without putting their benefits at risk, by re-introducing a 'work allowance' for people living in this type of accommodation.

Housing First

Housing First is an internationally recognised and effective health, care and housing intervention for people with the most complex needs. It provides a tenancy first as a platform for change, with intensive and flexible support to help clients address their needs at their pace. There are no conditions attached to being 'housing ready' – such as engaging in treatment for substance use – before someone is provided a home. It provides stable accommodation and flexible, consistent support that meets each individual's needs. However, although many point to its success in helping people who have extremely complex needs, homelessness exists in many forms, only some of which Housing First is designed to end. Further, while there are strong arguments for exploring Housing First as research shows it is a cost-effective approach to long term homelessness,¹⁰¹ Housing First is a comparably high investment as it is a relatively intensive service offering open-ended support. There is also increasingly limited access to the private rented sector and insecure tenancies which are potential barriers to upscaling the Housing First approach.

In the 2017 Autumn Budget, the Government provided £28m to fund three regional pilots in the West Midlands, Liverpool and Manchester. Evidence from these pilots has shown that the Housing First approach works. As of September 2020, the pilots had housed 450 people with tenancy sustainment rates

of between 86% and 89%, putting them in line with the international evidence.¹⁰² The pilots also report wider system benefits, with improved joint-working and person-centred, strengths-based approaches being embedded across local housing and health services.

As well as improving quality of life for individuals, research shows Housing First to be cost effective. The Centre for Social Justice estimated £9,683 is spent annually on average per Housing First client; but £15,073 is saved on other bills including homelessness services, the criminal justice system, NHS and mental health services, as well as drug and alcohol support.¹⁰³

Homeless Link's 2020 report on Housing First estimated an almost six-fold increase in the capacity of Housing First services across the country since 2017.¹⁰⁴ The organisation did, however, find services are unevenly geographically distributed, with a concentration of services in the South East (23% of services) and London (20%).¹⁰⁵

In submissions to the Commission, local authorities and homelessness providers advised that cost is the primary barrier to rolling Housing First out further, as it demands relatively high investment, although there are significant long term returns. Further, that it is best provided in social housing, of which there is limited supply. These are barriers which should be addressed to enact the necessary upscaling of the Housing First approach.

The funding for the Housing First pilots is due to end in 2022, and there is currently a cliff-edge in funding and a potential disruption to service delivery whilst a longer-term decision is made. It was strongly recommended in submissions that, first, the pilots should be extended or alternatively, that bridge funding should be made available to allow time for evaluation. The three Metro Mayors of the pilot areas recently joined forces to call for an extension, arguing that the pilots had been unquestionably successful and that this was an approach which “puts the

individual and the support they want and need at the forefront.”¹⁰⁶

What came through strongly in the Commission’s evidence submissions, is that Housing First can, and should be, an integral part of the approach to ending rough sleeping in England. It demonstrates the strengths of an approach which looks to homelessness as a health issue as well as a housing issue. However, to see its potential requires cross-departmental investment and leadership.

Recommendations:

- In its vision for scaling up Housing First provision for people with complex needs, Government must drive cross-departmental collaboration and should establish a joint ministerial funding stream, as well as cementing a shared understanding of what Housing First is in practice.

Social housing

For people with a history of rough sleeping, social housing can offer a new start, providing a bedrock for accessing prevention and maintaining support through long term recovery services.¹⁰⁷

At its best, social housing is affordable, safe, long term and allocated on the basis of need. Although social housing tenancies are no longer always for life, they still provide significantly more stability than the private rented sector (PRS).

Social rents have also remained consistently affordable for people on low incomes as they are pegged to local incomes, and increases are controlled by central Government.¹⁰⁸ Between 2016 and 2020, rents were reduced by 1% a year.¹⁰⁹

Research suggests that people living in the PRS were also less likely than those living in social housing to have received on-going support following homelessness,¹¹⁰ and it is also more difficult to deliver innovative wraparound support, such as Housing First, in the PRS.¹¹¹

Supply

Unfortunately, social housing has become scarcer to those in desperate need. There were 1.15 million households on local authority waiting lists on 31 March 2020.¹¹² Research

by the NHF on the number of people in need of social housing in England in 2020 found the number to be 1.6 million households – nearly 500,000 more.¹¹³ In the year to March 2020, there were only 306,000 new social housing lettings, a decrease of 2.5% or 8,000 lets from the previous year.¹¹⁴ The vast majority of these homes were old stock, which came up for rent as people moved out of their homes. In 2019-20, only 6,566 newly built properties were available at social rent.¹¹⁵ This is far below the 90,000 new homes at social rents that are needed every year.¹¹⁶

“Lack of social housing remains an acute difficulty that has kept women in abusive environments or in emergency accommodation spaces due to the lack of affordable and appropriate accommodation to move onto.” (Women/S34)

The decline in social housing is both due to a decline in new supply and a depletion of existing stock, including through Right to Buy.¹¹⁷ A report by the Housing, Communities and Local Government Committee sets out that the decline in supply is due to: the cost of land, the need for increased capital grant funding and a primary focus on home ownership interventions rather than affordable and social housing.¹¹⁸ It is crucial that an increased amount of social housing is looked to as one of the primary solutions for ending rough sleeping longer term, as it is fundamental to effective move-on solutions.

Homelessness prevention

During the pandemic, intensive partnership working between housing associations and local authorities also helped accommodate and rehouse people, with support where needed.¹¹⁹ It was reported to the Commission how local authorities worked with housing

associations to provide direct allocations to homeless households into social housing. The suspension of choice-based lettings and move to direct lets opened up routes for people housed in emergency accommodation and reduced dependence on supported housing and the private rented sector.

Onward Homes

Liverpool City Council, the Liverpool City Region Housing Association group and partner charities, together helped more than 1,000 households threatened with homelessness during the pandemic into sustainable new homes. The project was launched before the pandemic but accelerated during lockdown to make sure that ‘Everyone in’ did not become ‘Everyone back out’ when the funding stopped.

Following the breakdown of his marriage, Derek – 52, from Liverpool – found himself at rock bottom. With no home, no job, no money, he began sofa-surfing with family and friends. Life continued to spiral and Derek found himself living on the streets of Liverpool. The dangers of rough sleeping brought Derek mental and physical pain. In and out of hostels, he would often sleep in parks. Then one day he was beaten so severely by a stranger that he suffered brain damage. Derek found it too hard to break the cycle and lived like this for five years.

Derek said: ‘I don’t know how I got through it – it was really bad. I knew I couldn’t do it anymore.’

He was then referred by Liverpool City Council to Onward Homes. Onward is a North West housing association and one of number of Registered Providers (RPs) who worked together to commit homes and energy to the Liverpool Homelessness Partnership Project. Derek also received help from Crisis, which worked closely with Onward to find a home that would work for Derek long-term.

A suitable home was found at Kelton Park, Aigburth. Onward Neighbourhood Specialist Paula McIntyre helped Derek set up utility accounts and access a furniture package, funded by Fusion21 and coordinated by the Liverpool RPs.

Derek said: ‘It’s given me a big lift in my life, my own freedom, doing what I want to do – making it my home.’

However, people with experience of homelessness and rough sleeping still face significant barriers in accessing social housing. Prior to the pandemic, the number of homeless single people and couples without children in social housing decreased faster and further than the total fall in general needs social lets, from 31,411 in 2007-08 to 17,482 in 2017-18. This is a fall of 44%.¹²⁰

Due to the lack of social housing supply, local authorities ration their social housing by restricting who can ‘qualify’ to go on to housing waiting lists. The vast majority have introduced criteria excluding people who have a history of rent arrears, anti-social behaviour, criminal convictions or who haven’t lived in an area

for long enough.¹²¹ with 98% of councils having some form of restriction for people with a history of anti-social behaviour and 74% of allocations policies in all areas also have restrictions related to a history of offending or criminal behaviour.¹²² This leads to systematic barriers towards letting to people who have experienced homelessness, as these restrictions are likely to have a disproportionate impact on people who have slept rough, given their increased rates of conviction and debt and the fact that many people do not sleep rough near areas where they have a local connection. Only 14% of council allocation policies regard a history of rough sleeping as a reason to prioritise a housing request.¹²³

There is a further problem of housing associations – which own 60% of social housing¹²⁴ – having understandable concerns about their own expertise in supporting tenants with high or complex support needs. In consultation with housing associations, it was stressed that one of the primary ways to address this is investment in long term support, where there is an alignment between capital and revenue funds, as recommended in the Commission's interim report.

“There have been a number of positive changes to the design of RSAP this year. It is positive that housing associations can now also lead proposals as this was a barrier in the first year of the programme. Housing associations are very willing to take part in the fund but in the first year it was not always possible to do so if local authorities were constrained by time and could not lead proposals and submit bids.”

We recommend that future funding for rough sleeping reflect the RSAP model – a fund that focuses on rough sleeping that is about providing accommodation, where capital and revenue funding are joined up, revenue funding is longer term and funding criteria is flexible to include different proposal leaders. Ultimately, we recommend that there be a sustainable long-term mechanism for the funding of supported housing more generally.

The examples of housing associations leading proposals and providing high numbers of much-needed move-on homes shows that the new fund design is working better. The timescales for completion are still challenging however, especially given the current supply chain challenges, and we recommend making it possible for completion deadlines to roll over as with other funds, instead of the cut-off point being in the financial year in which projects commence. Longer timescales would also support the development of more innovative bids.”
National Housing Federation and Homes for Cathy.

Recommendations:

- To deliver the sector recommended target of building 90,000 social rented homes a year, the Government must increase grant funding delivered through the Affordable Homes Programme. The Government should increase the supply of supported housing through the continuation of the Affordable Homes Programme, but ensure capital funding is linked to multi-year revenue funding for support services.
- Social rented homes offer a quality and affordable route out of homelessness, but are in dwindling supply. The Government should commit the funds from the Right to Buy scheme to a strategic acquisition programme to deliver more social rented homes, and reforms to be introduced through the upcoming Planning Bill should provide local authorities with financing flexibilities to build more housing of this type.
- To encourage lettings for people with experience of homelessness, social housing providers should operate flexible allocations and eligibility policies which allow individual applicants' unique set of circumstances and housing history to be considered. This can be embedded through allocations guidance issued by Government.

Private rented sector

As access to social housing becomes scarcer, the private rented sector (PRS) is housing an increasing number of people who are moving on from rough sleeping.

However, the insecurity people experience in PRS both causes homelessness and inhibits attempts to resolve it.¹²⁵ In 2020, the ending of a private sector tenancy was the biggest single cause of statutory homelessness in England.¹²⁶ In London, 38% of people sleeping rough for the first time had previously been settled in the private rented sector.¹²⁷

The main challenges faced by PRS include: high rental costs,^{128, 129} insecurity of tenure,^{130, 131} low quality,^{132, 133} and the reluctance of landlords to let to individuals on benefits and/or with a history of homelessness.^{134, 135}

PRS tenancies are often short-term, generally lasting just 6-12 months. More than a third of tenants in the PRS went into debt to finance their last move,¹³⁶ and people with a history of rough sleeping are likely to have lower financial resilience than the general population. Some people also lack a network of family and friends who can provide support, which can make it extremely difficult to fund a deposit, rent advance or moving fees. This is in addition to the anxiety that the instability of the PRS can cause to people who have already experienced homelessness and sleeping rough.

The low quality of PRS which can be afforded at the Local Housing Allowance rate is also problematic. The English Housing Survey (EHS) estimates that in 2019 23% of PRS homes did not meet the Decent Home Standard compared with 18% of owner-occupied homes and 12% of social-rented homes.¹³⁷ Research by Shelter found that more than 6 in 10 renters (61%) had experienced at least one of the following problems over the past 12 months: damp, mould, leaking roofs or windows, electrical hazards, animal infestations and

gas leaks.¹³⁸ The Renters' Reform Coalition point out that currently “there is no record of who owns the 4.5 million private rented properties in the UK, and no checks on who becomes a landlord. As a result, taking action against landlords who let out unsafe homes or break the law is extremely difficult.”¹³⁹

These problems not only contribute to homelessness through loss of accommodation but also have a significant impact on health: moving frequently can damage recovery by taking people away from the support they depend on (like mental health or substance use services), poor conditions such as damp and cramped living can have a significant impact on mental and physical health, likewise, the stress caused by insecurity.

“Moving clients via the PRS route has really highlighted the discrimination that people who are on benefits face. There is a lack of local affordable housing within the borough and the local area. There are many landlords who are not willing to consider this cohort of people. In addition, when they are informed that clients are currently living in temporary accommodation they automatically assume that they have a support need.” (Housing/S6)

The Kerslake Commission's Interim Report raised the concern that there is a perfect storm coming with the end of the pandemic support measures, including the evictions moratorium, an end to furlough, rescinding the Universal Credit uplift, and expectations of a recession with associated rises in unemployment and household debt.¹⁴⁰ The likely result is an increase in homelessness from the PRS as private renters were vulnerable and insecure even before the pandemic struck,¹⁴¹ and half a million people are now in rent arrears due to the pandemic.¹⁴²

The PRS has a role to play in supporting people's recovery from homelessness, but the Government must urgently bring in its proposed renting reforms, to ensure that tenants are protected from the risk of homelessness.

Recommendations:

- To end the use of 'no fault' evictions, which is the leading cause of statutory homelessness,¹⁴³ the Government should urgently bring forward the Renters Reform Bill to repeal Section 21 of the Housing Act 1988. These reforms should also increase notice periods from two months in all but the most serious cases.

Chapter 5: Addressing unfairness and inequalities

Single white men who are UK nationals are the most common group found to be homeless or rough sleeping.¹⁴⁴ Since they are over-represented, homelessness support is generally geared to meet their needs. However, many different groups have distinct experiences of homelessness, often requiring different support. Some may require assistance with immigration advice; some may require employment support; and others need women-only services. This chapter looks at some of the inequalities faced by these groups and how they should be addressed to ensure that everyone can access help and support which best meets their specific needs.

Non-UK nationals

Non-UK nationals represent a significant proportion of the people who sleep rough in England. At the time of writing, the latest quarterly data shows non-UK nationals accounted for 47% (1,131 people) of people sleeping rough in London between April and June 2021, and whose nationality was known.¹⁴⁵ According to figures from the DLUHC on the number of people seen sleeping rough on a single night in autumn 2020 in England as a whole, 18% of people were EU nationals and 5% were from outside the EU and the UK.¹⁴⁶ However, this figure is also likely to be an underestimate due to the significance of hidden homelessness amongst non-UK nationals.¹⁴⁷

One reason for this is that some migrants are fearful of engaging with state and third sector organisations:

One non-uk migrant said: *“But, some people like refugees, they’re scared to hand over themselves to the authority, they want to sleep rough... the Home Office or the government are not going to give them shelter, because they gave them a false name, they gave them false ID, they gave them false thing, not to deport him.”*¹⁴⁸

Within the wider group of non-UK nationals, there are those for whom their immigration status, and therefore their eligibility for welfare

support or homelessness assistance, is unknown or unclear, as well as those who have No Recourse to Public Funds (NRPF) attached to their immigration status. For many individuals, having restricted access to support leaves them destitute.¹⁴⁹

However, there is little accurate data on the number of individuals with NRPF. On May 2021, DLUHC declared that it “is not possible to provide accurate figures on the number of people in the UK who are subject to NRPF at any given time.”¹⁵⁰

As set out in the rapid evidence review by the LSE for the Kerslake Commission, determining whether an individual has NRPF – or has the potential to have their conditions amended – is difficult technically and almost always requires professional support.¹⁵¹ However, following the cuts to Legal Aid under the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO), migrants find it difficult to obtain free legal advice and assistance in resolving their immigration issues/status.¹⁵²

This means that many vulnerable families, victims of domestic abuse¹⁵³ and others who also have unclear immigration status, or NRPF, are unable to access essential services.¹⁵⁴

A report by The Children’s Society found that immigration policies, including NRPF, left “thousands of children growing up in long-term

poverty, trapped in cycles of homelessness, destitution and mounting debt.”¹⁵⁵

Research carried out by Portsmouth University found that many migrants with NRPF as well as those without EU settled status lacked knowledge about their immigration status and how to resolve it.¹⁵⁶

One non-uk migrant said: *“So of course I did realise that I need papers, because of course, in any country where you go you need your papers. But to be honest, I just didn’t know how to go about it and I didn’t have anyone to help me...”*¹⁵⁷

People who face destitution can petition to have their NRPF condition legally changed. However, 90% of people surveyed who attempted to have their status changed unassisted were unsuccessful. Of these, 95% were subsequently successful upon receiving help.¹⁵⁸

In addition, resolving immigration matters can often take a long time due to the complexity of the application and the length of time it takes the Home Office to make decisions in these matters. The average number of days in receipt of Local authority support for single adults is 1055, and 629 days for family households.¹⁵⁹ However, benefit entitlements for those who are awaiting a decision from the Home Office on immigration matters are currently unclear, meaning many are unable to access support during this period. This means that the consequences of the lack of speed is falling on the individual or on the local authority. London Councils report that 65% of NRPF expenditure was solely on accommodation (the total annual expenditure average was estimated at nearly £1.7 million per borough).¹⁶⁰ Prior to receiving a decision, the Government should recognise that people need to be able to access support.

In addition to those with no, or limited, access to public funds, there is an additional group who are refugees and have recourse to public funds, but are also pushed into destitution. This is because they are only entitled to 28 days of accommodation and cash support after their notification of being granted refugee status. During this period, refugees who may not have been in the UK for very long, are unfamiliar with

the systems, may speak little English and will not have had access to employment and savings, have to very quickly obtain housing and a means to support and feed themselves and their families.¹⁶¹ Submissions to this Commission stressed the need to increase the notification period from 28 to 56 days for those leaving the asylum system with a positive decision.

A further avenue of support which can be appropriate in some cases, is providing advice and support regarding international reconnection. For some people, returning to their country of nationality, or another country in which they have entitlements, can be the most sustainable route out of rough sleeping.¹⁶² However, support to reconnect should always and only be offered on a voluntary basis and should always be preceded by immigration advice to ensure individuals make an informed decision.

The LSE’s rapid evidence review highlighted that having NRPF or unclear immigration status is a clear reason behind rough sleeping and destitution.^{163, 164} This has been exacerbated over the pandemic as many people with no, or limited, access to public funds, have lost their jobs due to their increased likelihood to working in frontline industries.^{165, 166} Those who have lost their job during this pandemic are at risk of destitution if they cannot access public funds or are forced to take up less stable, more exploitative employment out of desperation.¹⁶⁷

The Everyone In initiative introduced during the pandemic shifted the approach towards non-UK nationals as a wider group, as the support that was provided was interpreted as being applicable to everyone, irrespective of immigration status. This was broadly welcomed in the evidence submissions to the Commission and considered to be a key reason behind the success of the emergency response.¹⁶⁸

“Everybody was housed without question and I think that was a really key point that it didn’t matter where you were from, you were put into accommodation and you were fed which we’ve never experienced anything like...everybody taken off the streets and given a home.”¹⁶⁹

However, in May 2020 the Government's position on non-UK nationals access to public funds became less clear,¹⁷⁰ when the Housing Minister wrote to local authorities, reminding them of the legal restrictions on offering support to those ineligible for benefits.¹⁷¹

In July 2021, the Government released a letter to local authorities advising that the funding principle of the latest round of RSI funding is that councils should 'ensure that support offered to non-UK nationals who are not eligible for homelessness assistance will comply with any legal restrictions...'. The Government added that it expected councils to exhaust all options to support those who are unable to access homelessness assistance as a result of their immigration status.¹⁷² This leaves decisions subject to local variation as areas interpret what it means to exhaust all options – for example reconnection, or charitable support not using public funds – as well as a lack of clarity on actions if a person's options have been exhausted.¹⁷³

“Changes in policy for treatment of individuals with no recourse to public funds (NRPF), as well as greater clarity on what support can be provided, would improve on the current situation and the work done during the pandemic. Confusion around NRPF cases has made longer term strategic planning more difficult, and improved access to legal advice on NRPF would go a long way in ensuring councils are well equipped to deal with these cases.” (Local Authority/S65)

This variation will be exacerbated by local differences in what level of support is available to people with NRPF or unclear immigration status. Though there has been a significant improvement in collaboration between the range of organisations involved supporting non-UK nationals,¹⁷⁴ there is still significant variation in advice and support available between areas.

Co-ordinating advice services and support, and sharing best practice, for those with NRPF or unclear immigration status will be a key on-going requirement, as is providing secure accommodation without the use of public funds – for example through housing associations.

Norfolk County Council and Broadland Housing Group: Housing for migrants with No Recourse to Public Funds

In Norfolk alone, 72 people with No Recourse to Public Funds were provided accommodation under Everyone In.

However, well before the pandemic, Broadland Housing had worked with Norfolk County Council *People from Abroad* team to develop the *Housing to Work* project, which provided two flats at a peppercorn rent to people with nowhere else to go. Broadland's Board had seen the minimal cost of rent loss as one worth paying for the social value, as a way of meeting our Homes for Cathy commitments.¹⁷⁵

The *Housing to Work* partnership extended the existing project with two shared homes, housing another eight people at any one time. This accommodation, targeted at European rough sleepers, was offered for

a time-limited period, in conjunction with social work support. Health, social care needs and employment support were provided to people, along with help to find private rented accommodation once they had found work.

Although support funding for *Housing to Work* ended, the partnership has not and Broadland continued to offer homes at a peppercorn rent as part of its commitment to help tackle migrant homelessness.

This is not a new idea. It's not difficult. It does not cost a huge amount. Broadland was providing just 0.01% of its homes to house migrants with No Recourse to Public Funds. This partnership working could make a huge difference to the people it supports.

Recommendations:

- The Government must establish a clear policy position that limiting access to benefits for non-UK nationals should stop short of causing destitution. Destitution can be prevented through investing in good quality independent immigration and welfare advice, and employment support; clear guidance on access to benefits for non-UK nationals whose status is yet to be determined; and simpler and faster processes to clarify people's immigration status. Local authorities should be provided with guidance on what it means to 'exhaust all options within the law'¹⁷⁶ to support those sleeping rough and who are not eligible for statutory homelessness assistance, due to their immigration status. Local authorities should be provided with financial compensation where all other options have been exhausted to prevent destitution. Further, local authorities with a high number of non-UK nationals with unclear immigration status on the streets should look to funding immigration advice as part of their rough sleeping and homelessness prevention services. Collecting data on the number of individuals with no or limited access to public funds experiencing destitution, will help identify what resources are needed to assist this group out of homelessness.
- There are innovative ways that housing associations can respond to the housing and support needs of people with No Recourse Public Funds, or whose status is still to be settled, that are outside of normal business but often part of their charitable objectives. The Commission is encouraging housing associations to:
 - a. Offer peppercorn rent schemes within their existing properties;
 - b. Provide working accommodation for people with NRPF currently working or looking for work
 - c. Offer accommodation with legal advice to people with NRPF who may have a chance of a change in status
 - d. Provide free hostel and refuge spaces.¹⁷⁷

Wider equality issues

Individuals' experiences of homelessness are shaped by the impact of a range of overlapping factors, including race, ethnicity, religion, socio-economic status, class, sexuality, gender identity, age, disability and immigration status. Social and economic circumstances affect a person's exposure to harmful situations and their access to, and experiences of, resources and support, as well as compounding ill health. It is important that people who are homeless are not treated as one homogenous group, as the distinct needs and experiences of individuals mean a tailored, informed and inclusive offer of support is needed to alleviate homelessness.

This chapter examines the particular issues which arise for certain groups – women, young people, LGBTQ+ and BAME – but it is important to recognise that these interconnect and people do not experience the effects of each one in isolation.

Women

According to government statistics, 14% of people sleeping rough in England on a single night in autumn 2020 were women (377 people).¹⁷⁸ However, women are often hidden whilst homeless or rough sleeping: finding secluded sleep sites or using tents, staying with friends or family, sleeping on buses, or with strangers who expect sex in return for shelter; or wearing baggy clothes to hide their gender.¹⁷⁹

Hiding from harm means that women are hidden from help and missing from homelessness services and rendered statistically invisible. Further, women experiencing homelessness, but sheltered in refuges, are not counted as homeless.

The experiences and needs of women differ from men's. The trauma that women with experience of homelessness face is often rooted in gender-based sexual and domestic abuse – before, during, and after their experience of homelessness. A 2018 evidence review by the University of York reported that “experience of domestic violence and abuse is near-universal among women who become homeless.”¹⁸⁰ A 2015 study from Ireland found that as many as 92% of women experiencing homelessness had been exposed to violence or abuse during their lifetime.¹⁸¹ This connection between violence, abuse and women's homelessness is reinforced by international evidence.¹⁸²

This can significantly affect women's attitudes towards, and experiences of, support services and health services, aggravating their problems further and trapping them in a cycle of homelessness and ill health.

Other health needs of women experiencing homelessness also differ from men's: maintaining personal hygiene can be particularly challenging for women experiencing homelessness, who

may lack access to sanitary products¹⁸³ and safe women-only places to shower.¹⁸⁴ Difficulty accessing sanitary products can be due to cost but also if they are only accessible in a communal space where women do not feel comfortable getting them. The impact of menstruation and menopause on physical and mental health for women experiencing homelessness is rarely considered.¹⁸⁵ Another difficulty specific to women is discussing and making pregnancy and child-care decisions.¹⁸⁶

Despite this, women-specific and gender-informed homelessness services are absent across many areas of England. The Homeless Link Annual Review reveals that in 2019 only 10% of accommodation services provide female-only accommodation – a 1% drop compared with the previous year.¹⁸⁷ Homeless Link and Mapping the Maze identified between 99 and 155 women only homelessness and accommodation services in England¹⁸⁸ and 61% of all local authorities in England and most of Wales were reported to have no homelessness services specifically for women.¹⁸⁹

The No Woman Turned Away (NWTa) project: Women's Aid

The NWTa project had been funded since 2016 by the Ministry of Housing, Communities, and Local Government and run by Women's Aid Federation of England. The project, made up of four specialist domestic abuse practitioners provided emotional support, advocacy, information, referral, and signposting to survivors seeking refuge and safe accommodation. The project was specifically designed to support women fleeing domestic abuse facing structural barriers and inequalities to accessing a refuge space including: No Recourse to Public Funds, a disability, four or more children, language or cultural needs, alcohol or drug dependency needs, along with many more factors that limit a survivor's chances of obtaining safe refuge accommodation within a context of a national network of refuges facing significant challenges. Working over the 'phone and through email, the project was able to support women across England and Wales.

The project understood domestic abuse as a form of violence against women, and recognised the misogyny inherent in perpetrators' actions, along with taking into account the inequalities and sexist attitudes women face when they try to flee an abuser(s). For many women the sexism they face intersects with other forms of discrimination and structural inequalities such as racism, disability discrimination, ageism, and sexuality discrimination for lesbian and bisexual women. The service worked to help survivors access specialist domestic abuse services that have an understanding of this, along with exclusive 'by-and-for led' Black and minoritised services, because it recognised the importance of a 'no one-size-fits-all' approach when it comes to helping survivors. The NWTa recognised that a survivor may not feel comfortable directly disclosing domestic and sexual violence to a male professional,¹⁹⁰ and can therefore could advocate for them

in this way. Along with this, the practitioners recognised the importance of single-sex spaces and how vital it is for women to be placed somewhere safe, not forced to be on guard, or re-live previous traumas.

In one case, one survivor's housing application was not accepted because the perpetrator had said that this woman did have a home. Therefore, the woman had no option but to sleep in her car because she did not feel safe staying in the house with the perpetrator. The NWTa worker tried to find a refuge for this woman, however, this proved to be difficult because the woman felt unable to stay in a shared refuge due to her complex mental health needs. The survivor was also limited in terms of where she could travel because her 16-year old son still lived with the perpetrator. The NWTa worker liaised with the local mental health crisis team to appeal the survivor's homelessness application. This was accepted and the survivor is now residing in temporary accommodation. The NWTa team are continuing to support her in accessing permanent accommodation in the area, along with helping her access legal aid for her divorce from the perpetrator.

This case is an example of good gendered practices because it shows how women experiencing domestic abuse are often made to sleep rough because of the abuse. Rather than pressuring this woman to accept an offer in a shared refuge space the worker understood that this would be detrimental to her post-traumatic stress disorder diagnosis and the trauma she had experienced, and worked with the mental health team to find a better solution. The worker then took into account her relationship with her child and ongoing care responsibilities to support her to remain in the area but away from the perpetrator.



As highlighted in the Kerslake Commission's Interim Report,¹⁹¹ the lack of gender-informed provision continued during the Everyone In initiative, which was geared to meet the needs of people who were most familiar to services: adult men.¹⁹² The lack of tailored provision meant some women did not come inside or were potentially re-traumatised if they had experienced violence or abuse from a male perpetrator.

“Lack of women-only options meant women have been put at risk in large-scale accommodation shared with men where they risk abuse and violence from perpetrators already known to them or from strangers. Previous and often recent experiences of abuse and violence meant that in some cases women have chosen not to occupy this accommodation as a result.” (HomelessnessS19)

The rapid evidence review carried out by Crisis for the Kerslake Commission highlighted that there is little research to understand what happened for women as the pandemic unfolded. There is also little research to understand what happened to the services supporting them, aside from acknowledging the funding constraints they faced.¹⁹³

Young people

Centrepoin't's Youth Homelessness Databank showed that in the financial year 2019-20, more than 121,000 young people across the UK sought help because they were homeless or at risk of homelessness.¹⁹⁴

Along with women experiencing homelessness, young people are particularly likely to experience hidden homelessness and be less visible to services.¹⁹⁵

This is a group that is often overlooked. However, looking at earlier prevention – for example local authority commissioned services and pathways which focus on young people – means far fewer people come through the crisis pathway.¹⁹⁶ Yet research by St Basil's on provision for young people in the Everyone In initiative found 'For almost every local area there were significant gaps in services and the supply of suitable housing for young people to move into.'¹⁹⁷

Youth homelessness prevention – Birmingham City Council

Birmingham City Council used the Positive Pathway model as the structure for their City Homelessness Prevention Strategy. The Positive Pathway model was embedded in all of Birmingham City Council's commissioning of services, both for young people at risk of homelessness as well as families and older singles.

The Positive Pathway model was developed by St Basil's and sets out how to support young people to achieve positive outcomes in other areas of their lives alongside housing – for example in education, training and employment, health and emotional wellbeing. The Positive Pathway is a flexible framework for local authorities and their partners to use locally to provide a planned approach to homelessness prevention and housing options for young people. It aims to help public sector commissioners and providers of services to work together in planning and delivering services for young people.

There are five parts of the Pathway: (1) universal prevention – this includes information and advice for young people and families which is available to everyone in the local area (2) targeted prevention – early help targeted at young people and their families who may be at higher risk of homelessness (3) crisis prevention

and relief – a prevention hub, using a joint approach between Housing, Children's Services and other partners to resolve a housing crisis quickly. This also contains a single access point or gateway to commissioned accommodation and support (4) commissioned accommodation and flexible support – based on what works well and developed according to local needs (5) a range of housing options for young people – affordable and safe housing options when young people are ready to succeed living independently

Crucially, Birmingham City Council shifted the balance from a reactive crisis response to universal prevention, proactively addressing homelessness in all of its forms throughout a person's or family's journey.

The Birmingham City Council Homelessness Prevention Strategy was developed in 2017, and was being updated with even greater attention paid to an integrated community approach to prevention and early intervention. As the youngest City in the country, it has one of the lowest levels of under 25s rough sleeping or needing to use crisis services through 'Everyone In', largely because of the approach taken and the focus on all aspects of the Pathway model.

The main reason for homelessness amongst young people is family relationship breakdown: an estimated 52% of 16-25s presenting as homeless in 2018 was due to parents or others not willing to accommodate them.¹⁹⁸ Family breakdown can be caused by a range of issues including mental ill health and cultural differences, as well as changes in family dynamics, such as separation.¹⁹⁹ Structural issues such as poverty and poor housing also have a role in family conflict and breakdown.²⁰⁰

Policies such as the varying Universal Credit standard allowance for under-25s also mean an increased likelihood of homelessness for those young people who cannot live at home or who have been in care.^{201, 202} The Government announced in the March 2021 Budget that exemptions to the Shared Accommodation Rate (SAR) – a significant barrier for many young people – would be extended to include people under 25 years who had lived in a homeless hostel. The impact of this on access to the private rented sector should be reviewed.

Many young people who become homeless lack relationship and independent living skills.²⁰³ There is also an increased risk of exploitation, abuse and trafficking, and involvement in gang and/or criminal activity.²⁰⁴

Experiences of homelessness clearly have a significantly negative impact on education and future employment prospects for young people. A 2018 survey of 227 young people found that 40% said that homelessness had a negative impact on their ability to access or sustain education.²⁰⁵

It can also have a huge health impact.²⁰⁶ In the same survey, more than a quarter felt pressured to take drugs whilst homeless, 72% said that homelessness had a negative impact on their mental health, and 58% said that homelessness had a negative impact on their physical health.²⁰⁷

The pandemic has had an acute impact on young people experiencing homelessness: 'Between April and June [2020], 449 under-26s were seen sleeping rough, up by over

80% compared to the same period in 2019.' Although by December this number had fallen to 300, this still shows the high numbers sleeping rough during a national pandemic and lockdown.²⁰⁸

During the pandemic, unemployment has risen particularly steeply amongst this group, with many of the sectors that are disproportionately staffed by young people being the hardest hit.²⁰⁹ 582,000 young people aged 16-24 were unemployed in November 2020-January 2021, an increase of 76,000 (or 15%) from the same period the year before;²¹⁰ 57% of those calling the Centrepoin helpline were job seekers.²¹¹ As noted by Centrepoin, this can have a significant impact on health and wellbeing as well as finances.²¹² It is therefore predicted that homelessness amongst young people will rise.²¹³

Despite the different experiences and causes of youth homelessness, the Kerslake Commission's Interim Report highlighted that young people were another group whose needs were not adequately considered in the Everyone In response. There was a lack of youth specific provision, meaning many did not access emergency accommodation due to concerns over safety, or did enter and were exposed to unsafe situations.²¹⁴

The Crisis rapid evidence review highlighted that it is noted that young people have been disproportionately affected by the pandemic and the numbers of young people sleeping rough has increased. However, there is little research or insight into the specific challenges and experiences this cohort encountered during the early and on-going stages of the pandemic, which is particularly concerning given the economic context and employment.²¹⁵

It is vital that the distinct needs of young people are represented in service provision, or problems may escalate and an opportunity to limit the damage caused by their homelessness may be lost.²¹⁶

LGBTQ+

Being LGBTQ+ is an additional lens for many people's experiences of homelessness, and is one of the leading causes of homelessness for young people. Young people who are LGBTQ+ comprise up to 24% of the youth homeless population.²¹⁷ However, the Outside Project²¹⁸ looked at London CHAIN data²¹⁹ from 2017 and found that, after heterosexual, the second largest sexuality was 'prefer not to say' as people often do not feel safe discussing their sexuality or gender identity when rough sleeping. This has a knock-on impact as the lack of data makes it more difficult to commission and develop the appropriate services.

As with young people more widely, family rejection is the most common cause of homelessness, but amongst those identifying as LGBTQ+ this is even more pronounced: 77% of the young people experiencing homelessness say that family rejection and abuse after coming out was the primary cause.²²⁰ Discrimination in the workplace can also lead to people losing their jobs and becoming more likely to be homeless.²²¹

Research shows that, whilst homeless, LGBTQ+ youth are significantly more likely to experience violence, sexual exploitation, and health problems than other homeless youth.²²²

Many LGBTQ+ young people do not seek help from their Local Authority when they become homeless, instead turning to friends.²²³ There is also a lower awareness of the support services available to them.²²⁴ When they do reach out to services, many do not feel supported and homophobia, biphobia and/or transphobia can be perpetrated by services themselves, with experiences of misgendering and deadnaming.²²⁵ More than half of LGBTQ+ young people have faced some form of discrimination or harassment while accessing services.²²⁶ This means some individuals may disengage and leave the service before they are able to start recovery,²²⁷ and mental ill health can be exacerbated.

The generic nature of the Everyone In response meant many did not have the appropriate provision for their needs and therefore faced additional barriers in accessing emergency accommodation – for example, some young LGBTQ+ people did not feel safe in emergency accommodation.

BAME

Over the last five years, statutory homelessness rose by 71% among Asian households and 42% among Black households, compared to 9% across white households.²²⁸

Black people are 3.6 times more likely to experience homelessness than all other ethnic groups and between April 2019 and March 2020, 1 in 23 Black households became homeless or were threatened with homelessness, versus 1 in 83 households from all other ethnicities combined.²²⁹

Research suggests that this can partially be accounted for by structural factors linked to socio-economic inequalities. For example BAME communities are more likely to be living in poverty;²³⁰ are more likely to be in overcrowded, inadequate housing in a deprived area;²³¹ are more likely to be in insecure work;²³² and more likely to experience benefit sanctions.²³³

Covid-19 has highlighted existing health inequalities, with Black and minority ethnic groups at higher risk of dying from Covid-19 than the rest of the population.²³⁴ Research suggests that this is due to existing socio-economic inequalities which play a significant role in health, as outlined previously, and co-morbidities such as cardiovascular disease.²³⁵ Racism and discrimination can also have an impact on physical and mental health.^{236, 237} The health inequalities faced by many in the BAME community are then intensified by the health inequalities they face by experiencing homelessness.

There are then difficulties in mainstream provision for people who are BAME. In a survey by Race on the Agenda (ROTA), many of the African and African-Caribbean men described staff as stereotyping them as aggressive.²³⁸

As highlighted in the Kerslake Commission's Interim Report, specialist BAME providers have been particularly hard hit by falling local authority spend.²³⁹ Research by Agenda and AVA has identified that there is only a tiny number of services specifically for BAME women facing multiple disadvantages.²⁴⁰

It is important to note that the experiences of homelessness faced by people who are BAME are not homogenous. The differing issues for differing nationalities need to be recognised. For example, research shows a high number of older people of Irish origin who have previously experienced homelessness have become institutionalised in hostels.²⁴¹ Or, for instance, BAME women who may face discrimination on the grounds of their gender as well as race, and specific community-based difficulties.²⁴²

Recommendations:

- It is clear that the disproportionate impact of poor health and poor housing falls on many communities and groups with protected characteristics. However, there is insufficient research or analysis on the causes and solutions for these groups. To fill this gap, the Government should commission research on groups experiencing homelessness with further lenses of disadvantage, for example women, LGBTQ+ people, people who are BAME and those experiencing youth homelessness. This can be used to develop better designed data collection methodologies for these groups, who have different experiences of homelessness and are more likely to be hidden homeless.
- LGBTQ+ young people may face unique experiences of domestic abuse, familial abuse, homophobic, biphobic and transphobic harassment, and mental and physical harm, which is further compounded among BAME, trans and disabled LGBTQ+ young people. Local authorities must consider these vulnerabilities when establishing priority need and determining intentional homelessness.
- To improve access, experience and outcomes, among people with complex needs, local authorities should work with all services and agencies, including but not limited to homelessness, housing, healthcare, welfare and criminal justice to develop further training to enhance their understanding of complex needs, with a focus on gender, as well as LGBTQ+ and BAME experiences.
- To create more inclusive environments, homelessness organisations should commission training programmes for staff to raise awareness of the needs and experiences of LGBTQ+ people and women who are homeless or at risk of homelessness. This should include a focus on further marginalised groups such as BAME, trans and disabled people.
- Non-UK nationals and BAME groups often face inequalities in the service that they receive from homelessness organisations. To help address this, race and nationality should be used as feedback points for monitoring service outcomes, ensuring that the questions asked and the way data is reviewed involves input from BAME led organisations.
- Everyone In should continue to be financed through the Rough Sleeping Initiative (RSI), delivered through a minimum three-year funding settlement and with an annual spend of £335.5m. The RSI spend should have a focus on rough sleeping prevention, outreach, accommodation and support, and should pay for an increased supply of self-contained, good quality emergency accommodation, with tailored options for women and young people.

Vaccination

An overarching experience of unfairness for many of those who are experiencing homelessness is extreme health inequalities, as addressed in Chapter 3. It was therefore highly positive that people experiencing homelessness were included as one of the priority groups in the vaccine rollout.²⁴³

However, the UK Government is now following a policy response of 'living with Covid-19', which it will be basing on 'a sufficiently high proportion of the population being vaccinated.'²⁴⁴ There are significant concerns for the impact this will have on a population which has higher rates of clinical vulnerability²⁴⁵ and lower rates of vaccination when compared to the general

population,²⁴⁶ as well as increased likelihood of outbreaks, due to the lack of a safe home to self-isolate in and the difficulties people sleeping rough or in temporary accommodation face in following sanitation guidance.

It is therefore critical that steps are taken to prevent Covid-19 from becoming a permanent state of health crisis for people who are experiencing homelessness, and exacerbating health inequalities further.

The recommendations below are in addition to the recommendations in Chapter 3, which are a cornerstone in improving the structural health inequalities experienced by this group.

Recommendations:

- To allow for accurate targeting or resources, homelessness organisations should routinely collect Covid-19 and flu vaccination data amongst people experiencing homelessness, including clinical vulnerabilities, demography, locality, and a breakdown of reasons for low vaccine confidence.
- NHS England should work with local authorities and homelessness organisations to develop and implement effective delivery plans to ensure that this cohort are able to access the flu and Covid-19 vaccine. This should include tailored communication, alongside proactive in-reach and outreach programmes.

Criminal Justice System

Spending time in prison increases the risk of homelessness and a lack of stable accommodation then increases the risk of (re-)offending.²⁴⁷ CHAIN statistics show that 34% of those sleeping rough in London April 2019-March 2020 had experience of prison, which has risen in absolute numbers over the past five years.^{248, 249} Alongside this is the negative health impacts that prison can have on both mental health and substance use, which in turn can make it more likely for someone to experience homelessness and rough sleeping.

A Ministry of Justice survey found that nearly two in five prisoners stated that they would need help finding a place to live when they were released. Prisoners who had been sentenced to prison, probation or community orders before were more likely to report needing help finding accommodation than those who had not been sentenced before. Prisoners who reported needing help with a drug or alcohol problem were also more likely to report needing help finding a place to live when they leave prison.²⁵⁰ There are also particular challenges for female offenders, who are more likely than men to lose their accommodation whilst in prison,²⁵¹ and are at greater risk of sexual violence, prostitution or engaging in unhealthy relationships to access accommodation.

Levels of reoffending are much higher among people who are homeless.²⁵² Evidence suggests that having stable accommodation on release from prison can reduce the risk of re-offending by 20%.²⁵³ As reoffending can cost the economy £13.5bn annually,²⁵⁴ there is a significant cost saving to be made in investing in better homelessness prevention for prison leavers.

Despite this, ex-offenders and those leaving prison do not always receive the support they need, with some people provided with tents and sleeping bags on release from prison.²⁵⁵ Three in every seven people are released on a Friday afternoon²⁵⁶ which means they are left with a limited window before vital services close for the weekend.²⁵⁷ This can

mean sleeping rough immediately on release if the local authority housing office is closed, or an inability to access specific health services to ensure they are not without essential medication over the weekend.²⁵⁸

The self-perpetuating cycle of homelessness and experience of the criminal justice system is further exacerbated by the criminalisation of rough sleeping. This is through both the existence of the Vagrancy Act 1824, as well as the potential impact of the recent changes to the immigration rules which introduce rough sleeping as a new ground on which the Home Office can refuse or cancel permission to stay in the UK.

Vagrancy Act 1824

The Vagrancy Act criminalises sleeping rough and often drives people further from the support they need. It leads to stigmatisation, loss of trust and therefore loss of engagement.²⁵⁹ It does not help to deal with the root causes of rough sleeping and can also cause further problems by displacing people into more dangerous places or riskier activities,²⁶⁰ as well as pushing people into a criminal justice system which can create a vicious cycle of homelessness.

“The Vagrancy Act is simply not fit for purpose. New legislation must recognise there needs to be a combined health and housing approach to tackle rough sleeping.” Nickie Aiken MP

Since 2010 rough sleeping has increased by 52%.²⁶¹ Alongside this there have been reported rises in anti-social behaviour (ASB) such as “aggressive begging” and street drinking.²⁶² This has contributed to the increasing use of the Vagrancy Act to tackle rough sleeping and other ‘street activities’, through arrests, fines and sometimes prison sentences.

The number of cases brought to court for begging under section 3 of the Vagrancy Act increased from 1,626 in 2012-13 to 3,071 in 2014-15, before falling to 1,810 in 2016-17.²⁶³ This is only the tip of the iceberg, as many more individuals will have been arrested, but their cases will not have made it to court. Far fewer are prosecuted under section 4, but there are still examples of this outdated law being used to apply criminal sanctions to people for sleeping rough: 14 people were prosecuted for the act of rough sleeping itself in London between 2010 and 2015.²⁶⁴

Nickie Aiken MP has been working closely with the homelessness sector; to draft alternative legislation. The aim of the Vagrancy Act (Repeal) Bill would be to repeal the Vagrancy Act and ensure that an alternative approach is put in place, which incorporates assertive, persistent, but also trauma informed outreach, matched with offers of housing and ongoing support.

This alternative approach also addresses concerns surrounding community safety in regards to, for example, aggressive begging. This would be done through clarifying aspects of the Anti-social Behaviour, Crime and Policing Act 2014 which set out ‘enforcement principles’, providing safeguards so that people who simply need help are not criminalised, and that enforcement powers are only used where there is alarm and distress to the community (e.g. aggressive begging) and where there are no other approaches that are reasonably available.²⁶⁵ The Bill would set out that the 2014 Act powers should not be directed at people sleeping rough but rather begging-related offences.

Research shows that well targeted enforcement with genuinely integrated support can be effective at stopping anti-social behaviour and be a catalyst for people to move away from rough sleeping. However, if used without accompanying support it can be detrimental, leaving people marginalised and excluded from much needed support services.²⁶⁶ It was highlighted in submissions to the Commission that the role the police play should be developed to help people who are sleeping rough access support:

“The way the police recognise and respond to homelessness could be improved upon. Some participants found that the police officers were ‘considerate’, ‘friendly’ and ‘helpful’ when they responded to them during homelessness. However, this was not always the case, particularly among young women sleeping rough, who said they felt targeted by the police but were not offered appropriate support... We need to train police officers in trauma-informed approaches so they can appropriately deal with people who experience homelessness. This is an opportunity to invest in diversion to help vulnerable rough sleepers into wrap-around support rather than unnecessarily criminalising and traumatising them with further police action.” (Complex Needs/S15)

Immigration rules

On the 22 October 2020, the Government announced changes to the Immigration Rules. Some of these changes took effect on 1 December 2020, while others came into force at the end of the Brexit transition period on 31 December 2020.

These changes introduce rough sleeping as a new ground on which the Home Office can refuse or cancel permission to stay in the UK.

On 20 April, the Government published guidance on how the new rules on rough sleeping should be applied. The guidance states:

“The introduction of rough sleeping as a ground for the refusal or cancellation of permission is not intended to criminalise rough sleeping or to penalise those who inadvertently find themselves temporarily without a roof over their head. Instead, the rule will be applied to those who refuse to engage with the range of available support mechanisms and who engage in persistent anti-social behaviour.”²⁶⁷



There remains concern amongst the sector that the new rules will deter people from engaging with outreach and other homelessness services for fear of losing their permission to stay in the UK. In order to avoid detection, people are more likely to stay in unsafe situations, and the risk of exploitation and modern slavery is likely to increase.²⁶⁸

“These types of rule changes damage trust on the ground and are hardly constructive during a time when people are trying to rebuild their life as we move out of the pandemic.” (Homelessness/S44)

Recommendations:

- To ensure people are not released from prison or hospital into homelessness, the Government's rough sleeping strategy must introduce governance around transition points, to ensure planned and timely release, with community support and prior connections established. The Government should also end unplanned Friday releases from prison, to ensure people have adequate time to access vital services before they close for the weekend.²⁶⁹
- The police can have a positive role in supporting people's recovery from sleeping on the streets, which the Government can support by expanding at a national level the Community Service Treatment Programme, as recommended in the Dame Carol Black Review.²⁷⁰
- Anyone who is sleeping rough should be able to reach out for support without fear of losing their right to live and work in this country. The Government should review the new Immigration Rules which include rough sleeping as a grounds for deportation and work with the homelessness sector to deliver more positive and effective alternatives.
- The Vagrancy Act 1842 exacerbates problems linked to sleeping rough, and can drive people away from support. The Government should commit to the Vagrancy Act (Repeal) Bill, which seeks to repeal the Vagrancy Act and replaces it with assertive, persistent and trauma informed outreach, matched with offers of housing and ongoing support. The Government should also clarify aspects of the Anti-social Behaviour, Crime and Policing Act 2014, setting out 'enforcement principles' that provide safeguards, to ensure that people who simply need help are not criminalised.

Conclusion

The 'Everyone In' emergency response showed what can be achieved where there is political impetus, a shared overarching goal, and funding to match. However, as many of the submissions to the Commission have stressed, although there were positives, and drastic changes to the ways of working during the pandemic, at times this was in spite of the system, not because of it.

The emergency response must now be commuted to the 'new normal', with prevention, alleviation and recovery at the core of it.

This report has set out a vision for what kind of system there needs to be. It is one with the individual at the centre, where agencies and organisations work to support their needs and priorities, and ensure that support is accessible and inclusive.

It is also a system which recognises that problems cannot be divvied up into distinct boxes, but that they are complex, intersectional and often reinforce one another.

There was a gear shift during the pandemic in collaborative working – the result of which was hugely improved continuity of care with people less likely to slip through the cracks in service provision. This collaboration must be embedded into policy, practice and commissioning, as well as future funding settlements and models.

Right now, there is a crucial opportunity to continue the ways of working developed during the pandemic, which redefined what can be achieved when there is a singular shared goal of saving lives.

Everyone In cannot be allowed to become just a footnote in the history of the battle to end homelessness. It must be a pivotal moment – a catalyst for change – which results in a lasting legacy, not just for those who lived through it, but for generations to come.

To cement the spirit of Everyone In, the Kerslake Commission is committed to continuing to work together to maintain momentum and ensure that there is no going back. The independent Commission's Advisory Board, with experts from across the homelessness, health, housing, political and local government spheres, as well as those with lived experience of homelessness, will come together again to review the implementation of the recommendations contained in this report. There must be ongoing work to end rough sleeping for good.

This is a real opportunity to work together to change society for good – it must be taken.

Recommendations:

Everyone has a responsibility to adopt a consistent and collaborative approach to support people to live their best life. Preventing, alleviating and supporting recovery from homelessness and rough sleeping should be a shared ambition that cuts across all agencies, and cannot fall on one sector. When we work together it is remarkable what can be achieved.

This is very much a collective effort. Although the following recommendations highlight specific actors, this is to illuminate a leading role, not an exclusive one. Every one of these recommendations requires supporting actors to fully engage since – as has been made clear throughout evidence to the Commission – ending rough sleeping requires an integrated, system-wide approach.

Central government

The Everyone In initiative showed the difference it makes when central government embraces its leadership role and provides clear direction to delivery partners. The Government must continue to take ownership of rough sleeping and homelessness.

Better strategy, policy and delivery

1. A longer term rough sleeping strategy is needed if the Government is to achieve and sustain its goal to end rough sleeping by 2024. Building on the success of Everyone In and the lessons learnt, the new Inter-Ministerial Group on rough sleeping, led by the Department for Levelling Up, Housing and Communities (DLUHC), should set out the overarching vision of the Government, publishing a cross-Government national strategy with clear expectations and strategic engagement with key agencies, and an explicit focus on prevention. The strategy should be accompanied by a published annual review of performance, no later than three months after the annual count. This annual performance review should be carried out by DLUHC, working with regional and local government, and be used to analyse national trends and identify gaps in provision and strategy. A key responsibility for the Inter-Ministerial group in its terms of reference must be to push for cross government investment, to enable delivery of the strategy.
2. A joint Health and Homelessness Unit, akin to the Joint Health and Work Unit, should be established to ensure that cross-departmental working is carried through at a civil service level. The unit should have joint priorities and shared data to support the removal of barriers to effective working.
3. To support a whole systems approach to street homelessness, the Government should extend the Homelessness Reduction Act's Duty to Refer; to a Duty to Collaborate with relevant public agencies to both prevent and respond to homelessness. This should include the Department for Health and Care (DHSC), the NHS and Public Health England, Department of Work and Pensions and its agencies; the Home Office, and Ministry of Justice and its agencies and other government agencies with an involvement in homelessness and rough sleeping services. An example of this would be the sharing of data within Caldicott Principles.

4. The challenge of local variation, where this leads to differences in performance, can be addressed through the Government commissioning tripartite reviews of performance in homelessness services, including prevention and long term provision and support. Driving this system requires joined up performance management involving (1) local authorities, (2) local delivery partners, and (3) cross Governmental departments and bodies, namely DLUHC, DHSC, the NHS and the Office for Health Improvement and Disparities. The aim should be to find what has and has not worked for partner agencies, where there are issues of resourcing, and support improvement using examples of good practice. This should build on the successful DLUHC advisers model and be supplemented by direct offers of support, including the option of peer review. The Local Government Association has a role in supporting the development of good practice.
5. There should be a national review of how an individual's needs, strengths and aspirations are assessed and what data is collected. This should use an outcomes-based approach, and work with people with experience of homelessness, providers, and commissioners. This will ensure assessments and data collection have a clear purpose. This will be crucial in helping identify what action, support and resources are required to end rough sleeping, and enable successful outcomes to be measured by genuinely useful data.
6. There should be a cross-departmental focus on homelessness prevention. By investing in preventative measures – such as arrears/debt recovery, employment support, training on budgeting and knowledge of tenancy rights and responsibilities – the resilience of families and individuals will improve. This should be supported by a similar approach to early mental health support which would further underpin a prevention culture and would result in fewer households in crisis. These measures would reduce the number of people rough sleeping in the future.

Roles of accommodation and service models

7. Meaningful employment can play a crucial role in a person's recovery from rough sleeping, but only if it does not destabilise other parts of it. The Department of Work and Pensions should allow people living in supported housing to experience the positive effects of work without putting their benefits at risk, by re-introducing a 'work allowance' for people living in this type of accommodation.
8. Quality accommodation, provided with the right levels of support, has a material impact upon on a person's recovery journey. Poor accommodation, and inadequate support has the opposite impact. The Government should introduce a quality assurance framework for homelessness accommodation, with a national register that requires evidence that providers are meeting minimum standards set by the framework as a condition of registration. This is to ensure that accommodation is safe, decent and appropriate, and creates a better definition of the standard of care, support and supervision required. The work to regulate must be supported by funding for local authority teams to enforce homelessness standards.
9. In its vision for scaling up Housing First provision for people with complex needs, Government must drive cross-departmental collaboration and should establish a joint ministerial funding stream, as well as cementing a shared understanding of what Housing First is in practice.

10. Members of the public have a role to play in ending rough sleeping and have been able to help by using StreetLink, an innovative and effective referral mechanism that connects people sleeping rough with the local services that can support them. This system should be recommissioned at a national level.
11. Social rented homes offer a quality and affordable route out of homelessness, but are in dwindling supply. The Government should commit the funds from the Right to Buy scheme to a strategic acquisition programme to deliver more social rented homes, and reforms to be introduced through the upcoming Planning Bill should provide local authorities with financing flexibilities to build more housing of this type.
12. To end the use of 'no fault' evictions, which is the leading cause of statutory homelessness,²⁷¹ the Government should urgently bring forward the Renters Reform Bill to repeal Section 21 of the Housing Act 1988. These reforms should also increase notice periods from two months in all but the most serious cases.

Preventing inequalities and unfairness

13. The Government must establish a clear policy position that limiting access to benefits for non-UK nationals should stop short of causing destitution. Destitution can be prevented through investing in good quality independent immigration and welfare advice, and employment support; clear guidance on access to benefits for non-UK nationals whose status is yet to be determined; and simpler and faster processes to clarify people's immigration status. Local authorities should be provided with guidance on what it means to 'exhaust all options within the law'²⁷² to support those sleeping rough and who are not eligible for statutory homelessness assistance, due to their immigration status. Local authorities should be provided with financial compensation where all other options have been exhausted to prevent destitution. Further, local authorities with a high number of non-UK nationals with unclear immigration status on the streets should look to funding immigration advice as part of their rough sleeping and homelessness prevention services. Collecting data on the number of individuals with no or limited access to public funds experiencing destitution, will help identify what resources are needed to assist this group out of homelessness.
14. It is clear that the disproportionate impact of poor health and poor housing falls on many communities and groups within the protected characteristics. However, there is insufficient research or analysis on the causes and solutions for these groups. To fill this gap, the Government should commission research on groups experiencing homelessness with further lenses of disadvantage, for example women, LGBTQ+ people, people who are BAME and those experiencing youth homelessness. This can be used to develop better designed data collection methodologies for these groups, who have different experiences of homelessness and are more likely to be hidden homeless.
15. The police can have a positive role in supporting people's recovery from sleeping on the streets, which the Government can support by expanding at a national level the Community Service Treatment Programme, as recommended in the Dame Carol Black Review.²⁷³
16. Anyone who is sleeping rough should be able to reach out for support without fear of losing their right to live and work in this country. The Government should review the new Immigration Rules which include rough sleeping as a grounds for deportation and work with the homelessness sector to deliver more positive and effective alternatives.

17. The Vagrancy Act 1842 exacerbates problems linked to sleeping rough, and can drive people away from support. The Government should commit to the Vagrancy Act (Repeal) Bill, which seeks to repeal the Vagrancy Act and replaces it with assertive, persistent and trauma informed outreach, matched with offers of housing and ongoing support. The Government should also clarify aspects of the Anti-social Behaviour, Crime and Policing Act 2014, setting out 'enforcement principles' that provide safeguards, to ensure that people who simply need help are not criminalised.
18. To make sure that people are not released from prison or hospital into homelessness, the Government's rough sleeping strategy must introduce governance around transition points, to ensure planned and timely release, with community support and prior connections established. The Government must also end unplanned Friday releases from prison, to ensure people have adequate time to access vital services before they close for the weekend.²⁷⁴

Spending Review

19. To prevent an increased flow of people onto the streets, the Government must retain the welfare changes that have kept people afloat during the pandemic, whereby Local Housing Allowance rates were raised to the 30th percentile of local rents and Universal Credit was increased to £20 a week. In addition, the Government should review the benefit cap and seek to increase it in areas with high affordability pressure, and provide a financial package of support for people in arrears due to the pandemic.
20. To deliver the sector recommended target of building 90,000 social rented homes a year, the Government must increase grant funding delivered through the Affordable Homes Programme. The Government should increase the supply of supported housing through the continuation of the Affordable Homes Programme, but ensure capital funding is linked to multi-year revenue funding for support services.
21. Everyone In should continue to be financed through the Rough Sleeping Initiative (RSI), delivered through a minimum three year funding settlement and with an annual spend of £335.5m. The RSI spend should have a focus on rough sleeping prevention, outreach, accommodation and support, and should pay for an increased supply of self-contained, good quality emergency accommodation, with tailored options for women and young people.
22. The Rough Sleeping Accommodation Programme should be continued for the duration of the Rough Sleeping Initiative. The viability of this model can be improved, and take up increased, by aligning capital and revenue funding, allowing capital funding to roll over into subsequent years and drawing on continuous market engagement approaches. Strategic partnership working should be built into the programme and there should be flexibility to increase the maximum length of stay beyond two years.
23. The Department of Health and Social Care (DHSC) should reverse the disinvestment in drug treatment and wider recovery services, increasing funding by up to £552 million annually over the next five years, on top of the baseline annual expenditure from the public health grant, as recommended in the Dame Carol Black Review.²⁷⁵

Local authorities

Local authorities and regional authorities have a key role in convening services and agencies, to ensure the effective delivery of homelessness services.

Better strategy, policy and delivery

24. To prevent homelessness, and respond to it quickly where it does occur, local authorities should be expected to produce long term, integrated homelessness and health strategies, and rapid rehousing plans. This work should require a local assessment of need, conducted using local homelessness partnerships and based on a standardised methodology set by DLUHC. This assessment of need would aim to quantify the level of central government funding needed to ensure the most appropriate accommodation is available for the individual, and there are sustainable long term recovery options, with wraparound support where needed.
25. To encourage partnership working, local authorities and integrated care systems should put in place joint processes for commissioning services. This should include exploring longer contracts to give time to build practice and a culture of integrated working, where needed, whilst maintaining the ability to test and pilot initiatives to respond to changing circumstances. This must be supported through longer-term funding settlements.
26. To ensure that an appropriate offer of support is always available, local authorities should make greater use of pan-regional commissioning of specialised services.
27. Improving consistency and comparability of datasets will improve integrated working between local authorities and their delivery partners. Local authorities should collaborate with their partners, to maximise the potential of what data is collected and how it is then used.

Roles of accommodation and service models

28. Requiring verification that a person is sleeping rough before they can access a service, inhibits efforts to prevent rough sleeping. Local authorities should remove verification as a necessary step for accessing services, and instead incorporate it as part of the assessment process, in order to determine the appropriate offer of support and pathway.
29. To maximise resources, capacity and expertise in outreach services, local authorities should either embed specialist workers – such as drug and alcohol and mental health workers – in generic outreach teams; and/or develop specific accreditation for outreach workers who might specialise in particular areas. This should include working with the new integrated care systems to commission and coordinate effective specialist services, which are embedded into outreach teams. This may require additional and designated resourcing from public health grants.
30. Winter comes round every year but preparedness for its implications on rough sleeping amongst local authorities varies. Local authorities, in partnership with homelessness organisations, should conduct long term, strategic planning for peaks in weather, including extreme cold or severe heat, and other contingencies. This strategy should be grounded in prevention, to ensure that people supported through severe weather emergency protocol (SWEP) are kept to a minimum, and supported through long-term funding. The aim should be to reduce reliance on communal night shelters.

31. Local authorities must ensure that all commissioning, services and support – from health, to housing, to benefits advice – are person centred, trauma informed and psychologically informed, where the individual is supported to make their own choices and supported to identify what is important to them.

Preventing inequalities and unfairness

32. LGBTQ+ young people face unique experiences of domestic abuse, familial abuse, homophobic, biphobic and transphobic harassment, and mental and physical harm, which is further compounded among BAME, trans and disabled LGBTQ+ young people. Local authorities must consider these vulnerabilities when establishing priority need and determining intentional homelessness.
33. To improve access, experience and outcomes, among people with complex needs, local authorities should work with all services and agencies, including but not limited to homelessness, housing, healthcare, welfare and criminal justice to develop further training to enhance their understanding of complex needs, with a focus on gender, as well as LGBTQ+ and BAME experiences.

Homelessness organisations

Homelessness organisations are a key delivery agent, which should have a focus on improving client experience.

Better strategy, policy and delivery

34. Homelessness organisations are at the coal face of homelessness and rough sleeping, and should feed this wealth of experience into strategies and solutions developed by central and local government. They should also ensure that people using their services are supported to inform solutions through their wealth of lived experience.

Roles of accommodation and service models

35. Staff in the homelessness sector support very vulnerable people, often with complex needs, and it essential that they have the right skills and experience to do this job. To recognise the challenging job that they do, it is recommended that Homeless Link convene a consultation on professional accreditation. This should cover all areas of the workforce and include understanding the integration of specialist support, such as mental health and immigration advice.
36. Homeless service providers, charities and agencies have a responsibility to make sure that any accommodation model is safe and Covid secure using the following principles:
 - a. Operated from buildings that can be made Covid secure, for example can be well ventilated and are able to test temperature on entry.
 - b. If communal spaces, are part of an established pathway that allows for people to be given self-contained emergency accommodation if they need to isolate or test Covid positive.
 - c. If providing a shelter or communal space, the accommodation must have in place a testing regime where people are tested on entry and then are regularly tested when in the building.
 - d. Have a continuity plan that allows for managing an outbreak and decanting the space.

- e. Where shelters are not reopening, ways of harnessing the community response to homelessness and other forms of disadvantage should be considered; these range from floating support to large-scale food provision to smaller contributions.
- f. Regardless of shelter models, space to store possessions and access to showers should be provided where possible.

Preventing inequalities and unfairness

- 37. To create more inclusive environments, homelessness organisations should commission training programmes for staff to raise awareness of the needs and experiences of LGBTQ+ people and women who are homeless or at risk of homelessness. This should include a focus on further marginalised groups such as BAME, trans and disabled LGBTQ+ people.
- 38. Non-UK nationals and BAME groups often face inequalities in the service that they receive from homelessness organisations. To help address this, race and nationality should be used as feedback points for monitoring service outcomes, ensuring that the questions asked and the way data is reviewed involves input from BAME led organisations.
- 39. There are reportedly lower rates of vaccination among people experiencing homelessness and rough sleeping, though vaccination varies by demography, as do the reasons why people have not been vaccinated. To allow for accurate targeting or resources, homelessness organisations should routinely collect Covid-19 and flu vaccination data amongst people experiencing homelessness, including clinical vulnerabilities, demography, locality, and a breakdown of reasons for low vaccine confidence. The purpose of this is to address vaccine hesitancy, including where and how support organisations should target resources.

Housing providers

Safe and secure housing can be transformational in preventing and alleviating homelessness, and there is an opportunity for housing providers to expand on the good practice already taking place in the sector.

Better strategy, policy and delivery

- 40. Housing associations are not public bodies, and therefore do not have a legal duty to address homelessness. However, housing associations do have a social responsibility, and an important role to play in the provision of secure and safe accommodation, and support for people who are homeless or at risk of homelessness. The Commission recommends that the National Housing Federation, working with Homes for Cathy, continues to promote the positive work done by housing associations and drives forward this commitment to collaborate with their members to prevent and relieve homelessness. The Commission also recommends that the LGA continues to promote the benefits of local authorities and housing associations working together to develop solutions and longer-term strategies. To incentivise housing associations to prevent and contribute to homelessness solutions, the Regulator of Social Housing should monitor performance in this area.

Roles of accommodation and service models

- 41. To encourage lettings for people with experience of homelessness, social housing providers should operate flexible allocations and eligibility policies which allow individual applicants' unique set of circumstances and housing history to be considered. This can be embedded through allocations guidance issued by Government.

Preventing inequalities and unfairness

- 42. There are innovative ways that housing associations can respond to the housing and support needs of people with No Recourse Public Funds, or whose status is still to be settled, that are outside of normal business but often part of their charitable objectives. The Commission is encouraging housing associations to:
 - a. Offer peppercorn rent schemes within their existing properties;
 - b. Provide working accommodation for people with NRPF currently working or looking for work
 - c. Offer accommodation with legal advice to people with NRPF who may have a chance of a change in status
 - d. Provide free hostel and refuge spaces.²⁷⁶

Health organisations

The health sector has an important role to play in reducing health inequalities among people with experience of rough sleeping and homelessness, which can then help prevent and alleviate further homelessness.

Better strategy, policy and delivery

- 43. The forthcoming integrated care systems in England will play a crucial role in embedding health within local delivery agencies. Guidance for the integrated care systems should stipulate that Integrated Care Boards, Integrated Care Partnerships and Health and Wellbeing Boards have a dedicated focus on tackling health inequalities for inclusion health populations, including people experiencing homelessness and rough sleeping, and ensure that both mainstream and inclusion health services deliver trauma informed and psychologically informed services for this cohort, who may struggle to engage. This focus must also be shared by the new Office on Health Promotion. There should be an assessment of need and capacity within inclusion health services, to ensure that people are able to access care and support. As part of the Care Quality Commission's (CQC) system review framework, there should be a specific focus on whether integrated care systems explicitly reference homelessness and rough sleeping as part of their health inequality strategy. This should be used as a litmus test for the quality of integrated care systems' population health plans.
- 44. The existing specialist rough sleeping programme within NHS England and Improvement should continue to be delivered. The wider Long Term Plan mental health transformation must be inclusive of people experiencing rough sleeping and homelessness in line with the NHS Mental Health Implementation Plan. This should have a continued focus on reducing barriers to access and quality of care. Future expansion of existing programmes should be funded beyond the Long Term Plan so that services can reach people in every part of the country.
- 45. To effectively meet people's health and housing needs, there must be robust and effective cross sector data sharing. NHS England should put support and guidance in place to enable local systems to share data successfully, including vaccination uptake amongst people experiencing rough sleeping and homelessness. This should include providing examples of good practice, for example, the sample Data Protection Impact Assessments (DPIAs) and Data Sharing Agreements (DSAs) that have been developed to support data linkage around homelessness. This should then be supported at the local level through the duty to collaborate.

Preventing inequalities and unfairness

46. It has been reported has been lower uptake of the Covid-19 vaccine among people with experience of homelessness, in comparison to the general population. This poses a serious risk to public health. NHS England should work with local authorities and homelessness organisations to develop and implement effective delivery plans to ensure that this cohort are able to access the flu and Covid-19 vaccine. This should include tailored communication, alongside proactive in-reach and outreach programmes.
47. It is crucial that the healthcare organisations at a local and neighbourhood level prioritise the needs of people experiencing homelessness and rough sleeping. NHS England and Improvement have released service requirements asking Primary Care Networks (PCNs) to 'work from October 2021 to identify and engage a population experiencing health inequalities within their area, and to codesign an intervention to address the unmet needs of this population. Delivery of this intervention will commence from March 2022.' As people experiencing homelessness and rough sleeping experience some of the worst health inequalities in society, PCNs should identify them as a population to engage with as part of these service requirements.
48. Health organisations should ensure that mainstream services are accessible to people experiencing homelessness and rough sleeping. This can be improved upon by providing flexible appointment times and training for staff to increase understanding of issues related to homelessness.

Appendices

Appendix A: Glossary

Housing and accommodation

Emergency accommodation – accommodation often administered on a nightly basis so a person does not have to sleep rough e.g. night shelters.

Temporary accommodation – accommodation usually provided to people/families who the local authority have accepted as having a duty to house but haven't made a decision on what housing should be offered, or do not have appropriate housing available.

Interim accommodation – accommodation offered to someone whilst a local authority considers their homelessness application and subsequent duties to them.

Move-on accommodation – 'move-on' is the process of moving on from short term accommodation e.g. temporary/emergency or other homelessness services, into more permanent tenancies. This may be done through move-on accommodation, but could also refer to a long term or permanent tenancy without support.

Supported accommodation – a housing service where housing, support and/or care services are provided as a package to help people to live as independently as possible.

Social housing – social homes are provided by housing associations (not-for-profit organisations that own, let, and manage rented housing) or a local council, with rents based on average local incomes so that they are affordable.

General needs housing – housing provided to those with no specific support needs.

Housing Options – an information and advice process or team that councils use when someone approaches them with a housing problem.

Direct allocations/direct lets – a process where a housing applicant is directly assigned a specific property. This system is often used for specific and vulnerable groups e.g. those with disabilities, in need of sheltered housing, care leavers etc. Direct allocations and lets are an alternative to choice based lettings.

Choice based lettings – a system where applicants for social housing are able to look at the available vacant properties online, and place a bid for a property that they wish to live in.

Registered Providers – a social housing provider registered with the Regulator of Social Housing.

HA nominations – the nomination by local authorities of prospective tenants for vacant properties in partner housing associations.

LHA – the Local Housing Allowance is determined by Valuation Office Agency Rent Officers to calculate housing benefit rates for tenants renting from private landlords.

Help to Rent – projects to support homeless people, vulnerable tenants and their landlords. These projects help fund services that will match tenants with landlords, and provide financial guarantees for deposits and rent, as well as ongoing support for both parties. From 2010 Government funding helped deliver more than 150 Help to Rent projects across England. However the Government ended funding for these services in 2016.

Shared Accommodation Rate – Most single private renters under 35 can only get the shared accommodation rate of LHA. This applies even if you do not share your home with others. The shared accommodation rate is lower than other LHA rates.

People and ways of working

Trauma informed – an approach which seeks to improve awareness of trauma and its impact, to ensure that services provided offer effective support and, above all, that they do not re-traumatise those accessing or working in services.

Gender-informed – a way of working which acknowledges how gender may affect someone's needs and necessitate a tailored way of working.

Psychologically informed environments – services that are designed and delivered in a way that takes into account the emotional and psychological needs of the individuals using them.

Wraparound support – a comprehensive package of support that does not focus just on one immediate issue of need but considers the whole person, and all their needs and aspirations. e.g. support with accessing the correct benefits, attending health appointments etc.

Upstream interventions – a focus on addressing structural issues that, in this context, may make a person facing homelessness more susceptible to further issues e.g. supply, access and affordability of housing, and the welfare system, for example the availability and level of benefits, employment protection etc.

Complex needs – individuals with complex needs have multiple related physical and mental health conditions, often including substance use.

Multiple disadvantage – a state in which someone experiences a combination of problems that negatively affects their life chances, for example homelessness, substance misuse, contact with the criminal justice system and mental ill health.

Multi-disciplinary team – workers from different professions/teams e.g. Adult Social Care, Housing providing services to the same clients.

Deadnaming – calling someone by their birth name after they have changed their name. This term is often associated with people who are trans who have changed their name as part of their transition.

Services

Floating support – usually targeted at people with low to medium needs and exists to support people to live independently in their own home. Focused on preventing the loss of housing and, in the case of people who have slept rough, a return to the street.

Mixed provision – services which are not offered based on characteristics such as gender, age, sexuality etc.

SWEP – Severe Weather Emergency Protocol, the process by which extra shelter spaces are opened for people sleeping rough when there is an increased risk of death due to the weather e.g. temperatures falling near or below freezing or extreme heat.

Community-based services – services delivered in a wide range of settings e.g. homes, community clinics, centres and schools to help people live independently.

StreetLink – a service which enables members of the public to connect people sleeping rough with the local services that can support them.

Combined Homelessness and Information Network (CHAIN) – CHAIN is a multi-agency database recording information about people sleeping rough and the wider street population in London. The system, which is commissioned and funded by the Mayor of London and managed by St Mungo's, represents the UK's most detailed and comprehensive source of information about rough sleeping. It allows users to share information about work done with rough sleepers and about their needs, ensuring that they receive the most appropriate support and that efforts are not duplicated. Reports from the system are used at an operational level by commissioning bodies to monitor the effectiveness of their services, and at a more strategic level by policy makers to gather intelligence about trends within the rough sleeping population and to identify emerging needs.

Pathway – services and interventions made available to an individual to provide a route to resolve their issues e.g. a local authority homelessness pathway could comprise services such as emergency and supported accommodation.

Single service offer – a process whereby a rough sleeper is offered a single route away from the streets which they are expected, and encouraged, to take up. Usually, the individual is denied further assistance if the identified single service offer is refused.

Duties

Duty to Refer – introduced as part of the Homelessness Reduction Act as a duty on specified public authorities to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness/housing options teams.

Duty to collaborate – a requirement on relevant public body agencies working with those experiencing homelessness to support local authorities in their duty to end and prevent homelessness.

Commitment to collaborate – a commitment on housing associations to support local authorities in their duty to end and prevent homelessness.

Somewhere Safe to Stay duty – a duty that requires local authorities to provide a safe place to stay, such as emergency accommodation, so that no one has to sleep rough after seeking help from their local authorities.

Definitions

Caldicott Principles – The Caldicott Principles are eight principles to ensure people's information is kept confidential and used appropriately.

Everyone In – the name of the Government's policy to help all people sleeping rough into accommodation during the Covid-19 pandemic.

Local connection – one of the criteria to determine whether an individual is eligible for support within a specific local authority area, based on their current or past residency, employment, family connections in the area or special circumstances. Those who are determined not to have a local connection may be determined ineligible for support by that local authority.

Intentionality criteria – the local authority does not have to provide longer-term housing if they decide someone is in priority need but intentionally homeless. This could be because of something that someone deliberately does, or something that someone fails to do.

Verification – people who have been seen and recorded as rough sleeping by outreach workers.

Statutory homelessness – a statutory homeless person/household is one who has been accepted by the local authority as having a duty to house them.

Homelessness Code of Guidance – Government guidance on how local authorities should exercise their homelessness powers and responsibilities.

Benefit Cap – a limit on the total amount of benefit someone can get. It applies to most people aged 16 or over who have not reached State Pension age.

Annual count – the process by which local authorities across England take a snapshot of people sleeping rough on a single night in autumn. They either use a count-based estimate of visible rough sleeping, an evidence-based estimate meeting with local agencies or an estimate informed by a spotlight street count, where a street count is undertaken in hotspot locations on the chosen 'typical' night.

Secure Estate – This includes prisons, approved premises, bail accommodation and youth detention accommodation.

Tripartite review – a review between three stakeholders, in this case local authorities, the homelessness sector, and DLUHC.

Places

Pan-London – services which are commissioned for use across London.

Combined authority – a legal body set up using national legislation that enables a group of two or more councils to collaborate and take / collective decisions across council boundaries.

Funding

Capital funding – funding for the purpose of purchasing assets or making significant repairs to existing assets.

Revenue funding – funding used where there is no lasting asset e.g. staffing costs.

Bridge funding – temporary or intermediate funding to cover short term expenses until long term funding can be secured.

Rough Sleeping Initiative – central government funding programme for rough sleeper services applied for/awarded to local authorities, charities and other organisations.

Health

Population health – an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

Public health – all organised measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole.’

Inclusion health – a ‘catch-all’ term used to describe the approach to working with people who are socially excluded, typically experiencing multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experiencing stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes.

Non-clinical outreach workers – those who do not provide direct health treatment, diagnosis or care for patients, and do so in non-clinical settings e.g. schools, community centres etc.

Co-morbidities – a state where a person suffers from more than one long term condition at a time, which may or may not be related.

Appendix B: Bilateral meetings

Councillor James Jamieson and Jo Allchurch (Local Government Association); Councillor Alex Phillips (The Big Issue); the Rough Sleeping Strategy Group; the Step Down Recovery Group; Pratchi Chatterjee (Crisis); Elsa Corry-Roak, Anna Henry and Zahra Wynne (Revolving Doors); Sam Rodger (NHS Race and Health Observatory); Ian Canadine (CHAIN), Petra Salva (St Mungo’s) and Bobby Sandhu (St Mungo’s); Jon Sparkes (Crisis) and Rick Henderson (Homeless Link); Tom Copley (GLA) and Darren Rodwell (London Councils); Councillor Sharon Thompson (Birmingham Cabinet Member for Vulnerable Children and Families) and Jean Templeton (St Basil’s); the NHS Health Inequalities Board Meeting (attended by Dr Bola Owolabi); Catherine Ryder (National Housing Federation) and David Bogle (Homes for Cathy); Molly Bishop (GMCA); Lucy Sutton (Association of Directors of Public Health); Sarah Pickup and Paul Ogden (LGA); Gill Leng (National Health and Homelessness Advisor) and Olivia Butterworth (Head of Public Participation for NHSE/I); Charlotte Bates (Expert Citizens); Lucy Sutton (Association of Directors of Public Health); Verena Hutcheson (Reading Borough Council Housing); Ruth Rankine and Karen Higgins (NHS Confederation); Nickie Aiken MP; Heather Clarke and Sarah Risby (Westminster City Council).

Non-UK migrants

Non-UK national – someone who possesses no type of British nationality e.g. citizen, overseas citizens, subject.

No Recourse to Public Funds – a condition applied to someone subject to immigration control meaning they have no entitlement to the majority of welfare benefits, including income support, housing benefit and a range of allowances and tax credits.

Settled status – Settled status is the grant of indefinite leave to EU nationals who can evidence continuous UK residence for at least five years.

Pre Settled Status/Limited Leave to Remain – Pre-Settled Status is the immigration status granted under the EU Settlement Scheme (EUSS) to European citizens (EU, EEA or Swiss citizens) and their non-European family members who have not yet lived in the UK for a continuous 5-year period at any point in the past. It is the status that allows those individuals to work towards meeting the requirements for Settled Status.

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