HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	**Homeless Health**
Meeting date	20 July 2026
Status	Public Report
Executive summary	Homelessness is a serious societal and complex public health issue that is an indicator of fundamental breakdown in a person's life with wide-ranging causes and consequences including ill-health. Rough sleeping is the most visible and extreme end of homelessness. There is a strong link between health and homelessness with poor health a major cause of homelessness, and homelessness/rough sleeping increasing the risk of additional health needs developing and/or exacerbation of existing ones. It is now well recognised that those experiencing homelessness often suffer multiple disadvantage, experiencing a combination of problems including substance misuse, contact with the criminal justice system and mental ill health. They often fall through the gaps between services and systems, making it harder to address their problems and lead fulfilling lives. Solutions to improve the health and wellbeing of the homeless population require both a systemwide commitment and well-coordinated local services. A range of services (both commissioned and those provided by the charitable sector) are available across the BCP conurbation to support the health needs of the homeless population. Dedicated provision to address the needs of rough sleepers is commissioned by NHS Dorset. A multi-disciplinary team approach has been maturing and brings together a range of partners to manage a personalised approach to individuals with complex presenting needs. Despite positive developments in recent years, a recent Healthwatch report allied to local data and intelligence indicate ongoing challenges associated with the current configuration of service provision. Working in partnership, BCP Council and NHS Dorset will undertake a Homeless Health Needs Assessment to better understand any unmet need within the population cohort alongside the effectiveness of existing pathways of care in meeting identified needs.

	The health needs assessment will incorporate: • Scale and size of population (using an agreed definition) • Impact and outcomes associated with all current commissioned local homeless health provision including primary care • Impact and outcomes associated with local non-statutory provision • Areas of strength / weakness / gaps in the current model of care • Quantitative & qualitative intelligence associated with population cohort including lived experience The needs assessment will then be used to inform future strategic commissioning intentions where indicated, including the potential for a co-produced redesign of existing models of care.
Recommendations	Members of the Committee are recommended to **NOTE** current progress to date and planned work to undertake a Homeless Health Needs Assessment as a means of informing future service redesign where indicated.
Reason for recommendations	A formal Health Needs Assessment will provide a clearer understanding and articulation of current needs, including any gaps in commissioned service provision, and will provide an objective basis from which to inform co-production of a revised care pathway and model of care.
Portfolio Holder(s):	Cllr Kieron Wilson – Housing and Regulation
Corporate Director	Laura Ambler – Corporate Director of Wellbeing
Report Authors	Ben Tomlin – Head of Strategic Housing and Partnerships Mark Harris – Deputy Director of Modernisation & Place, NHS Dorset
Wards	Council-wide
Classification	For Update and Recommendation

Background

1. Homelessness is a serious societal and complex public health issue that is an indicator of fundamental breakdown in a person's life with wide-ranging causes and consequences including ill-health. Rough sleeping is the most visible and extreme end of homelessness.

2. Whilst the connection between housing and homelessness is well understood, the strong link between health and homelessness is often overlooked. Poor health is a major cause of homelessness, and homelessness and rough sleeping can lead to additional health needs developing and/or exacerbate existing ones. It is now well recognised that those experiencing homelessness often suffer multiple disadvantage, experiencing a combination of problems including substance misuse, contact with the criminal justice system and mental ill health. They often fall through the gaps between services and systems, making it harder to address their problems and lead fulfilling lives. Solutions to improve the health and wellbeing of the homeless population require both a systemwide commitment and well-coordinated local services.

3. The newly published BCP Homelessness and Rough Sleeping Strategy 2026-2031 provides the strategic framework for the proposed Homeless Health Needs Assessment and the associated review of current homeless health pathways and commissioned provision. The Strategy sets out a shared partnership ambition that homelessness in Bournemouth, Christchurch and Poole should be rare, brief and unrepeated, with a strong emphasis on earlier prevention, rapid and compassionate responses, sustained housing stability, stronger health integration, trauma-informed practice and the meaningful involvement of people with lived experience. This report supports delivery of the Strategy by focusing specifically on the health inequalities, access barriers and fragmented pathways experienced by people who are rough sleeping, homeless or vulnerably housed. The proposed Homeless Health Needs Assessment outlined later in this report will provide the shared evidence base needed to inform future commissioning, strengthen integrated pathways across housing, health and care, and ensure that future service redesign is aligned with the Strategy's wider objectives and delivery plan.

Current Homeless Health Provision in BCP

4. NHS Dorset commissions universal healthcare provision for all registered residents within the BCP local authority area. Services are available to all citizens living in BCP regardless of accommodation status.

5. Individuals without settled accommodation are eligible to register with any GP practice in their local area and cannot be refused based on their accommodation status.

6. In recognition of the unique challenges associated with those deemed to be rough sleeping, NHS Dorset commissions a bespoke Homelessness GP Service currently provided by South Coast Medical Primary Care Network.

7. Specific aims of the service include provision of a convenient, accessible and comprehensive medical service that addresses the specific and complex needs of the homeless population – specifically those deemed to be rough sleeping. The South Coast Medical provision includes outreach in the form of a clinic offered 7 days a week at the St Pauls Supported Housing project. The service has been enhanced in recent years with the addition of a mental health practitioner, social prescribers, long term health conditions nurse specialists and an additional seven hours of weekly GP support. These additions were enacted as a direct response to presenting need within the population.

8. South Coast Medical works closely with the Bournemouth & Poole Rough Sleeper Team to ensure that the service is aimed at the target client group, i.e. rough sleepers in Bournemouth, and is invited to the Homelessness Multi-Disciplinary Team (MDT) as a means of facilitating partnership working to improve outcomes for the population cohort in scope. The MDT consists of agencies directly involved in supporting people who are homeless, including health services, local authority teams and third sector agencies.

9. NHS Dorset also commissions specialist Homeless Health provision, the Rough Sleepers Health Outreach Service, via Dorset Healthcare. The service provides intensive, community-based support for adults who are rough sleeping and struggling with a physical illness or mental health condition. The team proactively engages with adults who are rough sleeping and who are not accessing mainstream healthcare services. Emphasis is placed on engaging with people who are rough sleeping and working alongside them to support their health needs whilst they are rough sleeping.

10. The service operates through an outreach model and sees people in a range of locations, including on the streets, in emergency B&B accommodation, public places, day centres, NHS sites, community settings and faith-based buildings. Interventions are provided for as long as a person is rough sleeping and in need of a healthcare intervention, assessment or signposting to a relevant service.

11. University Hospitals Dorset also has a homelessness team with the aim of enabling improved links into community-based provision, including mental health support, medication reviews, blood-borne virus testing, liver disease management and close co-ordination with housing services, social care and local drug & alcohol services.

12. The MDT has matured over recent years and has embedded joined-up, person-centred working as "business as usual" practice. Each professional within the MDT contributes their specialist expertise, enabling a fuller understanding of individuals' needs and supporting those experiencing rough sleeping with more coordinated and effective interventions. Relational service development through the MDT operates beyond the formal meetings, resulting in increased joint working across services and improved identification and response to individuals experiencing multiple disadvantage.

Current Challenges

13. Healthwatch produced a report in September 2024 - *Voiceless, unheard and socially excluded Accessing health and care while homeless or vulnerably housed (Dorset Homeless Report final Sept24r-v2.pdf)* - which set out a number of recommendations based on themes arising from their work to find out first-hand about the barriers and challenges faced by known groups of single people experiencing homelessness and those who are vulnerably housed when they try to access health and care services in BCP, including primary, secondary, social and community care.

14. Despite positive steps and service developments in recent years, the issues highlighted within the Healthwatch report indicate that the current configuration of commissioned provision is not achieving the desired outcomes with some individuals continuing to receive a poor experience of care linked to areas of fragmentation across services.

15. Latest intelligence data (DiiS, June 2026) also suggests evidence of ongoing health inequity for the homeless population in BCP and reinforces the need to go further in our efforts to meet the needs of this specific population cohort. Key highlighted health inequalities in comparison to the overall Dorset resident population include:

- Significantly higher prevalence of depression, asthma and severe mental illness
- Greater frequency of use of urgent and emergency services
- Lower rates of vaccination
- Lower life expectancy and lower healthy life expectancy.

Proposed Actions

16. Understanding the needs of the homeless population is a fundamental step towards addressing health inequalities faced by people experiencing homelessness locally. A health needs assessment (HNA) is a tool used to build a picture of the health problems and needs of different populations, with the aim of informing service provision to address identified needs and maximise health gain within the population of focus.

17. Working in partnership, BCP Council and NHS Dorset will undertake a Homeless Health Needs Assessment as a means of better understanding the current needs of the population and effectiveness of existing pathways of care in meeting those identified needs.

18. The health needs assessment will incorporate:

- Scale and size of population (using an agreed definition)
- Impact and outcomes associated with all current commissioned local homeless health provision including primary care
- Impact and outcomes associated with local non-statutory provision
- Areas of strength / weakness / gaps in the current model of care

- Quantitative & qualitative intelligence associated with population cohort including lived experience

19. The needs assessment will then be used to inform future strategic commissioning intentions where indicated. This may include a co-produced redesign of the existing model of care.

Key Lines of Enquiry

What progress have we made in strengthening the Homelessness Multi-Disciplinary Team (MDT) to improve joined-up, person-centred care?

20. The Homelessness MDT has been operational for four years, supporting a cohort who have experienced rough sleeping. Agencies invited to be part of the MDT include a wide range of representation, including housing, social care, drug and alcohol services, healthcare, relevant voluntary and third sector agencies.

21. Since 2024, the MDT has supported 80 individuals, with 8 returning for further input when again at risk of homelessness. The MDT is currently working with 22 individuals (June 2026). The MDT has strengthened its approach, moving from a primary 'housing' focus to a more holistic, person-centred approach focusing on outcomes in five core areas: housing, mental health, physical health, substance use and risk. The MDT has also matured to consider factors such as communication and learning needs, intersectional factors and system alienation. This has enhanced the MDT's ability to better understand and respond to the complexity of need.

22. Each professional within the MDT contributes their specialist expertise, enabling a fuller understanding of individuals' needs and supporting those experiencing rough sleeping with more coordinated and effective interventions. Joined-up, person-centred working is now embedded as "business as usual". Relational service development through the MDT operates beyond the formal meetings, resulting in increased joint working across services and improved identification and response to individuals experiencing multiple disadvantage.

23. Over the past two years, there has been a marked increase in MDT engagement with women, alongside improved recognition of hidden homelessness, including those moving between rough sleeping and unsafe accommodation. This is evidenced by an increase in female cases discussed at MDT. The experience below highlights the effectiveness of the MDT in enabling coordinated, multi-agency person-centred responses.

Case Study:

Individual A was referred to the Homeless MDT in October 2025, having been moving between periods of rough sleeping and unsafe accommodation. She was experiencing multiple disadvantage, including domestic abuse, substance use, physical and mental health concerns, alongside homelessness. Individual A was also engaged in sex work and had an established relationship with Dorset Working Women's Project (DWWP).

Individual A initially sought help from DWWP, who were able to support her to access the HealthBus as a place of safety away from her partner. While there, she was seen by nursing staff, engaged with the Hepatitis C team, and a GP appointment was arranged. On the same day, she was also supported to meet with a Housing Officer, resulting in her being placed into temporary accommodation. The following day, she attended a With You appointment and commenced pharmacological treatment.

At the subsequent Homeless MDT meeting, partners collectively agreed a coordinated support plan, including a move into women-only supported accommodation. This was arranged, assessed, and completed within the same week. Since then, individual A has continued to receive coordinated, person-centred support. This has included assistance to resolve her benefits (which she had not been claiming), engagement with a Safeguarding Social Worker, and ongoing support to attend health appointments.

What plans for a First Contact Health Service to support GP registration, mental health access and more flexible appointments are we proposing?

24. First contact access for health support is primarily through primary care (the dedicated Homeless Health provision for rough sleepers) and/or through the multi-disciplinary team partnership.

What are we doing to support the expanded wound care provision, including outreach clinics?

25. Primary care remains available to support the management of wounds with this being within the scope and remit of the commissioned service provided by South Coast Medical. Partnership work with local drug service provision has also enhanced the current offer concerning wound care. Dorset Healthcare's health outreach service also includes the provision of physical health interventions as a means of providing a holistic response. It is recognised though that further work may still be required to more effectively manage wound care and this will be informed by the Health Needs Assessment.

What ongoing work are we progressing to improve dental access for inclusion groups?

26. **Dorset Oral Health Programme:** Dorset has established an Oral Health Programme, with the aim of supporting the health and wellbeing of BCP and Dorset residents through improved oral health by providing accessible and equitable NHS dental care and empowering people to take care of their own oral health. This will be achieved by targeting the delivery of improvements across the oral health workforce, access and prevention.

- Workforce is crucial to meet the demands of our community.
- Prevention is key - promoting oral health across our community and reducing the incidence of dental problems before they start.
- Access ensures that those most in need receive dental care.

27. **Health Inclusion Groups:** Our focus remains on those health inclusion groups where funding has been secured through the Programme. We are designing a new specification for an outcomes-based commission to support populations that are excluded and face barriers to access, including people who are homeless. In addition, we are commissioning training for the non-dental workforce to support communities. This follows a Dorset Health Needs Assessment to support care homes, housebound residents, family hubs, general medical practices, community health and health visitors, and voluntary groups to support prevention and referral into the new commission.

28. Dentaid has been re-commissioned to continue to provide dental care for people experiencing homelessness and those impacted by domestic abuse in Bournemouth and Weymouth for the next 18 months. They now offer two clinical sessions per month in both Bournemouth with HealthBus and Weymouth with the Lantern Trust, and alternate monthly clinics with Bournemouth Churches Housing Association (BCHA). We have commissioned Bournemouth University and the Health Sciences University, working with HealthBus and the Lantern Trust, to better understand need as part of the Research and Engagement Network. This will ensure that the research is focused on the needs of the community to shape future provision using a blend of Dentaid and the new commissioned service, with a planned delivery date of quarter 3 in 2027.

How has the emphasis on training, engagement and integration across statutory and voluntary partners increased?

29. The BCP Homelessness Partnership is now a mature local partnership of statutory and voluntary sector partners aligned to a single Charter of shared values.

30. Whilst there are several examples of collaboration around workforce development, co-production and joint working, there remains a strategic intention to build upon these foundations and what works to strengthen the collective ambition to demonstrate that, where homelessness cannot be prevented, it is rare, brief and unrepeated.

31. The extensive programme of stakeholder engagement for the updated Homeless & Rough Sleeping strategy demonstrates a wide range of partners, residents, professionals and people with lived experience increasingly playing a role in this work. Feedback informed the shaping of the Strategy's aims and commitments and helped identify the system changes that matter most to those affected, including the role of health and social care.

To what extent have we been following the document produced by NHSE in November 2022 entitled:

'Supporting people experiencing homelessness and rough sleeping: Emergency Department, pathway, checklist and toolkit'?

32. University Hospitals Dorset has a dedicated Homeless Care Team operating across Bournemouth and Poole. The team works proactively with the Council's Hospital

Housing Team and Homeless Intervention (social work) Team to support patients who are homeless or at risk of homelessness, both during admission and in planning for discharge. They link with wider services to ensure that individuals are not simply discharged back to unsafe or unstable circumstances, but have a more sustainable housing, health, care and support plan in place at discharge.

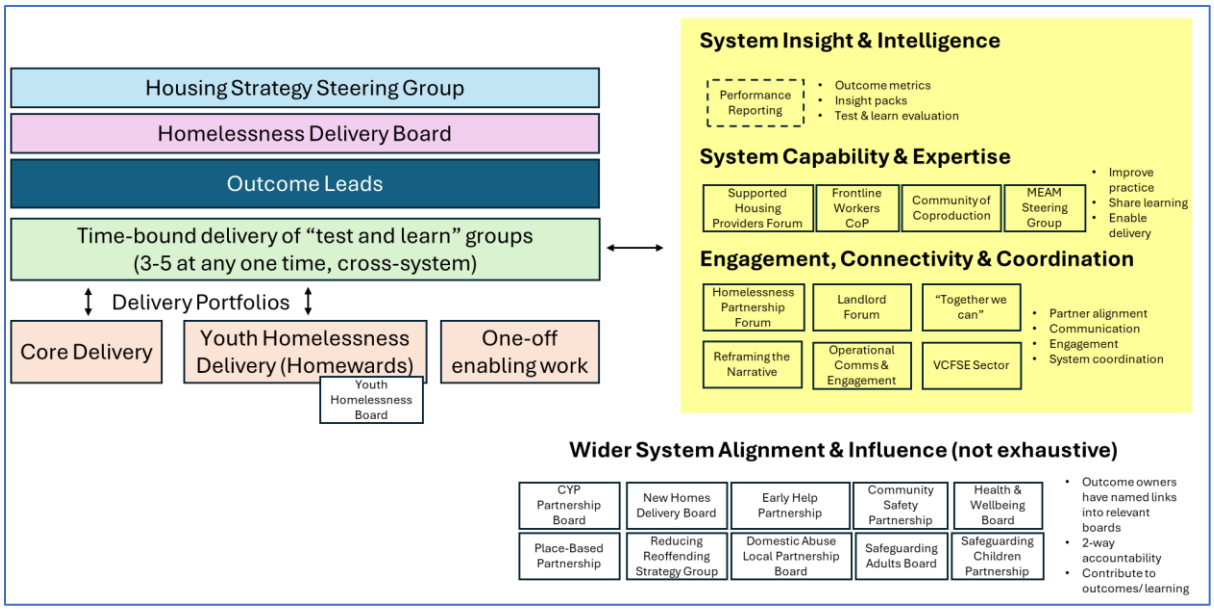
33. Dorset HealthCare provides specialist homeless health support via a Rough Sleepers Health Outreach Service. The service offers outreach-based support, including mental health and physical health support. This helps provide a degree of continuity beyond the acute setting, which is often where people disengage. Specialist community-based outreach support commissioned by the Council supports drug and alcohol, mental health and reablement interventions.

34. There is active work in place to strengthen the hospital discharge processes and protocols from both acute and mental health hospitals. This will ensure improvements are made in earlier identification of housing risk, clearer escalation routes, and more consistent partnership working across the system to eradicate any instances of homelessness crisis at discharge. This aligns with national guidance, which frames hospital admission as a key "window of opportunity" to address homelessness and emphasises the need for coordinated working between health, social care and housing partners to support safe and sustainable discharge.

35. There is strong local evidence of effective practice; however, inconsistency remains across the housing, health and social care system due to wider service pressures and demands.

Is there a single point of contact or homelessness lead within the system?

36. Delivery of the Homelessness and Rough Sleeping Strategy is overseen by an independently chaired Homelessness Delivery Board, reporting to the Strategic Steering Group. Both groups have wide multi-disciplinary sector representation, including statutory and non-statutory partners and the private sector.



What are the mechanisms between the NHS and voluntary sector to ensure seamless and continuing support?

37. Health providers and wider voluntary sector partners are part of the Homelessness MDT. This provides a live forum for dialogue framed around a personalised approach to individuals presenting need, especially those experiencing rough sleeping.

Summary of Financial Implications

38. Homelessness and rough sleeping services are funded through a combination of national grant allocations, programme-specific funding and Council base budget. BCP Council has received an initial three-year settlement which consolidates several previously separate grant streams. Resources to commission a homeless health needs assessment have been identified from Government Grant funding, specifically the Preventing Homelessness, Rough Sleeping and Domestic Abuse Grant.

39. Homeless pressures are not expected to create additional financial pressures within the Medium Term Financial Plan (MTFP). It is assumed that the new three-year settlement and existing base budget will be sufficient to support delivery. Should service demand or funding levels change significantly, the financial impact will be reviewed as part of the Council's budget monitoring and MTFP process.

Summary of Legal Implications

40. Improved responses to homeless health need to be planned within a clear statutory framework across housing, health and social care. This includes the Council's duties under homelessness legislation to prevent and relieve homelessness, publish and deliver a homelessness strategy, and work with public bodies through the duty to refer. It also includes NHS and Integrated Care Board duties to reduce health inequalities, ensure access to healthcare, support safe hospital discharge, and remove avoidable barriers, such as lack of address or documentation, when people seek primary care.

41. The response must also reflect the Council's responsibilities under the Equality Act 2010, Public Sector Equality Duty, Care Act 2014 and safeguarding framework. This means recognising that people experiencing homelessness may have protected characteristics, care and support needs, trauma, mental ill health, substance use, disability or multiple disadvantage, and may face significant barriers to accessing services. Any new model should therefore include lawful information sharing, clear consent arrangements, safeguarding pathways, inclusive access, and coordinated commissioning between housing, public health, NHS, adult social care and voluntary sector partners.

Summary of Equality Implications

42. Homelessness is not experienced equally and is both a cause and consequence of wider inequality. Evidence shows disproportionate impacts for groups including young adults, women experiencing hidden homelessness or domestic abuse, racially minoritised communities, LGBTQ+ residents, people with learning disabilities, people

with mental ill health, people with physical disabilities or long-term conditions, and people affected by trauma, substance use or multiple disadvantage. These inequalities can affect how people access, understand and sustain engagement with housing, health and care services.

43. The proposed health needs assessment will strengthen understanding of these unequal impacts and support more inclusive service design. Equality considerations should remain central to governance, commissioning and delivery, using data, lived experience and partner intelligence to identify barriers, improve communication, strengthen trauma-informed practice and ensure future pathways are responsive to different needs and protected characteristics.

Summary of Public Health Implications

44. Homelessness is a significant public health issue and a major driver of health inequality. People experiencing homelessness, particularly those rough sleeping or vulnerably housed, are more likely to experience poor physical health, mental ill health, trauma, substance use, long-term conditions, disability, infectious disease risks, poor oral health, unmet care needs and premature mortality. Local intelligence indicates higher prevalence of depression, asthma and severe mental illness, greater use of urgent and emergency care, lower vaccination rates and significant differences in life expectancy compared with the wider Dorset resident population.

45. The proposed homeless health needs assessment provides an opportunity to inform future commissioning intentions using a population health approach, combining data, lived experience and partner insight to understand need, gaps, outcomes and inequalities. Strengthening integration between BCP Council, NHS Dorset, public health, primary care, mental health services, hospitals, adult social care, drug and alcohol services, dentistry, and voluntary and community sector partners will support earlier identification of risk, more coordinated pathways, proactive outreach, safer hospital discharge and future commissioning focused on prevention, equity and measurable health improvement.

Summary of Risk Assessment

46. The principal risks relate to the continuation of poor health outcomes for people experiencing homelessness if current service gaps, access barriers and fragmented pathways are not addressed, including avoidable deterioration in physical and mental health, increased use of urgent and emergency care, unsafe hospital discharge, repeat homelessness, rough sleeping, safeguarding concerns and continued health inequalities for people with overlapping housing, health, care and support needs. These risks are mitigated through the existing range of statutory, non-statutory and voluntary sector services across BCP, including homelessness prevention, rough sleeping outreach, hospital discharge work, multidisciplinary support and partnership governance. The proposed homeless health review and health needs assessment will strengthen mitigation by improving the shared evidence base, identifying gaps in provision, supporting more integrated commissioning and enabling better use of data, lived experience and partner intelligence to improve practice and outcomes.