Housing and Health

Insights from Sector Professionals

August 2025

Prepared by Sophia Fedorowicz

Co-contributors Andy Meakin, Phil Parkes, Chris Gidlow, Nicola Evans, Lee Dale

Expert Citizens CIC

Keele University

CHAD centre for health and development

NHS Midlands Partnership University NHS Foundation Trust

Contents

Summary

Health and housing are deeply connected, with people experiencing homelessness facing poorer health outcomes and significant barriers to care. While programmes like Changing Futures and the 10-Year Health Plan offer promise, systemic challenges persist. This report brings together lived and sector professional experiences to explore how housing and health are understood, whether they're seen as inherently connected, and how far current ways of working enable the integration of housing into healthcare.

In Stoke-on-Trent, the Housing and Health project used participatory, creative methods with people with lived experience of homelessness and insecure housing to deepen understanding of housing's broad impact on health. Funded by REN and delivered by Expert Citizens in partnership with Midlands Partnership University NHS Foundation Trust, Keele University and the Centre for Health and Development (University of Staffordshire), the project highlighted two key themes: the importance of psychological and physical safety, and access to essential facilities and community connections.

To understand the bigger picture, insights from sector professionals in Staffordshire were gathered to explore how housing and health are understood, whether they're seen as inherently connected, and how far current ways of working enable the integration of housing into healthcare.

A survey was developed by the same team of Expert Citizens in partnership with Midlands Partnership University NHS Foundation Trust, Keele University and the Centre for Health and Development (University of Staffordshire). Responses were collected throughout June and July 2025.

Findings indicate most sector professionals frequently see housing-related issues impacting health and wellbeing in their roles, with none saying they never do. There is strong agreement that housing quality, stability, and community affect health. However, fewer believe colleagues view housing as a health issue, and many report poor inter-agency collaboration. Key barriers include fragmented funding, misaligned systems, and housing not being recognised as a health priority. Structural challenges outweigh communication or safeguarding concerns. While awareness is high, practice and policy lag, requiring strategic alignment, shared investment, and cultural change to better integrate housing and health services. Sector professionals highlighted the potential for stronger integration between housing and health systems. They recognised that safe, suitable housing plays a vital role in promoting health, recovery, and inclusion. There is growing momentum to build on positive examples of collaboration and shared commitment to change. Many practitioners already champion person-centred and trauma-informed approaches, and work creatively across boundaries.

Recommendations

1. Co-Design Integrated Housing and Health Commissioning Models

Collaborative, co-produced commissioning should integrate health, housing, and social care, embedding positive health outcomes into temporary accommodation and countering the harmful conditions highlighted in this report.

2. Embed Trauma-Informed, Person-Centred Practice Across Services

Embed trauma-informed, person-centred approaches across housing and healthcare, shaped by lived experience and supported by co-produced training, reflective practice, and design tools. While services often claim to be trauma-informed, this report finds gaps between philosophy and practice.

3. Strengthen Transitions Between Services and Settings

Poorly managed transitions—such as hospital discharge, leaving treatment, or prison—undermine health when accommodation is lacking. These gaps stem from siloed commissioning, conflicting targets, and a lack of collaboration, which can incentivise services to "shunt" demand. Co-designing solutions with people who have lived experience and sector professionals—such as joint protocols, shared outcomes, and housing-inclusive care planning—would align commissioning across health, housing, and social care, reducing risks and improving outcomes.

4. Expand Access to Suitable, Secure, and Health-Promoting Housing

Co-develop housing models that promote health and dignity, addressing barriers to suitable homes—especially for groups with intersecting needs. Prioritise adaptable, inclusive design and supportive environments shaped by lived experience and professional insight.

5. Build Legal Literacy Across the System

Build legal literacy across housing, health, and social care so staff, leaders, and people with lived experience can navigate rights and duties under key legislation. Co-produced training, guidance, and cross-sector programmes would reduce responsibility-shifting, strengthen accountability, and ensure lawful, person-centred responses.

See page 21 for a more comprehensive overview of recommendations.

Context

Health and housing are deeply interconnected. Safe, stable, and quality housing is fundamental to physical health, mental wellbeing, and social participation. The All-Party Parliamentary Group for Ending Homelessness (APPGEH, 2023) underscores this connection, identifying secure, affordable housing as the foundation for sustainable health and social outcomes[1].

Since 2010, life expectancy in England has stalled, especially in under-resourced communities, where widening inequalities in education, income, employment, and housing contribute to poorer health outcomes[2]. The ongoing housing crisis including homelessness and substandard living conditions exacerbates these disparities, underscoring the need to view housing as a determinant of health and social wellbeing.

People experiencing homelessness face significantly poorer physical and mental health than the general population. In 2022, Homeless Link reported that 45% had a diagnosed mental health condition, and 48% had visited A&E in the past year which was three times the national average[3]. Nearly a quarter of hospital discharges led directly back to the streets, exposing gaps in discharge planning and housing support[2]. Respiratory illnesses like asthma and COPD are common, worsened by cold, damp, and unsanitary conditions[4]. Mental health issues often both contribute to and result from homelessness, driven by inadequate support, employment instability, stigma, and social isolation[5, 6].

Despite evidence of high levels of need among people experiencing homelessness, they often face substantial barriers to accessing healthcare. These include difficulties registering with general practitioners, stigma, and mistrust of services[7]. The APPGEH report highlights that for many individuals, housing alone is not enough. Rough sleeping and inappropriate temporary accommodation often coincide with trauma, substance misuse, and domestic abuse requiring trauma-informed, person-centred approaches embedded across services.

---

[1] All-Party Parliamentary Group for Ending Homelessness. (2023). *Executive summary: Ending homelessness for good*. Crisis UK. https://www.crisis.org.uk/media/250542/appgeh-executive-summary-2023.pdf
[2] Marmot, M., Allen, J., Boyce, T., Goldblatt, P., & Morrison, J. (2020). *Health equity in England: The Marmot Review 10 years on* (Report No. 2/2020). Institute of Health Equity. The Health Foundation. Institute of Health Equity.
[3] Homeless Link. (2022, October 27). *The unhealthy state of homelessness 2022: Findings from the Homeless Health Needs Audit* (Report). Homeless Link.
[4] Public Health England. (2018). Health matters: Rough sleeping. https://www.gov.uk/government/publications/health-matters-rough-sleeping
[5] Fazel, S., Geddes, J. R., & Kushel, M. (2014). The health of homeless people in high-income countries: Descriptive epidemiology, health consequences, and clinical and policy recommendations. The Lancet, 384(9953), 1529–1540. https://doi.org/10.1016/S0140-6736(14)61132-6
[6] Mental Health Foundation. (2017). Fundamental facts about mental health 2016. https://www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016
[7] Baker, C., & Cotton, M. (2019). Barriers to healthcare access among homeless populations: A systematic review. Journal of Health Care for the Poor and Underserved, 30(4), 1360–1377. https://doi.org/10.1353/hpu.2019.0123

The Housing Act 1996 and Homelessness Reduction Act 2017 clearly set out the legal duties for local authorities in England to prevent homelessness [8, 9]. While the Act mentions vulnerability (such as due to mental illness or disability) as a factor in assessing priority need, it doesn't place health outcomes at the heart of temporary accommodation provision.

The UK government's 10-Year Health Plan aims to decentralise care through Neighbourhood Health Services; community hubs that offer diagnostics, mental health support, and rehabilitation to reduce hospital admissions and integrate care locally, making it more accessible[10]. This move has the potential for positive impacts for people experiencing homelessness, particularly those experiencing multiple exclusion, although we it is not yet clear what this might look like and how it might be delivered for people experiencing homelessness. Alongside this, a £2 billion investment announced in March 2025 will fund up to 18,000 new social and affordable homes, part of a broader commitment to deliver 1.5 million homes by the current Parliament[11].

The £91.8 million Changing Futures programme supports 15 local partnerships, including Stoke-on-Trent, to deliver joined-up, person-centred services for people facing multiple disadvantage [12]. Its focus on innovative funding and accountability across health, housing, and social care aims to transform local provision. For many Changing Futures beneficiaries securing housing is a key goal and a critical first step toward recovery, echoing the APPGEH's call for rapid rehousing models like Housing First [13]. While these initiatives highlight progress, systemic barriers such as fragmented commissioning, inconsistent funding, and misaligned sector priorities hinder system-wide change[14]. Overcoming these barriers is essential to translate policy into sustainable improvements for people experiencing homelessness.

---

[8] HM Government. (1996). Housing Act 1996. https://www.legislation.gov.uk/ukpga/1996/52/contents
[9] HM Government. (2017). Homelessness Reduction Act 2017. https://www.legislation.gov.uk/ukpga/2017/13/contents/enacted
[10] Department of Health and Social Care; Prime Minister's Office. (2025, July 3). *Fit for the future: 10 Year Health Plan for England* [10-year health plan]. GOV.UK. Retrieved from https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
[11] UK Parliament. (2025, March 25). *Social and Affordable Housing Capital Investment* (House of Commons debate, vol. 764, col. 2100008). Retrieved from https://hansard.parliament.uk/Commons/2025-03-25/debates/25032521000008/SocialAndAffordableHousingCapitalInvestment
[12] UK Government (2021) *Changing Futures*, Collection, GOV.UK, 17 July. Available at: https://www.gov.uk/government/collections/changing-futures
[13] Ministry of Housing, Communities and Local Government and Department for Levelling Up, Housing and Communities (2025) *Evaluation of the Changing Futures programme: Fourth interim report*, Research and analysis, GOV.UK, 1 February. Available at: https://www.gov.uk/government/publications/evaluation-of-the-changing-futures-programme
[14] CHAD (Centre for Health and Development). (2023, November). *Evaluation of the Changing Futures programme: Commissioning report*. Retrieved from https://www.chadresearch.co.uk/wp-content/uploads/2023/11/CHAD-Commissioning-Report-final.pdf

Relevant legislation

Housing Act 1996

Priority need:

Housing Act 1996, s.189(1)(c): people have a priority need if they are "vulnerable as a result of old age, mental illness or handicap or physical disability or other special reason." This is where health conditions can make someone more vulnerable if homeless.

See: Housing Act 1996, c.52, s.189

Suitability of accommodation:

Housing Act 1996, s.206: "accommodation secured by a local housing authority under this Part must be suitable for the applicant and any other person who might reasonably be expected to reside with him." Suitability includes consideration of physical and mental health.

See: Housing Act 1996, c.52, s.206

Homelessness Reduction Act 2017 (HRA 2017)

Amends the Housing Act 1996 to strengthen prevention duties.

Assessment duty:

Housing Act 1996, s.189A (inserted by HRA 2017): Local authorities must carry out an assessment including:

- "the circumstances that caused the applicant to become homeless or threatened with homelessness,"
- "the housing needs of the applicant,"
- and "what support would be necessary for the applicant to have and retain suitable accommodation."
- See: Housing Act 1996, s.189A

Duty to refer:

Housing Act 1996, s.213B (inserted by HRA 2017): public authorities must refer individuals they think may be homeless or threatened with homelessness to a local housing authority, with consent.

See: Housing Act 1996, s.213B

Care Act 2014

Duty to assess:

Care Act 2014, s.9(1): where it appears an adult may have needs for care and support, the local authority must carry out an assessment.

See: Care Act 2014, c.23, s.9

Duty to meet eligible needs:

Care Act 2014, s.18: if needs meet eligibility criteria and are not otherwise met, the local authority must meet them. Housing-related needs may fall within this.

See: Care Act 2014, c.23, s.18

Equality Act 2010

Definition of disability:

Equality Act 2010, s.6: a person has a disability if they have a physical or mental impairment with a substantial and long-term adverse effect on day-to-day activities.

See: Equality Act 2010, c.15, s.6

Reasonable adjustments duty:

Equality Act 2010, ss.20–21: requires service providers and public authorities to make reasonable adjustments for disabled people. This applies to housing processes and services.

See: Equality Act 2010, c.15, ss.20–21

Mental Health Act 1983

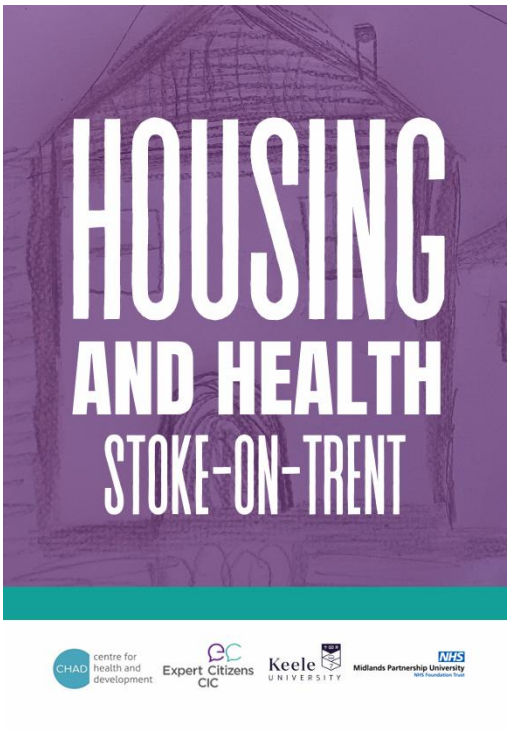
Aftercare duty:

Mental Health Act 1983, s.117: places a joint duty on health and social services to provide aftercare for people discharged from hospital after detention under certain sections. Housing is explicitly recognised in case law and guidance as part of aftercare.

See: Mental Health Act 1983, c.20, s.117

A lived experience perspective

The Housing and Health Stoke-on-Trent project worked with people with lived experience of homelessness and insecure housing, using participatory, creative methods to grow a nuanced understanding of the impacts of housing, or lack of housing, on health in the broadest sense in Stoke-on-Trent.



The Housing and Health Stoke-on-Trent project began as a public engagement project delivered by Expert Citizens in partnership with Midlands Partnership University NHS Foundation Trust, Keele University and the Centre for Health and Development (University of Staffordshire). The project was funded by The Research Engagement Network Development Programme (REN) and Expert Citizens CIC. Two themes were identified through this valuable piece of work:

> "WHEN YOU LOOK AT OTHER PEOPLES STORIES, AND HOW THEY ARE PUTTING PEOPLE IN SUCH BAD CONDITIONS, IT'S CHANGED HOW I THINK ABOUT THE CONNECTION BETWEEN HOUSING AND HEALTH"
>
> PROJECT VOLUNTEER

Safety

The importance of psychological and physical safety. To be able to control your own front door, and to *know* that you are safe in your home and community.

Access

To have access to cooking and laundry facilities, showers and privacy in the place where you live. To be able to access your loved ones and community.

The project report can be found here.

The current report

To understand the bigger picture, insights from sector professionals in Staffordshire were gathered to explore how housing and health are understood, whether they're seen as inherently connected, and how far current ways of working enable the integration of housing into healthcare.

The aim of this engagement activity was to provide a snapshot of broad feelings and experiences to inform future work in this area.

The survey (see Appendix 1) was developed by a multidisciplinary team with expertise in commissioning, strategy development, research, and lived experience of homelessness and insecure housing. It was built using Microsoft Forms and distributed using the relevant networks and mailing lists of the partner organisations. Recipients were encouraged to share it with colleagues. Responses were collected from 20th June to 18th July 2025.

Respondents

Forty-Seven sector professionals responded to the survey. Respondents represented a broad range of expertise, including criminal justice, mental health, commissioning, public health, primary care, housing and homelessness, policing, drug and alcohol treatment, tenancy support, young people and women's specialist services, and peer mentoring. Responses were received from individuals in a variety of roles, including volunteers, frontline support workers, team leaders, managers, and directors.

To protect anonymity, specific organisations and job roles will not be disclosed.

Analysis

Quantitative survey responses were collated into aggregated statistics.

Qualitative responses underwent theming, initially carried out by Expert Citizens and then reviewed by the wider Housing and Health Project team, before being sense checked by sector professionals.

Findings

The findings are presented in two parts: an initial quantitative snapshot, followed by a deeper exploration of qualitative insights.

Quantitative Snapshot

Most respondents (42 out of 47) reported that they frequently see housing-related issues impacting people's health and wellbeing, with only a small number saying this occurs sometimes (4 respondents) or rarely (1 respondent). No one reported that they never see housing related issues affecting people's health and wellbeing.

The data indicate that housing is perceived as a significant and consistent determinant of health and wellbeing by most respondents, suggesting that this connection is not only common but perhaps deeply embedded in their day-to-day professional experience.

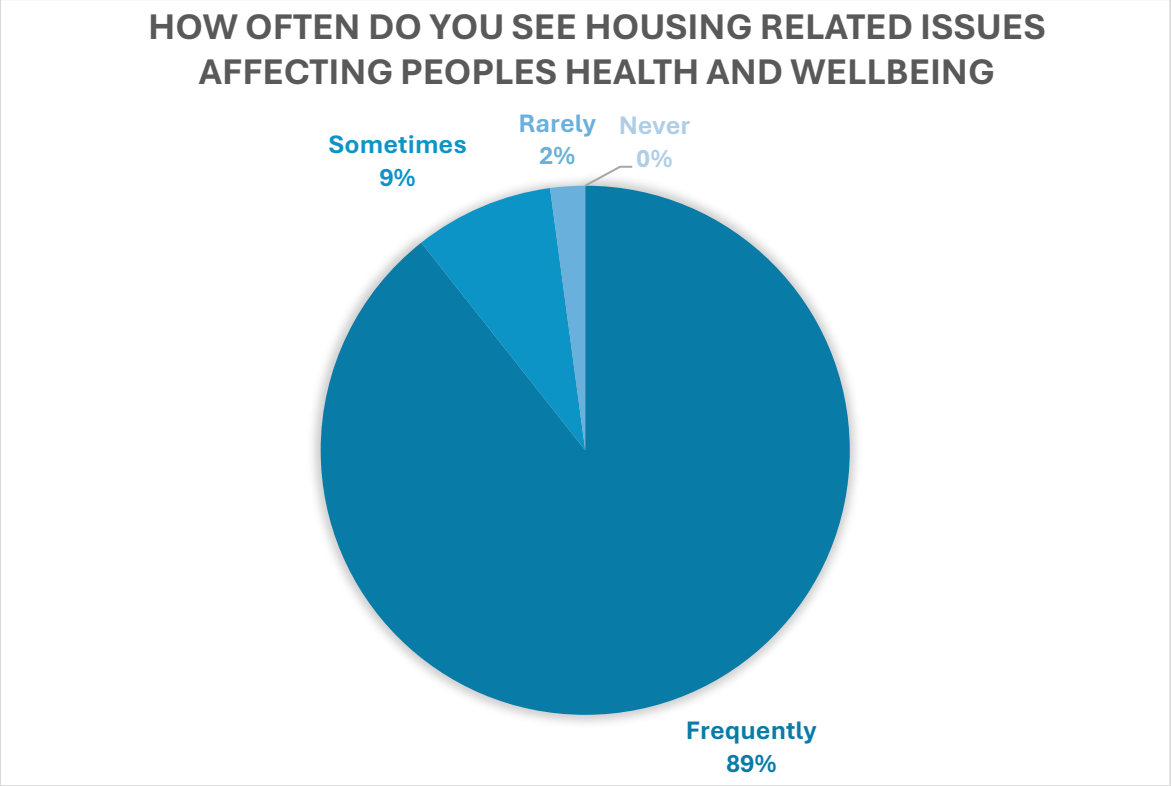


Figure 1. Responses to the survey question 'How often do you see housing related issues affecting people's health and wellbeing'.

The survey responses highlight a strong consensus among sector professionals about the intrinsic link between housing and health. The majority agreed that the area or community a person lives in impacts their health and well-being (81.3% strongly agreeing and a further 14.6% agreeing). There was unanimous agreement (87.5% strongly agree; 12.5% agree) that both the quality and the stability and security of a person's housing situation impacts their health and well-being.

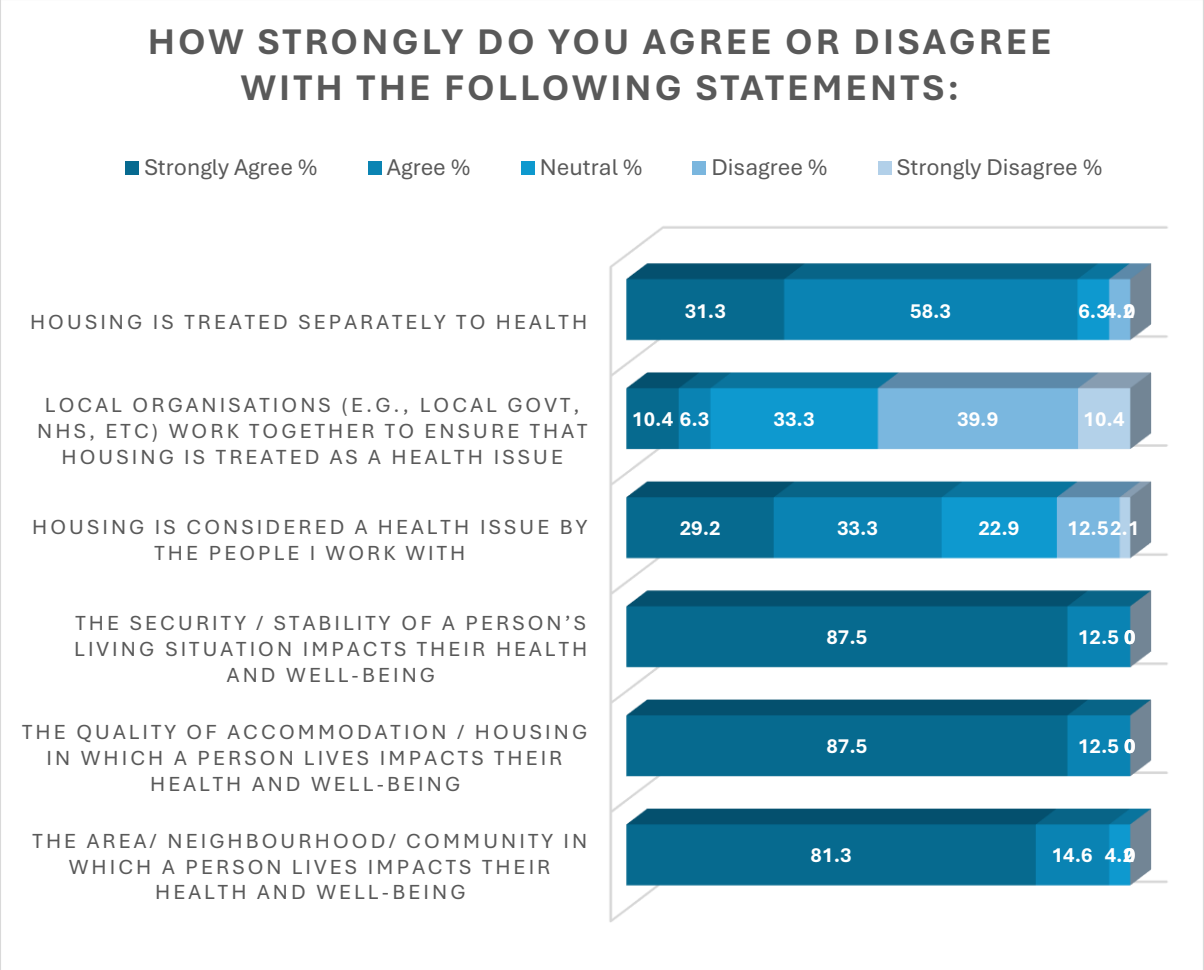


Figure 2. Responses to agree/disagree statements

When asked whether housing is considered a health issue by colleagues, the responses were more mixed. While 62.5% either strongly agreed or agreed, a notable 22.9% were neutral, and 14.6% disagreed or strongly disagreed. This could suggest that despite recognition of the issue, it is not consistently framed or treated as a health priority in practice.

This disconnect is further evidenced by perceptions of inter-agency collaboration. Only 16.7% agreed that local organisations work together to ensure housing is treated as a health issue, while a combined 50.3% disagreed or strongly disagreed, and a third (33.3%) were neutral. This highlights an important gap in perceived coordinated working, despite high levels of awareness of the impact that housing can have on health outcomes.

Finally, nearly 90% agreed or strongly agreed with the statement that housing is treated separately to health. This could be indicative of a siloed approach which ultimately makes integrating housing into health strategies, policies, and service delivery, or health outcomes into housing allocations or temporary accommodation specifications challenging.

To explore this further, respondents were asked to rank key barriers to integrating housing and health (see appendix 2 for a breakdown of the ranking). The most frequently identified as the primary barrier was the perception that housing is broadly not seen as a health issue, with 34% ranking it first. This reinforces the notion of a disconnect between the widely acknowledged link between housing and health and how this link is understood or prioritised in practice.

Figure 3. Key barriers presented to survey responders.

Funding and commissioning were also a major concern, ranked first by 26% and second by 32% of respondents. This indicates that resource constraints and the way funding flows across sectors continue to be significant obstacles to joined up working in relation to housing and health. A closely related issue was separate budgets or systems, such as the lack of alignment between NHS and housing services, which was ranked second most often (34%) and received high rankings overall.

Lack of shared priorities between sectors was frequently ranked in the middle of the list (3rd and 4th), with 30% placing it 4th, reflecting that while it may not always be the most immediate barrier, it is a consistent and underlying challenge across systems.

Challenges in cross-sector relationships or communication were more often ranked lower, with 36% placing it 5th and 26% 4th suggesting that while communication issues exist, they may be more symptomatic of deeper structural or systemic problems.

Finally, risk, safeguarding, or legal concerns were generally viewed as the least significant barrier overall, with 68% ranking it last (6th). Although relevant, these concerns are not seen as major drivers of disconnection between housing and health.

Qualitative Exploration

This section brings together the qualitative reflections shared by sector professionals through the survey. Their insights offer a detailed view of the complex and interconnected challenges facing people experiencing homelessness or who are at risk of homelessness and highlight opportunities for more integrated solutions.

Five thematic themes were identified:

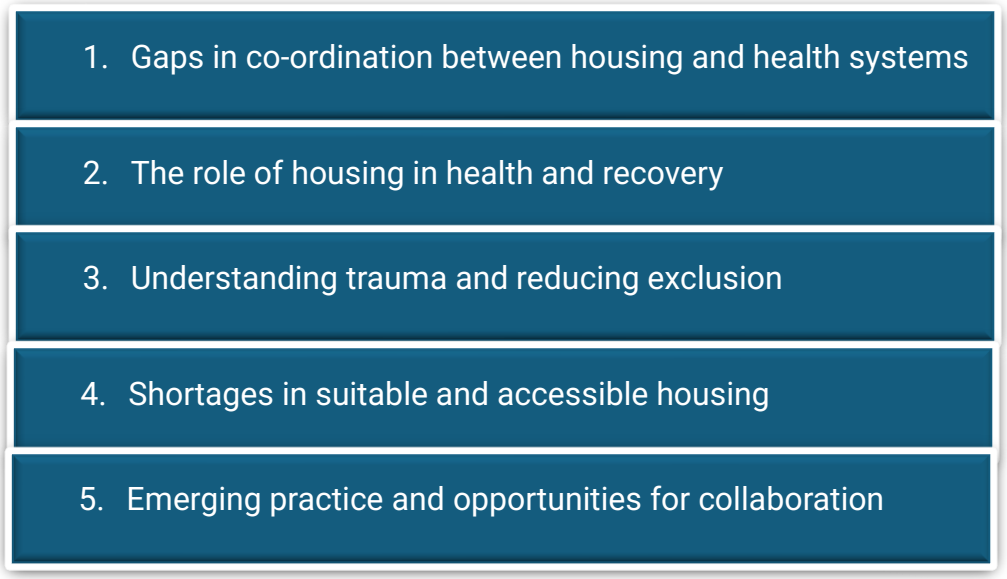


Figure 4. Five thematic themes identified in survey responses

Gaps in Coordination Between Housing and Health Systems

Participants consistently described a system in which housing and health operate in parallel but disconnected ways. Despite shared goals around supporting wellbeing, services are often structured, funded, and measured separately creating barriers to joined-up working. This lack of alignment not only creates inefficiencies but also leads to missed opportunities for early intervention and holistic support.

> *"The housing and health systems remain not only estranged from each other in operational and strategic silos, but also work against their competing strategic objectives. People attend inpatient / residential drug treatment at great expense and, remaining homeless on completion, are returned to hostels that are rife with drugs and alcohol." (ID 10)*

This described fragmentation is especially visible at key transition points, such as discharge from hospital or entry into supported accommodation, when a lack of shared planning or accountability can leave people without the care or housing stability they

need. In some cases, people are treated in clinical settings for conditions that are intrinsically linked to poor housing, only to be discharged back into the environments that contributed to their ill health.

"Treatment is often for conditions that would be alleviated through the provision of suitable accommodation." (ID 23)

Several respondents described how commissioning arrangements and funding constraints contribute to this separation. Services are often designed in isolation, with narrowly defined outcomes and limited incentives to work across boundaries. As a result, even well-intentioned professionals can feel restricted in their ability to respond to people's full circumstances.

"Everything boils down to finances and funding. Communication between different parties is poor." (ID 26)

At a systems level, this reinforces a reactive rather than preventative model, where crises are more likely to be addressed than their root causes. For people with overlapping support needs, the cumulative effect is often frustration, repeated exclusions, and cycling between services that are not equipped to address individual's overall need.

It was also clear that there are pockets of effective collaboration, driven not by formal structures, but by relationships and a commitment to person-centred working.

"Good practice is often reliant on strong professional relationships… not yet a culture of partnership working across the system." (ID 11)

This theme underscores the broader structural issue highlighted by the quantitative snapshot; the divide between housing and health reflects how systems have historically been organised, despite changing beliefs and attitudes about their inherent connection. This often takes the form of a struggle over resources, where individuals' needs are framed in ways that shift responsibility for care and support across organisational boundaries. Such tensions frequently emerge between housing and social care, mental health and substance misuse services, and other related sectors. What results is a kind of system-gaming behaviour, driven by scarcity of time and resources. In practice, people are left caught in the middle. Services invest energy into avoiding responsibility, while the individual receives little or no support. The cost is not eliminated, but merely displaced onto other parts of the system, such as emergency departments, the police, or the prison service.

"Whilst it is clear to me that these issues intersect in a strong way, I would not necessarily say that my colleagues view this in the same light and can sometimes compartmentalise issues and treat [them] as problems experienced by the individual." (ID 27)

Tackling these gaps requires more than encouraging better relationships, it calls for systemic redesigns that support integrated commissioning, shared data, and collective accountability for outcomes.

The Role of Housing in Health and Recovery

Respondents highlighted a safe and stable home is not just a basic need, but a foundation for health, recovery, and social inclusion. Yet across the responses, there was deep concern about the standard, safety, and appropriateness of the housing currently available to people with care and support needs.

"People are put in temporary accommodation with no access to cooking or cleaning, no locks on the doors and just left there for months and months." (ID 4)

Many described environments that not only failed to support recovery but could be characterised as harmful to a person's health and wellbeing. Temporary and supported housing was often reported to lack the most basic conditions for dignity. This is particularly harmful for people with experiences of trauma, illness, and disability. Several respondents spoke about the transformative power of appropriate accommodation: a safe space to rest, recover, and reconnect with community and services if they need them.

"Housing is critical as the first rung in their recovery. A safe space gives a chance to build on." (ID 10)

When placements are made without consideration for an individual's background or goals, such as placing someone in recovery alongside people engaged in on-going substance and/or alcohol use, these decisions can undermine progress and be '*quite detrimental*' (ID 20), leading to deterioration in health and wellbeing.

The direct link between unsafe housing and declining physical health was made. Respondents shared examples of people living on the streets with untreated wounds and infections that became exacerbated by exposure and lack of sanitation. These accounts challenge any assumption that housing is simply a logistical issue. They position housing firmly as a health priority, and a matter of social justice.

"People on the streets with ulcerated legs and open wounds, becoming worse due to no sanitation or washing facilities." (ID 35)

When people are placed in unsafe or unsuitable environments, the system is often compounding their difficulties and increasing pressure on emergency and acute health services in the process. This highlights the importance of careful placement decisions, when housing is safe, secure, and matched to people's needs, it becomes a platform for stability and healing. Treating housing as part of the care pathway, rather than a separate domain, could unlock significant gains in both health outcomes and system efficiency.

Understanding Trauma and Reducing Exclusion

Respondents consistently emphasised the importance of recognising how trauma shapes people's behaviours, choices, and needs: *"A lot [of customers] live with trauma and addiction every day and feel alienated" (ID 10).*

Many respondents felt that services too often interpret trauma-related responses, such as avoidance, withdrawal, or anger, as non-compliance or personal failure. This misinterpretation can lead to eviction, exclusion from support, or missed appointments and opportunities for early intervention.

> *"When placing those affected by domestic abuse we often see poor health - mental and physical, obvious and hidden disabilities and due to their trauma their responses aren't seen for what they are and then tenancies fail and people end up back in a cycle of homelessness." (ID 2)*

Rather than addressing the root causes of distress, some services were seen as relying on overly medicalised approaches that manage risk rather than support recovery. Several respondents called for a shift in mindset from treating symptoms in isolation to understanding the wider context of trauma and poverty.

> *"Dual diagnosis is also a major barrier for people and this can impact suitability for housing. Risk is often seen as a priority rather than what can be put in place to prevent risk happening." (ID3)*

This perspective reflects a growing recognition across sector professionals that trauma is not just an individual experience, but often a response to structural disadvantage.

> *"There can be the tendency to pathologize mental health struggles and problem solve, rather than asking: 'why are so many people living in supported housing experiencing poor mental health?'" (ID 27)*

When systems do not take this into account, they risk reinforcing the very patterns they are meant to disrupt. Stigma, both internal and systemic, was another recurring theme. Some individuals avoid seeking help due to fear of judgment or past negative experiences,

while others encounter discriminatory attitudes from professionals or within services themselves.

> *"Self-stigma and stigma from others compounds this… individuals are less likely to seek help." (ID 8)*

These insights point to a pressing need to change the traditional 'service user' model built around compliance, appointments, and fixed eligibility that does not always work for people living with trauma.

Shortages in Suitable and Accessible Housing

A persistent concern across survey respondents was the shortage of housing that truly meets the diverse needs of people experiencing homelessness or who are at risk of homelessness. This challenge extends beyond the numbers; while an overall increase in housing stock is vital, the focus must be on the right kind of housing: affordable, accessible, and designed to support people's health, safety, and independence.

> *"People are denied access to housing or are offered very problematic housing (and then housing expect the very "damaged" traumatised, mentally ill person to resolve the problem)." (ID 33)*

> *"poor housing conditions offered to clients as only option." (ID7)*

Respondents also drew attention to significant gaps in provision for groups whose needs are often overlooked, such as women fleeing violence or people with complex health conditions.

> *"Vulnerable Women [are] discharged from hospital as NFA. Not enough funding for suitable safe accommodation just for women." (ID 24)*

These gaps point to the need for housing policies and services that are tailored, recognising that one-size-fits-all approaches can deepen exclusion. Even where housing exists, delays in adaptations translate directly into preventable injuries, hospital admissions, and premature moves into costly institutional care.

> *"Delays to receiving adaptations… result in increased likelihood of falls, hospital admissions, and inability to remain living safely in own home." (ID 9)*

Respondents commented on the work done by their respective organisations, and related progress in customers who accessed support and built their strengths and readiness for independent living, being undermined by a lack of suitable housing options.

"We try to develop the assets in a young person… but the move from a supportive environment into independence is made much harder due to a lack of decent, affordable housing." (ID 28)

Emerging Practice and Opportunities for Collaboration

Despite the many challenges outlined, respondents also pointed to a growing sense of possibility and momentum within the housing and health sectors.

"We have recently started doing more collaborative work on 'housing and health' working closely with our district and borough partners and health. Partnership working and collaboration can be a challenge, but we have started to make some great developments in this area." (ID 32)

Some participants proposed bold, system-level ideas that could fundamentally reshape how housing and health interact. For instance, enabling healthcare professionals to formally influence housing decisions, such as doctors "prescribing" suitable housing or repairs, reflects a progressive approach that recognises housing as a social determinant of health rather than a separate issue.

"One thing I have advocated in the past is that doctors could write prescriptions for suitable housing or repairs." (ID 23)

This idea aligns with growing evidence supporting 'social prescribing' and the integration of non-medical supports within healthcare pathways, and the proposed move towards prevention. It signals a shift towards holistic care models that consider the full context of a person's wellbeing.

Respondents were clear that although there are promising practices, they remain fragile and inconsistent, often depending heavily on individual relationships and personal initiative rather than being embedded within policy, infrastructure, or culture.

"Often good practice… is reliant on established individual professional relationships rather than a culture of partnership working." (ID 11)

"The staff have wonderful ideas on how to make meaningful change to people's lives, but because the service being underfunded and short staffed, they're unable to do any of that, meaning they often quit, and are being replaced by agency staff who rarely have a chance to build relationships with the customers" (ID 34)

This reliance on informal networks reveals a critical gap: without systemic backing, innovation risks being unevenly distributed and vulnerable to staff changes or shifting priorities. Despite this, these reflections from sector professionals demonstrate a

landscape rich with potential. Yet to realise transformative change, efforts must move beyond isolated pockets of good practice toward embedding integrated approaches across organisations and systems.

Summary of qualitative exploration

Theme	Key Points
Gaps in Coordination Between Housing and Health Systems	Housing and health operate in parallel but disconnected. Fragmentation at transitions (hospital discharge, supported accommodation). Funding and commissioning reinforce silos; good practice relies on personal relationships.
The Role of Housing in Health and Recovery	Safe, stable housing underpins wellbeing and recovery. Poor-quality or temporary housing harms health. Mismatched placements undermine progress.
Understanding Trauma and Reducing Exclusion	Trauma shapes behaviour and engagement. Risk-focused, medicalised approaches fail to address root causes.
Shortages in Suitable and Accessible Housing	Limited affordable, safe, and adapted housing. Vulnerable groups (women, complex health needs) disproportionately affected. Delays in adaptations increase hospital admissions.
Emerging Practice and Opportunities for Collaboration	Some collaborative initiatives exist but are fragile. Good practice often depends on individual effort.

Recommendations

Sector professionals identified critical gaps between housing and health systems. These systems were often described as siloed and reactive, rather than preventative. A lack of shared planning or accountability was also highlighted.

While safe, appropriate housing was widely viewed as essential to people's health, recovery, and inclusion, it remains inaccessible or inadequate for many. Respondents highlighted that current models frequently reinforce exclusion rather than support, especially shining a light on the challenge of translating trauma-informed approaches into practice and policy. Ongoing challenges in sourcing appropriate accommodation undermine people's ability to sustain recovery and access care.

Despite these challenges, examples of effective collaboration exist, but they tend to rely on individual relationships rather than being embedded in system-wide structures. Although relational approaches are welcome and demonstrate good practice, real progress requires integrated commissioning, culturally competent care, and policy change that recognises housing as a core component of healthcare.

To support this, further work is recommended in the following areas, with a focus on co-design with people with lived experience and sector professionals:

1. Co-Design Integrated Housing and Health Commissioning Models

Work collaboratively to develop integrated commissioning approaches that bring together health, housing, and social care. This includes designing shared outcome frameworks, pooling budgets, and building joint accountability structures.

Co-produced commissioning models, such as specifications for temporary accommodation that actively support physical and mental health, would help to build health outcomes into people's experiences of temporary accommodation, contrary to the circumstances that many sector professionals describe in this report.

2. Embed Trauma-Informed, Person-Centred Practice Across Services

Develop and embed trauma-informed, person-centred ways of working across housing and healthcare systems. This should be shaped by lived experience and include co-produced training, reflective practice, and service design tools. The goal is to create environments that promote psychological safety and reduce exclusion at every level of service delivery.

A key finding of this report is that although delivery is often described as trauma informed, there are challenges in translating that philosophy into practice and policy.

3. Strengthen Transitions Between Services and Settings

Transitions between services and settings (e.g., hospital discharge, leaving residential treatment, and leaving prison) remain challenges that negatively impact people's health outcomes when they occur without appropriate accommodation in place. These difficulties are often a symptom of siloed commissioning, where services are left to design their own interfaces rather than these being actively considered, consulted on, and commissioned in an integrated way. Gaps emerge between services because commissioning teams fail to collaborate, and performance metrics can unintentionally incentivise organisations to "park" or "shunt" demand. For example, targets set by drug and alcohol commissioners may conflict with those set by supported housing commissioners, discouraging providers from working with people who are considered "difficult" or resource intensive.

To address this, commissioners should work with people who have lived experience of difficult transitions, alongside sector professionals, to co-design approaches that close these gaps. This could include joint protocols, shared outcome frameworks, and tools that ensure housing is embedded as a core part of care planning. By aligning commissioning approaches across housing, health, and social care, systems can reduce the risk of people returning to unsafe or unsuitable environments and improve health and wellbeing outcomes.

4. Expand Access to Suitable, Secure, and Health-Promoting Housing

Co-develop housing/accommodation models and specifications that promote health outcomes and dignity for people recovering from periods of homelessness.

Focus on understanding and overcoming the barriers to delivering suitable homes, particularly for groups with over-lapping and intersecting needs, such as women, disabled people, or those with co-occurring conditions. Explore adaptable, inclusive design and supportive housing environments that are tailored to what people say they need, and what sector professionals have seen work for the people they support.

5. Build Legal Literacy Across the System

Strengthen awareness and understanding of the legal duties that shape housing, health, and social care provision at every level of the sector. This includes ensuring frontline workers, managers, commissioners, and people with lived experience are confident in navigating rights and responsibilities under legislation such as the Housing Act 1996, Homelessness Reduction Act 2017, Care Act 2014, Equality Act 2010, and Mental Health Act 1983.

Developing co-produced training, accessible guidance, and cross-sector legal literacy programmes would help staff recognise when legal duties are engaged, avoid the "passing on" of responsibility, and empower individuals to advocate for their entitlements. Embedding legal literacy can reduce system failures, strengthen accountability, and ensure that housing and healthcare responses are both lawful and person-centred.

"We are on the frontline. We take those that have fallen through the social network. Often this leads to alienation from the community and therefore services that would be accessed by most. Housing is critical as the first rung in their recovery. A safe space gives a chance to build on.

Most will be on benefits and private sector housing is simply unobtainable. A lot live with trauma and addiction every day and feel alienated apart from in their own small social circles which perpetuate their cycle of behaviours. They exist but have no life outside of this."

(ID10)

I work with care leavers who are trying to manage a tenancy for the first time. Main issues seem to be deep rooted in years of social decline that goes back generations. We are therefore working with a lot of young people who have very limited aspirations, low self-esteem and community value.

This obviously impacts both physical and mental health.

(ID 25)

Appendices

Appendix 1: Understanding Views on Integrating Housing and Health Care in England: Stakeholder engagement survey

We're gathering insights from stakeholders across sectors to better understand the extent to which housing and health are viewed as inherently linked/part of the same issue, and the extent to which organisations work in a way that makes integrating housing into healthcare possible.

This short survey should take no more than 5–10 minutes.

Section 1

- Which best describes your employer – local gov, NHS, VCSE, private sector, other
- What is your current role and organisation?

(Open text)

- In your work, how often do housing-related issues impact people's health and wellbeing?

- [ ] Frequently

- [ ] Sometimes

- [ ] Rarely

- [ ] Never

- [ ] Not sure

- to what extent do you agree with the following statements (5-point scale – strongly agree – strongly disagree):
    - The area/neighbourhood/community in which a person lives impacts their health and well-being
    - The quality of accommodation / housing in which a person lives impacts their health and well-being
    - The security / stability of a person's living situation impacts their health and well-being
    - Housing is considered a health issue by the people I work with
    - Local organisations (e.g., local govt, NHS, etc) work together to ensure that housing is treated as a health issue
    - Housing is treated separately to health

Section 2:

- What are the main barriers or challenges that make it harder to link housing and health in your work? (Rank)

- [ ] Time or capacity

- [ ] Lack of funding or flexible commissioning

- [ ] Separate budgets or systems (e.g. NHS and housing not aligned)

- [ ] Lack of shared priorities between sectors

- [ ] Poor cross-sector relationships or communication

- [ ] Housing not seen as a health issue

- [ ] Risk, safeguarding or legal concerns

- [ ] Other (please specify)

- Can you give a brief example of how these challenges have shown up in your work?

(Open text)

Section 4:

- Would you like to stay informed or involved in future work on this topic?

- [ ] Yes (please share your email)

- [ ] No

Appendix 2: Ranking

	1st		2nd		3rd		4th		5th		6th	
	N	%	N	%	N	%	N	%	N	%	N	%
Funding or commissioning	12	26	15	32	8	17	6	13	6	13	0	0
Separate budgets or systems (e.g. NHS and housing not aligned)	7	15	16	34	11	23	9	19	4	9	0	0
Housing is broadly not seen as a health issue	16	34	6	13	9	19	4	9	6	13	6	13
Lack of shared priorities between sectors	8	17	6	13	9	19	14	30	6	13	4	9
Challenges in cross-sector relationships or communication	3	6	3	6	7	15	12	26	17	36	5	11
Risk, safeguarding or legal concerns	1	2	1	2	3	6	2	4	8	17	32	68

Contact

Expert Citizens
The Dudson Centre
Hope Street
Stoke-on-Trent
ST1 5DD

info@expertcitizens.org.uk
expertcitizens.org.uk

01782 683006