NHS
Wessex
Cancer Alliance

Best Practice Guidance:

Providing Cancer Care for People Experiencing Homelessness in Wessex



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Introduction

People experiencing homelessness are individuals without stable, safe housing who often face complex challenges such as social exclusion, deprivation and health issues, alongside significant barriers to accessing mainstream healthcare. This document has been developed to promote shared learning and provide practical guidance for delivering effective cancer care and support to people experiencing homelessness. While the guidance is aimed primarily at cancer clinical nurse specialists, many of the approaches described are transferable across wider health and social care settings.

The content is informed by learning from the *Right by You Wessex* service, which supports people experiencing homelessness across Southampton City, Hampshire.[1] One third of Hampshire and Isle of Wight Integrated Care Board's homeless population are in Southampton City, underscoring the scale of local need.[2] As of November 2025, the *Right by You* service has provided personalised cancer care and support to 23 people experiencing homelessness, offering valuable insights into the challenges, opportunities, and effective practices in this area.

Background

Homelessness

A person is classed as homeless if they:[3]

- Have no accommodation available to occupy
- Have no legal right to occupy their accommodation
- Have accommodation but cannot secure entry to it (e.g. illegal eviction)
- Have accommodation but it is not reasonable for them to continue to occupy it (e.g. hostels or temporary accommodation)
- Have accommodation which is a moveable structure with nowhere lawfully to place it.
- Are at risk of violence or domestic abuse

Rates of homelessness are rising nationally. One in every 200 households is experiencing some form of homelessness, including rough sleeping, sofa surfing, living in temporary accommodation, or being at risk of losing housing.[4] In 2024, rough sleeping increased by 20% compared with the previous year and by 91% compared with 2021.[4] The number of people living in temporary accommodation is at its highest recorded level.[5] As of March 2025, more than 131,000 households were living in temporary accommodation—an increase of 12% from the previous year.[4]

Health and Homelessness

People experiencing homelessness have significantly poorer physical and mental health, with mortality rates three to six times higher than the general population.[5–7] Non-geriatric frailty is highly prevalent, with many individuals showing levels of physical decline typically associated with much older adults. Multiple comorbidities are common, with almost two-thirds reporting a long-term condition or disability.[5,6]

Rates of acquired brain injury are also substantially higher at 48% compared with 21% in the general population. Most injuries occur before the onset of homelessness.[8] Acquired brain injury can affect memory, concentration, decision-making, and emotional regulation, further complicating engagement with healthcare and adherence to treatment.

The combination of chronic illness, mental health difficulties, substance use, trauma histories, and unstable living circumstances creates a level of health complexity rarely seen in the general population.

Local Context

Hampshire and Isle of Wight

Southampton City

Southampton City is the most deprived local authority within Hampshire and the Isle of Wight and, as of 2023, accounted for one-third of the region's homeless population.[2] In 2021/22, homelessness rates were significantly higher than the national average, at 10.4 per 1,000 households compared with 6.1 per 1,000 nationally.[9] Levels of rough sleeping had tripled between 2021 and 2022, alongside a substantial number of 'hidden homeless' individuals staying with family or friends in shifting circumstances.[2]

More recently, homelessness rates have fallen to approximately 7 per 1,000 households, now below the 2024/25 national average of 11.4 per 1,000.[10] Despite this improvement, the scale and complexity of need in Southampton remains high, with persistent pressures on housing, health, and support services.

Hampshire

Across Hampshire, conservative estimates suggest that more than 100 people are rough sleeping on any given night, with concentrations in city centres and coastal towns.[2] Although Hampshire's homelessness rate (8 per 1,000 households) is below the national average, it remains higher than many other counties in the South West.[10] The county has also seen a steady rise in households placed in temporary accommodation, particularly in urban areas such as Portsmouth and Southampton, reflecting increasing housing instability and demand for support.[10]

Dorset

Homelessness rates in Dorset are slightly below the national average at 9 per 1,000 households,[10] but the number of households facing homelessness has continued to grow. Since 2020/21, the rate has increased by 2.5 per 1,000 households, indicating rising pressures on local housing and support systems.[10]

Issues and Challenges

Homelessness and Health Inequalities

People experiencing homelessness face profound and overlapping health inequalities. They are disproportionately affected by the social determinants of health, with additional risks linked to poor nutrition, chronic stress, and higher smoking rates. [2,5,12] Rates of severe mental illness are significantly elevated, and substance use disorders, often co-occurring with mental health difficulties, are common. [13] The instability and unpredictability of homelessness, combined with poor living conditions, further undermines both physical and mental health and exacerbates existing inequalities. [11]

Homelessness and Cancer

Cancer is twice as prevalent among people experiencing homelessness, largely due to higher exposure to risk factors such as environmental hazards and unhealthy behaviours. These factors contribute to later presentation, more complex disease trajectories, and poorer outcomes.[7]

Barriers to Healthcare Access

People experiencing homelessness are at high risk of social exclusion, and mainstream health and social care services are often inaccessible and not designed to meet their needs. As a result, access to healthcare is frequently obstructed. [5,7] Digital exclusion, stigma, and discrimination further limit access.[13] Many individuals are excluded from support services altogether, reinforcing cycles of unmet need and contributing to poorer health and social care outcomes. [5,7]

Challenges in Cancer Management

Cancer management traditionally requires stability, coordination, and continuity over an extended period of time, conditions that are often incompatible with the realities of homelessness. Individuals may struggle to organise and attend appointments, maintain contact with healthcare teams, or adhere to complex medication regimens. This leads to fragmented care, reduced treatment adherence, and poorer disease management. [7]

Disease Management Challenges

- Poor nutrition can make cancer treatment more difficult to tolerate.
- Many individuals experience multiple disadvantages and complex needs.
- Diagnoses are often delayed, with symptoms masked by lifestyle factors or self-medication (including drug misuse).

Challenges from the Perspective of People Experiencing Homelessness

- Previous negative experiences can reduce trust in services, often linked to stigma, including behaviours being misinterpreted as 'drug-seeking'.
- Competing priorities can limit the extent to which cancer is prioritised, with health often overshadowed by more immediate or pressing needs **s**uch as safety or shelter.
- Substance misuse or addiction may take precedence over health.
- Limited family or social support can make navigating a cancer diagnosis more difficult.
- Financial constraints can limit the ability to travel to appointments.
- Unpredictable or unstable living circumstances can disrupt continuity of care.
- Acquired brain injury, often a hidden disability, can impair memory, concentration, decision-making, and the ability to process information, affecting consent, adherence, and engagement. [14,15]

Challenges from a Healthcare System Perspective

- Homelessness frequently co-occurs with mental health issues, substance use, and acquired brain injury, requiring integrated and sensitive oncology service responses. [16]
- Although specialist homeless healthcare teams exist, many individuals remain registered with mainstream GPs, with limited follow-up or coordinated oversight.
- Information-sharing barriers can prevent non-clinical teams from supporting access to care.
- Lower literacy levels can hinder understanding of treatment plans.
- Stigma and discrimination within healthcare settings can reduce the quality of care offered and deter individuals from continuing treatment.[7]
- Mainstream healthcare systems are often inflexible and poorly equipped to meet the specific needs of this population, resulting in fragmented pathways and reduced access to effective cancer care.[7]

Impact of Poorer Cancer Support

People experiencing homelessness have a high prevalence of cancer risk factors, often alongside complex physical and mental health needs.[5] Barriers in accessing healthcare support lead to heavy reliance on emergency services.[6] People experiencing homelessness attend A&E six times more often, are admitted four times more often and stay three times longer than the general population.[5] A recent (2018-2021) homeless health needs audit found that 38% of respondents had been admitted to hospital in the previous year, most commonly for physical health conditions.[6] The societal and financial costs are substantial, with NICE indicating that most interventions addressing homelessness are likely to be cost-effective or cost-saving from the wider public sector perspective.[5] Without improved access to early, community-based care, people experiencing homelessness will continue to

experience poorer outcomes and an over-reliance on acute services, with significant system-wide implications.[5,7]

Support Sources

People experiencing homelessness can be supported through a range of community-based and outreach services, including:

- **Community outreach services**, such as *Right by You*, providing flexible, relationship-based support.
- **Day centre hubs**, offering signposting, practical assistance, and a stable point of contact.
- **Outreach teams**, who locate newly rough sleeping individuals and connect them with day centres and local support pathways.
- **Drug and alcohol outreach services**, offering harm-reduction, treatment access, and ongoing support.
- **Specialist homeless health teams**, where available, providing targeted primary care and health navigation.
- **Local authority homelessness services**, supporting access to accommodation, benefits, and safeguarding pathways.
- **Voluntary and community sector organisations**, offering food, clothing, advocacy, and social support.
- **Peer support networks**, which can help build trust, engagement, and continuity of care.

Recommendations

Effective cancer care and support for people experiencing homelessness requires a flexible, person-centred, and trauma-informed approach. NICE and the Centre for Homelessness Impact emphasise the need for integrated, coordinated, and accessible healthcare pathways to improve engagement and outcomes.[5] This includes considering not only the medical aspects of cancer care, but also the social determinants of health and the psychological needs that significantly shape the experiences of people experiencing homelessness. It is also essential to support individuals to navigate fragmented healthcare systems and promote active participation in their care. The following recommendations outline both the *principles* and the *practical actions* that can support safe, equitable cancer care.

1. Adopt a Flexible, Accessible Approach to Care

Make appointments easier to attend

- Book appointments while the patient is with you, rather than expecting them to arrange these later.
- Offer longer appointments to allow time for building rapport, checking understanding, and supporting decision-making.
- Provide walk-in or same-day options where possible.
- Cluster multiple appointments on the same day to reduce travel burden.

- Use text reminders (where appropriate), printed plans, and simple appointment cards with dates, times, and locations.
- If someone has no phone, agree an alternative method of contact (e.g., hostel staff, day centre, outreach worker).
- With consent, contact hostels or day centres in advance so staff can prompt or accompany the person.
- If someone has a phone, support them to set reminders for medication and appointments or help them use the NHS App.
- Encourage attendance with a trusted person (support worker, outreach staff, peer advocate).

Reduce practical barriers

- Provide bus tickets, travel vouchers, or link with local charities (e.g., Two Saints, Society of St James, Trinity Winchester) or apply for grants that can support transport.
- Where safe, store medications at a hostel or service if the patient cannot manage them independently.

2. Communicate in Clear and Accessible Ways

Adapt communication for cognitive load, acquired brain injury and low literacy

- Write down information in plain English, avoiding jargon.
- Use bite-sized information, one step at a time.
- Use visual aids or pictures where available.
- Check understanding frequently ("Tell me in your own words what you've understood").
- Allow extra time for decision-making and processing.

Build trust

- Acknowledge previous negative experiences and avoid assumptions (e.g. around substance use).
- Maintain a non-judgemental, calm, and consistent approach.
- Offer choices wherever possible to support autonomy.

3. Strengthen Multi-Agency Working and Information Sharing

Ask patients about the support services they are involved with, and request permission to contact, involve, and share relevant information with those professionals or teams.

Proactive collaboration

Where available, engage early with:

- **Right by You Wessex** (For people in Southampton (SO14-SO19 only)).
  Right By You - Cancer Matters Wessex | Email: RBYteam@uhs.nhs.uk
  Telephone: 07585 625461 (messages can be left out of hours)
- **Homeless Healthcare Teams *e.g. Southampton Homeless Healthcare Team***
  Homeless Healthcare Team :: Hampshire and Isle of Wight NHS Foundation Trust

Email: diana.hogsflesh@nhs.net (general enquires, no identifiable info)
Telephone: 0300 123 3991

- **Street outreach teams e.*g. The Society of St James***
  Tackling Homelessness in Southampton
  Email: admin@ssj.org.uk | Telephone: 023 80 634596
  e.g. Two Saints Day Centre (Southampton)
  Southampton - Two Saints | Telephone: 02380 223443
- **Drug and alcohol services *e.g. Inclusion Recovery Hampshire***
  Telephone: 0300 124 0103
  Contact us - Inclusion Hants
  e.g. Change Grow Live (Southampton)
  Email: southampton@cgl.org.uk
  Telephone: 023 80 717171
  Change Grow Live Southampton - drug and alcohol support service
- **Day centres *e.g. The Booth Centre***
  Phone: 02380 330797 The Booth Centre, Southampton Lifehouse | The Salvation Army
- **Local authority homelessness teams *e.g. Southampton City Council***
  Phone: 023 8083 2327 Out of hours: 023 8023 3344
  Email: homelessness@southampton.gov.uk | Homelessness advice and housing options
- **Talking Therapies *e.g. Talking Therapies Hampshire***
  Telephone: 023 80 383920 | Email: hiowh.tth@nhs.net
  Hampshire :: Hampshire and Isle of Wight NHS Foundation Trust
  e.g. Steps2Wellbeing Dorset
  Steps 2 Wellbeing | Telephone: 0800 484 0500
  Email: dhc.s2w.rural.admin@nhs.net
- **Community Mental Health Teams (CMHT)**
  e.g. Hampshire CMHT
  Community Mental Health Services (Adults) :: Hampshire and Isle of Wight NHS Foundation Trust
  e.g. Dorset CMHT
  Community mental health (adults) :: Dorset HealthCare University NHS Foundation Trust
- **Crisis Support**
  e.g. Access Mental Health Dorset
  Access Mental Health - supporting you in a crisis :: Dorset HealthCare University NHS Foundation Trust
  e.g. Help in a Crisis Hampshire
  Help in a crisis :: Hampshire and Isle of Wight NHS Foundation Trust
- **Voluntary sector partners**
  e.g. CLEAR
  Southampton-based charity providing information, guidance and learning support for local refugees, people seeking asylum and their families.
  Telephone: 023 8022 1111 | Email: info@clearproject.org.uk

e.g. Lantern Trust

Weymouth-based charity providing crisis intervention, emotional and practical support, and a single point of contact to help people facing homelessness, hardship or complex life challenges.

Telephone: 01305 787940 | Email: info@lanterntrust.org.uk

Contact – Lantern Trust

**Please note that the above contact information is correct as of May 2026. We recommend you use the website link to check before making contact.*

Information sharing: legal, consent, safeguarding

- Always seek consent to share information with other professionals or services.
- Explain clearly what will be shared, with whom, and why.
- If consent is refused but there are safeguarding concerns, follow local safeguarding procedures and share information on a 'need to know' basis in line with the Care Act and Caldicott Principles.
- Document consent discussions and decisions.
- Use secure communication routes (NHS email, approved systems).
- Share:
    - Key risks (e.g. red-flag symptoms)
    - Escalation pathways
    - Appointment schedules
    - Treatment plans
    - Known barriers to engagement
- Consider joint MDT discussions between oncology teams, homeless services, mental health, and substance use teams to coordinate care.

Warm handovers

For referrals:

- Contact the receiving service while the patient is with you to ensure a safe handover.
- Provide a clear summary of the person's circumstances, risks, and required adjustments.
- Clarify who holds responsibility for follow-up and ongoing contact.
- Ensure the patient understands what will happen next.

4. Create a Joint, Person-Centred Care Plan

A shared care plan should consider:

- Literacy level and communication needs
- Substance use or substitution therapy prescription regimes
- Acquired brain injury considerations
- Medication management plan
- Appointment schedule
- Named contacts across services and phone numbers
- Out-of-hours and crisis instructions (including acute oncology risks and escalation processes)

- Preferred and available methods of contact
- Any reasonable adjustments required

Provide the patient with a copy, and (with consent) share with:

- GP
- CNS/oncology team
- Acute Oncology Service
- Outreach team
- Hostel/housing provider
- Mental health or addictions worker

Crisis information

Create a wallet-sized card containing:

- Acute Oncology Service number
- Emergency Department location
- Red-flag symptoms
- Key contacts

This supports both the patient and any professionals who may encounter them in crisis. See appendix for an example template.

5. Promote Engagement and Continuity of Care

- Inform outreach teams of different investigation, treatment and follow-up stages so they can check in and support attendance.
- Share red-flag symptom lists with relevant teams so they know when to escalate.
- Ensure all community-based staff have access to a 24-hour acute oncology number.
- Encourage consistent follow-up and relational continuity wherever possible.

6. Address Social Determinants of Health

- Consider the impact of housing instability, trauma, substance use, and mental health on engagement.
- Support individuals to navigate fragmented systems, including benefits, housing, and social care.
- Advocate for reasonable adjustments and flexible pathways within mainstream services.

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Authorship

Amanda Cummings

With special thanks to Beth Hawkins, Pam Campbell and the Right by You Wessex team.

Appendix

Template wallet sized card for crisis information

EMERGENCY CARD

Acute Oncology Service (AOS) Telephone Number:

_____(24hr Helpline)

Emergency Department:

_____

Seek urgent help if you experience:

• Fever or infection • Uncontrolled pain
• New/worsening breathlessness • Sudden confusion •
Bleeding/bruising • Severe vomiting/diarrhoea
• Chest pain • Rapid swelling (legs/face)
• Other: _____

Key Contacts:

• Cancer Nurse Specialist (CNS)

Name _____

Tel _____

• GP Practice

Tel _____

• Other Useful Contacts

_____

_____

* Always carry this card with you *