Fulfilling the Promise of Prevention: The Role of General Practice in Homeless and Inclusion Health

One of a series of Pathway Policy Papers to inform the next decade of healthcare

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About the author

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She has spent time working with the charity Doctors of the World both in the UK and abroad, providing healthcare to refugees and developing tools to help improve access to GP surgeries for excluded populations.

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Foreword

We are at a turning point in the long and proud history of our National Health Service. Described as ‘broken’ by the Secretary of State, there is a clear choice in how the Government restores when developing its 10-year Plan. This choice is between the continued, widespread exclusion of people facing severe deprivation from care, or rebuilding the NHS inclusively, slanting effort and resources towards those people in inclusion health groups, whose needs are among the most complex and severe in our country.

Pathway is publishing these policy papers to inform this choice. Drawing on the expertise of some of our Pathway Fellows and Faculty members, as well as our colleagues with lived experience, we offer to shine a light on what is possible and to offer thoughts and actionable ideas for change. We invite Ministers to take these ideas and the problems they are designed to solve into account when shaping the 10-year Plan.

The challenges described in the papers echo those seen every day by our Pathway hospital teams. Patients who could have received help earlier only receiving it at crisis point, wasting human potential and precious resources. The desperate challenges people face accessing help for combined mental health and substance use problem. The failure of our housing system to provide safe places to recover from illness and to stay well.

It is not like this everywhere, however, and it does not have to be like this forever. The papers point to evidence of what works in health and care services to meet the needs of people in inclusion health groups, as well as beacons of good practice around the country. Together, they show how choices could be made within the NHS to reverse the inverse care law, tilting time and resource towards those who need it most. Prevention is a strong theme throughout, showing how people's problems can and should be addressed before they spiral out of control.

The benefits of action go far beyond health - meeting people’s health needs unlocks other gains, addressing underlying risks of homelessness in particular, enabling people to live well and for longer, as the Government wants to see us all do.

I am very grateful to our Pathway Fellows and other experts who have made time, often in the midst of busy clinical and frontline jobs, to share their thoughts and expertise in these papers. Britain led the world with the establishment of the NHS more than 70 years ago. As we write the next chapter of its history, let’s make care and compassion for those who need them most central to its mission.

Alex Bax, CEO, Pathway

Summary

- General practice can play a critical role in addressing extreme health inequalities and preventing poor outcomes for people in inclusion health groups.

- There is significant evidence on effective practice in general practice and inclusion health, including in the NICE guideline. However, despite pockets of good practice, system change to make this a widespread reality has not taken place. The system of GP funding in particular mitigates against the flexible and holistic approach and longer appointment time patients need in general practice.

- This results in persistently poor health outcomes, with people frequently presenting in need of urgent and unplanned care[1]. It also contributes to high-frequency encounters, missed appointments, and unmanaged health conditions that drive economic inactivity and early mortality.

- Universal general practice services need to be made more accessible to people in inclusion health groups, while specialist practices have an important role in play in places where population levels demand it. New neighbourhood hubs could collocate much needed services to provide holistic care for inclusion health populations.

- In its 10-year Plan, the Government should maximise the preventative potential of general practice for inclusion health groups. Using a PHM approach to proactively identify those most at risk and target access and interventions could support overburdened practices to prioritise access for inclusion health patients. Steps should include reviewing the core GP contract, QoF and other GP incentive and monitoring mechanisms to ensure funding and resource is unlocked to allow practices to do the holistic, complex work required with this population.

What is inclusion health?

Inclusion health is a growing field of research, activism, clinical practice, and care devoted to improving health and social outcomes for the most excluded groups in society. Although much early impetus focussed on improving health services for people experiencing homelessness, over the last 15 years the concept of inclusion health has expanded to cover a range of groups where extreme social and economic exclusion creates extreme health risks and health harms.

The degree of risk and harm observed in inclusion health groups falls far below even the depressing ‘normal’ range of health inequalities in British society. Disease prevalence rates can be up to 50 times higher than in the general population and mortality gaps between inclusion health groups and the average can be 30 or 40 years. Inclusion health groups can be defined by this observed extreme distance from the general population in terms of health status.

People in inclusion health groups include people experiencing homelessness, Gypsy, Roma and Traveller people, people engaged in sex work, vulnerable migrants and people in contact with the Criminal Justice System. There is a strong body of evidence of what works to improve health and care for these groups: NICE published guidance on homelessness in 2022 and NHS England produced a national inclusion health framework in 2023, but there is an ‘implementation gap’. The good practice evidence is available but all too often that evidence is ignored or only followed spasmodically.

Introduction

General Practice is at a critical juncture, struggling under the weight of funding shortages, staffing crises, and mounting patient demand. The inverse care law remains prevalent, with areas in greatest need receiving the least resource. For socially excluded populations, also known as inclusion health groups, already significant barriers to accessing care are exacerbated.

Despite the NHS's long-standing commitment to universal access through a “registration for all” policy, people in inclusion health groups frequently face registration refusals, preventing access to primary care[2]. Additionally, widespread adoption of total triage and more remote and digital consulting in general practice have created new barriers and worsened existing ones for this population[3]. This poor access to primary care results in persistently poor health outcomes, with people frequently presenting in extremis in need of urgent and unplanned care. These barriers also contribute to high-frequency encounters, missed appointments, and unmanaged health conditions that drive economic inactivity and early mortality.

Addressing the systemic issues such as stigma and discrimination people in inclusion health groups face are even lower priority than previously. General practice lacks the capacity to provide trauma-informed approaches, further alienating individuals with histories of adverse childhood experiences (ACEs). Holistic support, providing continuity of care to manage socially complex multimorbid patients who require complex and compassionate multidisciplinary team (MDT) support, can be effectively provided in specialist services, but is regularly lacking. Provision of specialist services is patchy and often driven by compassionate individuals, rather than embedded in systematic coordinated care driven by coordinated inclusion health needs assessments.

These challenges ultimately result in more costly, less effective care for both the patient and the NHS. Resolving the challenges in primary care for people in inclusion health could be critical to achieving two of the Government’s three ‘shifts’ for this population – from hospital to community, and from sickness to prevention and instrumental in achieving the Government’s ambitions to transform the NHS more widely.

The Darzi Review outlines reforms essential to ensuring that general practice remains the cornerstone of the NHS, calling for a shift toward preventative care, better integration, and population health management (PHM). The review emphasises proactive identification of those at risk, better MDT support, and a shift from reactive to preventative care, all of which are essential for improving outcomes for people in inclusion health groups. These reforms thus have the potential to improve care for the most medically and socially complex, and costly populations. Indeed, many successful specialist inclusion health services already

embrace these principles and can be seen to be in the vanguard of these reforms. By designing general practice with inclusion health needs in mind, the healthcare system can not only address extreme health inequalities but better address complex, socially determined health needs for all, and work effectively toward an equitable, sustainable transformation.

Policy Background

Recent policy developments in health inequalities, inclusion health and primary care have focused on providing guidance on what good looks like, but have not matched this with system change or financial incentives to make a reality of this on the ground.

Core20PLUS and the Inclusion Health Framework

The NHS England Inclusion Health Framework provides essential guidance on addressing the health needs of inclusion health groups. The strategy for Healthcare Inequalities birthed the Core20PLUS definition of at-risk populations. Clearly defining that inclusion health groups fall within the PLUS category has helped places to consider a PHM approach to identifying those most at risk across systems. However, both policies lack a structured link to commissioning decisions or resource allocation. As a result, proactive efforts to address inclusion health needs are often limited by a lack of capacity and resources in general practice, or driven forward only by passionate individuals.

NICE Guidance

The adoption of NICE guidance for integrating health and social care for people experiencing homelessness was a positive step toward standardising care for inclusion health populations. There is now a collection of evidence based best practice articulated in the language of general practice to draw from to meet inclusion health patients' needs. Actionable recommendations for general practice include:

- Improving access: This focuses on universal registration for all, flexible appointments, including longer appointments if required, prioritising continuity of care, and using a PHM approach to be proactive in identifying those in most need.
- Embedding a trauma informed approach: This includes making general practices psychologically informed environments and addressing holistic needs and social

determinants along with medical needs in a person-centred approach, as well as collocating services to address these needs.

- Specialist and outreach services: This highlights the need for integrated MDTs to ensure comprehensive support in flexible low threshold settings.
- Despite the overwhelming evidence of the effectiveness of the approaches listed in the NICE guidance there remains a lack of capacity, resource and accountability for general practice to enact changes to systems to embed these recommendations.

The Fuller Report

The Fuller Report urged integrated care systems (ICSs) to adopt neighbourhood-based models, fostering better collaboration between local authorities and NHS services. The expansion of MDT staff working in general practice with the Additional Roles Reimbursement Scheme (ARRS) has allowed for the implementation of innovative MDT holistic support. What is lacking, however, is a unified approach linked to commissioning decisions and resourcing for frontline clinicians to be able to unlock the resourcing required.

Structural and Incentive Barriers

The structural barriers to providing adequate care for inclusion health groups in general practice are significant, and none of these policy measures over the past 15 years have addressed these. There are no clear mechanisms for either incentivising the embedding of a health inequalities approach or monitoring those responsible to ensure progress is made systematically across the country. Examples of great initiatives have been led by champions fighting against systems that do not incentivise or support the work needed to shift the dial on outcomes for inclusion health populations.

Funding for general practice falls into three key areas: the GP contract, Directed Enhanced Services (DES) and the Quality Outcome Framework (QoF). Increasingly, funding is being directed into PCNs through (DES) payments, which should support a PHM and proactive care approach. The recent GP contract 2024/25 showed promise, placing an emphasis on PCNs tackling health inequalities and prioritising proactive care, however, asking for more from primary care without adequate funding and addressing the existing deficits has rightly been rejected by the profession, leading to the first collective action ever[4]. The QoF incentive structure poses a significant barrier. Although central policies state working with inclusion health groups and addressing health inequalities should be part of core business,

under QoF, now working with more complex/multimorbid patients brings no additional funding and makes practices less likely to achieve full QoF renumeration.

When accounting for the needs of more deprived populations, practices in deprived areas receive up to 7% less funding and care for 10% more patients[5]. Practices in deprived areas are more likely to serve patients in inclusion health groups, and those who face risk factors for becoming socially excluded, thereby carrying a high demand for complex multimorbid care. Without funding to match need, providing capacity to deliver the aspirations of the inclusion health framework such as longer flexible appointments, delivering continuity of care in a trauma informed environment and enquiring about social determinants will remain a fantasy.

A recent study[6] of outcomes for people experiencing homelessness and where they access their primary care confirmed that mainstream primary care practices were less able to meet inclusion health patient needs, providing fewer appointments, less continuity and achieving worse outcomes than specialist services[7]. There needs to be a radical rethink in how the incentive structure could support this work, and how the commissioning of specialist services for inclusion health groups is coordinated around population health based strategic needs assessments, monitored and enforced.

Solutions

Despite these barriers, several innovative approaches have demonstrated that improving outcomes for inclusion health patients is possible through innovative commissioning, partnering with the charitable sector and integrated working. These examples should be scaled up and supported by structural changes to general practice and commissioning.

Specialist Provision and Integrated Care

Specialised contracts, such as enhanced services and inclusion health clinics either as stand-alone or embedded within mainstream practices, help to meet the complex needs of patients in inclusion health groups, while partnerships with charities and community outreach programs complement these efforts.

Arch Healthcare CIC[8] and other providers have shown that it is possible to embed inclusion health practitioners providing MDT support within primary care. This can enable holistic approaches addressing physical health, mental health and addiction services all within the primary care setting, and has been shown to improve health outcomes.

Successful partnerships with charities, such as Groundswell's Homeless Health Peer Advocacy Scheme, have shown improved engagement and health outcomes. Another example is the Safe Surgeries initiative by Doctors of the World improving registration rates of inclusion health groups.

Integrating interventions addressing the social determinants of health, such as debt and welfare advice, embedded within general practice in the Citizens Advice on Prescription Liverpool[9] and the Bromley by Bow Model[10] have been shown to be effective. There are also opportunities to remove barriers for true integration across housing and health and social care to ensure that there are clear accountability mechanisms, and commitment from all to effectively integrate services such as in the Marmot Places[11].

Population Health Management and Proactive Identification

Some areas have adopted a population health approach, proactively identifying inclusion health patients and innovating new ways of service provision. Focused Care[12] has scaled up across Greater Manchester and works to identify specific cohorts of patients in inclusion health groups for whom care as usual in mainstream primary care is not meeting their needs. They proactively allocate workers proportionate to need direct to primary care. These workers then provide holistic, household-based support to address complex social and medical issues together, with great outcomes.

At system level, a formalised PHM approach to identifying the needs of deprived and inclusion health populations is needed. This requires national definitions of vulnerability taking into account both medical and social needs, linked to clinical coding and a formalised approach for how to identify at risk populations (see the paper on data and coding in this series by Sam Dorney-Smith). Once there is a formalised definition of who is vulnerable within the system there can then be the opportunity for commissioning decisions to be linked to this and identification of where additional resource is needed.

Some places have attempted to help mainstream practices to be more permeable to inclusion health patients through central flagging in triage systems, coupled with allowing the task shifting of non-complex cases away from GPs into digital first pathways and allowing proactive identification and flow of complex cases to GPs who are specialists in providing complex medical and social support[13]. However, there needs to be a fundamental shift in the GP contract to explicitly state that it is the duty of primary care services to cover inclusion health populations and that PCNs/ICBs must show how they are addressing the needs of their patients in inclusion health groups, which is then monitored. If the system of financial

incentives for general practice remains, then there needs to be an unlocking of funding that adequately supports those working in areas of high deprivation and therefore need, that appropriately compensates the complexity of work needed to meet the needs of people in inclusion health groups.

Capacity Building and Prioritising Prevention

Prioritising prevention work streams, giving capacity to mainstream practices to do the work of identifying those at risk of homelessness and other crisis points and collocating support mechanisms to avert crisis, has been attempted in places like Bromley-by-Bow. However, there is a lack of widespread adoption of this approach and funds are taken from budgets such as charities with unsustainable grant funding. Incentivised ring-fenced funding to allow for effective MDT working, collocating support through care navigators, debt, welfare and housing advisors and also the complex MDT support such as specialist dual diagnosis drug and alcohol and mental health workers, would be more effective. There could then also be ambitions to develop neighbourhood hubs where complex patients are prioritised for diagnostics, MDT assessments and treatment plans with holistic support.

Supporting Workforce Development

The Deep End Model of primary care implemented initially in Scotland has spread across the UK, providing much needed peer support, training and development for GPs working in areas of high deprivation, and improving recruitment and retention.

What is needed to move beyond peer-based support networks is the formalised professionalisation and support of GPs and Allied Healthcare Professionals working in deprived areas and inclusion health services. The development of skills training focusing on trauma-informed care, addiction management and mental health through GPs with special interests roles and GP training in deprivation medicine[14] would support the Government's ambitions to retain staff in more deprived areas.

Recommendations

The Government needs to prioritise systemic change that embeds inclusion health within all levels of primary care and public health services, creating long-term sustainability and addressing the complex needs of these patients. For people in inclusion health groups, who

bear disproportionate medical complexity and poor social determinants of health, better access to and experience of primary care is a critical first step towards better health. Making a reality of the shift from sickness to prevention and from hospital to the community is particularly important for this group of patients, given their intensive use of acute services. General practice is central to these efforts. Tangible steps in the 10 year NHS Plan to achieve these aims should be as follows.

Short Term

The Government should take urgent steps to provide General Practice with the support to provide appropriate care for complex multi-morbid populations.

Steps include:

- Address the morale, funding, capacity and staffing issues in general practice with a focus on addressing the inverse care law and delivering funding to match the medical and social need of patients.
- The core GP contract, QoF and other GP incentive and monitoring mechanisms need to be reviewed to ensure funding and resource is unlocked to allow practices to do the holistic, complex work with this population and deliver continuity of care, including longer appointments under flexible appointment systems. This will also serve older, frailer complex multimorbid populations.
- There needs to be an urgent revision of the Carr-Hill formula and a drive for support for practices in areas of deprivation to retain those staff who are burned out otherwise the Government will fall short on its ambitions to reduce health inequalities.
- Embedding effective accountability and monitoring mechanisms that can evaluate and support general practice to embed evidenced based change for inclusion health groups, linking to incentives and resourcing being released as part of the review of GP funding structures.

Government and NHS England need to work with ICBs to drive the proactive identification of people who are most at risk medically and socially using population health management, allowing General Practice to prioritise them for care.

This approach will allow for cost effective management in primary care, reducing the burden on secondary care, and allow this to occur within existing staffing and funding constraints alongside planned expansions for schemes such as digital first self-management and

pharmacy first for those who do not need more intensive support. This approach can then inform commissioning of specialist provision where needed most and mobilise resource where needed to support for mainstream primary care.

Steps include:

- The development of nationally agreed definitions of those who are more complex/vulnerable and in need of GP and MDT support without arbitrary age cut-offs.
- Support for General Practice to proactively identify those at rising risk of becoming more medically complex, and proactive approaches to prevent escalation addressing the social determinants of health. This could be in the form of complex care MDT neighbourhood hubs providing community-based diagnostics, care and specialist provision responsive to the local population's needs - a "one stop shop" model. In an area with a high proportion of inclusion health patients this would need to include specialist services where addiction services, mental health support, housing and welfare advice is collocated with general practice.

Medium Term

The Government should drive a focus on prevention, supporting general practice to identify people and families at escalating risk and support them to make changes before crisis points.

Steps include:

- Funding allied support workers who can work with families to address the social determinants making them ill.
- Prioritising the prevention, detection and treatment of ACEs that prevent the life course accumulation moving towards inclusion health.

The Government and NHS England should make sure more GPs want to work and stay working in deprived communities.

Steps include:

- Looking to Deep End and deprivation medicine training and professionalisation of the specialism of inclusion health to support recruitment and retention of GPs and AHPs.

Long Term

Support the development of thriving healthy communities.

Steps include:

- In line with the Government's ambitions for poverty reduction, and pushing a societal shift towards supporting community cohesion, we know that investing in healthy supported communities, giving every child the best start in life, will stem the flow of inclusion health patients into the system.
- Providing adequate housing throughout childhood, early prevention treatment services for mental health, and adopting a family-based approach integrating health, social care and education.

Lived Experience Perspective

Joanne Kennedy, Lived Experience Programme Volunteer, Pathway

Introduction

My name is Joanne and I'm writing this from the perspective of a person with lived experience of homelessness and chronic health issues including chronic obstructive pulmonary disorder (COPD) and mental health challenges. I have found the need for a trauma informed approach to holistic healthcare. This must be underpinned by compassion, understanding and continuity of care delivered by those who generally care about my wellbeing.

I found myself caught in a cycle of registration refusals and the absence of identification which they say is a requirement. The lack of understanding from professionals who often viewed me through the lens of stigma and discrimination left me feeling invisible and voiceless.

Getting help with my ID and other documents and having a healthcare mentor to get you through it would have been really helpful for me. Not everyone gets this – only if you live in certain areas.

My own challenging conditions, particularly my COPD, led to frequent, urgent and unplanned care – like ambulances. My mental health deteriorated as I felt increasingly isolated. This compounded my feelings of anxiety and depression. If I'd had an intervention earlier, I wouldn't have been in those situations. I have felt like I've been passed from pillar to post, like a tennis ball at times. Although I felt overwhelmed, I was able to get myself an advocate. Other people may not be able to do that.

I am now giving something back to what I took out of the system to make a better experience for others.

Solutions

- A trauma informed approach is essential to address these issues. A holistic approach is vital – for me, it's a healthcare environment that prioritises safety, trust and empowerment so that I deal with things.
- The NICE guidelines must be adhered to. The effectiveness of health and local authorities to work together will identify gaps in services and address specific needs.
- Charities such as Pathway and Groundswell show improved outcomes when those with Lived Experience can be involved in improving healthcare.
- One-stop shops, you don't need to travel to lots of appointments, especially if you have no money.
- Embedding mental health and addiction services within practices. It's everyone's business to get people well.

Recommendations

- Government needs to support GPs to provide appropriate care for those most at risk and provide more funding to enable everyone to do this.
- A focus on prevention and identifying people and families at escalating risk and supporting them to make changes before it reaches crisis point.
- Look after our GPs, less workload, and more GPs to provide for people in deprived communities. The good doctors leave because they're bogged down, and patients feel mistrust because they have to start again.
- Investing in healthy communities and giving every child a good start in life.

- Recognise frailty – if someone is in their 30s, homeless and using drugs or alcohol with mental health or other underlying health conditions, they will be frail – recognise this and give them all the other things they will need.

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