"Helping or Harming?" The Homeless & Inclusion Health Barometer 2025

By Theo Jackson & Dee O'Connell

Pathway Homeless & Inclusion Health
Crisis Together we will end homelessness
Specsavers

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Pathway
Homeless & Inclusion Health

Crisis
Together we will end homelessness

About the Homeless and Inclusion Health Barometer

Pathway and Crisis' 'Homeless and Inclusion Health Barometer' series brings together original and existing evidence to provide an independent account of the state of homeless and inclusion health in England. The series considers key issues such as access to and experience of health services, workforce development, health outcomes and the wider social determinants of health.

About Pathway and Crisis

Crisis is the national charity for people facing homelessness. We help people directly out of homelessness and campaign for the social changes needed to solve it altogether. We know that together, we can end homelessness.

Pathway is the UK's leading homeless and inclusion health charity. We exist to improve the health of people experiencing homelessness and other forms of severe social exclusion. Pathway's Partnership Programme supports NHS organisations to scope, commission and create local Pathway teams to improve outcomes for inpatients facing homelessness.

Crisis and Pathway entered into a formal partnership in 2021 to increase our efforts to tackle the health inequalities that affect people who are facing homelessness. We recognise that poor health is both a cause and a consequence of homelessness, and we aim to harness our combined research, clinical and campaigning abilities to bring about significant change to this picture.

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Foreword

In his report into the state of the NHS last September, Lord Darzi, quoting last year's Barometer report, described homelessness as a 'health catastrophe.'

As we wait for the new government to set out in more detail its long term plans for the NHS, for housing, and cross-government homelessness strategy, we believe improving the health of the most excluded members of our society should be a core priority. There is a huge opportunity to lay the right foundations now and get things right for people in our society who are too often forgotten and left behind.

Through our work supporting people experiencing homelessness and other inclusion health groups, Pathway and Crisis see first-hand that the people who need the most help are often the least likely to get it. This report shows that, time and time again, our public services miss opportunities to provide the support that people desperately need, and to intervene before they reach crisis point. Unsafe practices such as discharges from hospitals to the street are still all too common and the lack of safe and secure accommodation remains a foundational obstacle to reducing extreme health inequalities.

Despite these challenges, this report also shows that improvements are happening, and that there is at least a growing awareness of challenges of inclusion health at a system level. Fundamentally, these improvements are realised and pushed forward by the hard work, dedication and compassion of the thousands of staff across our health, housing and care systems who are committed to helping those facing the most extreme forms of exclusion. People will always be at the center of how we create a better society and ensuring that staff have the support, training and resources they need to continue creating change is essential.

Contributions to this year's report from people with lived experience of homelessness and other forms of social exclusion again emphasise the importance of compassion, care and basic humanity in supporting people to turn their lives around. We recognise the incredible pressures our health and housing services are under, but the importance of creating more empathetic and caring cultures within our public services cannot be overstated.

For the government to realise its stated goals - shifting care to the community and investing more in prevention - for people facing social exclusion, we need to see sustained investment in the provision of specialist inclusion health hospital, primary care and step-down services, along with reforms to make mainstream services more accessible and welcoming. These improvements in care must happen alongside a step-change in the provision of safe, good quality, genuinely affordable homes. Building the 90,000 social rented homes per year that we need will make a huge contribution to the population's health.

Collectively we know how to deliver safer, more effective and compassionate services. If we want to get things right for people in our society with the most complex health and social needs then we need bold, concerted leadership from Government, setting clear, common objectives, aligning funding, breaking down barriers between services and supporting front-line staff. And getting this right for the most vulnerable will bring huge gains to us all.

Alex Bax
Chief Executive of Pathway

Matt Downie
Chief Executive of Crisis

Key terms and glossary

Acute care	Short–term treatment, usually in a hospital, for patients with any kind of illness or injury.
Care navigators	Trained professionals whose role is to actively listen, to signpost people to sources of help, advocacy and support, and to help people play an active role in managing their own health.
Changing Futures Programme	a 4-year, £77 million programme aiming to improve outcomes for adults experiencing multiple disadvantage – including combinations of homelessness, substance misuse, mental health issues, domestic abuse and contact with the criminal justice system.
Community health-care	Community health services cover a wide range of services and provide care for people from birth to the end of their life. Community health teams play a vital role in supporting people with complex health and care needs to live independently in their own home for as long as possible. Services also include health promotion services such as school health services and health visiting services
Core20PLUS5	Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.
Digital exclusion	Where a section of the population have continuing unequal access and capacity to use Information and Communications Technologies (ICT) that are essential to fully participate in society
Dual diagnosis	When a person has both a substance use disorder (alcohol or drugs) and a mental health condition.
Emergency Care Dataset (ECDS)	The Emergency Care Data Set (ECDS) collects information about why people attend emergency departments and the treatment they receive to: improve patient care through better and more consistent information. allow better planning of healthcare services.
Health and Care Act 2022	The Act reformed the NHS to promote integration between health and social care services, giving more power to local systems. It also introduces measures for better workforce planning, patient safety, and regulation of social care providers.
Housing First	A homelessness intervention strategy, aimed at people with multiple and complex needs, particularly rough sleepers. It provides access to permanent housing as a starting point to help tackle their non-housing needs as well.
Intermediate care	Intermediate care provides rehabilitation, support and care for individuals who have been in hospital and require additional support before they can return home.
Mental Health Data Set (MHDS)	The Mental Health Services Data Set (MHSDS) collects data from the health records of individual children, young people and adults who are in contact with mental health services.
NHS Inclusion Health Framework	This framework focuses on the role that the NHS plays in improving healthcare and how partnerships across sectors, such as housing and the voluntary and community sector, play a key role in addressing wider determinants of health.
National Institute of Care Excellence (NICE) Guideline	NICE guidelines are evidence-based recommendations for health and care in England and Wales. They help health and social care professionals to prevent ill health, promote good health and improve the quality of care and services.
No Recourse to Public Funds	Applies to people who are subject to immigration control and as a result of this have no entitlement to certain welfare benefits, homelessness assistance and an allocation of social housing through the council register.
Pathway Teams	Pathway Teams are clinically led, multi-disciplinary Teams that provide holistic support for patients experiencing homelessness and other vulnerable groups within acute and mental health hospital settings.
Peer Advocates	Peer Advocates will support people to either speak for themselves or if requested will speak on their behalf. Peer advocates promote the right to being informed, choice, peer support, choice and self-determination.
Preventative healthcare	Preventive health encompasses a set of health services meant to screen and possibly identify health issues before symptoms develop.
Primary Care	Usually a patient's first point of contact and includes general practice, community pharmacies, dentistry and eyecare.

Quality Outcomes Framework (QoF)	The Quality and Outcomes Framework is a system for the performance management and payment of general practitioners in the National Health Service in England, Wales, Scotland and Northern Ireland.
Rough Sleeper Initiative (RSI)	The Rough Sleeping Initiative is a package of measures, including a pot of funding allocated by the government to tackle rough sleeping. It exists to provide targeted support for frontline services who work directly with people who are sleeping on the streets.
Secondary Care	Planned or elective hospital care, urgent and emergency care including A&E, mental health care.
Self-neglect	A form of safeguarding risk when a person is unable, or unwilling, to care for their own essential needs. It can cover a wide range of behaviour including neglecting personal hygiene, health or surroundings, refusal of necessary support and obsessive hoarding.
Specialist inclusion health service	Covers a range of services such as specialist general practices, mental health teams, hospital-based teams and substance misuse services. Typically multi-disciplinary in nature, and with specific knowledge and training around providing care for people in inclusion health groups.
Step-down	Intermediate care services for people following discharges from hospital.
Trauma-informed care	Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development.
Integrated Care System (ICS)	Local partnerships which bring together partners, such as the NHS, local authorities, and the voluntary sector to plan and deliver joined-up care based on local needs.
Integrated Care Board (ICB)	A statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
Urgent & Emergency Care	Includes A&E, ambulances and urgent treatment centres.
Voluntary, Community and Social Enterprise (VCSE)	Organisations that operate for social benefit rather than profit, including charities, nonprofits, and community groups.

Executive Summary

Introduction

This report is the second in Pathway and Crisis' 'Homeless and Inclusion Health Barometer' series, which brings together original and existing evidence to provide an account of the state of homeless and inclusion health in England. The series considers key issues such as access to and experience of health services, workforce development, health outcomes and the wider social determinants of health.

'Inclusion health groups' include people facing homelessness, people engaged in sex work, migrants in vulnerable circumstances, people from Gypsy, Roma and Traveller communities, and those in contact with the criminal justice system. People from these backgrounds often share experiences of housing precarity, including homelessness, trauma and deep social exclusion. They are also defined by sharing some of the worst health outcomes in our country, and their access to healthcare is also among the worst. The pattern of poor access, experience and outcomes experienced by people in these groups stands in direct contravention of the founding spirit of the NHS and the NHS Constitution.

We are currently facing a homelessness crisis, with an estimated 4,667 people rough sleeping on a single night in autumn 2024 (a 91% increase from 2021)[1], and 126,040 households living in temporary accommodation between July and September 2024, the highest number recorded for this period[2]. However, with a new government in place, this report comes at a time of opportunity, following fourteen years of policy decisions and inaction that have driven these rising figures. Drastic improvements are needed in the NHS and Social Care systems, along with significant investment in social housing, Housing First and other forms of specialist and supported accommodation. With Lord Darzi's review of the NHS reinforcing that 'homelessness is a health catastrophe'[3], the NHS 10-Year Plan on the horizon and a proposed cross-governmental strategy on ending homelessness imminent, the time for action is now.

About this report

This report draws upon the views of 180 staff working across the health, housing, social care and third sector, collected through our annual survey of The Faculty for Homeless and Inclusion Health, a national membership body for people working to support people in inclusion health groups.

Overall, 44% of our survey respondents were working in specialist homeless/inclusion health services, 17% in third sector organisations, 17% in mainstream health services and 11% in Local Authority services. We received responses from across England, with London (29%), South East (17%) and Yorkshire & The Humber (11%) being the most common.

The report also draws upon the perspectives of members of Pathway's Lived Experience Programme – people with lived experience of homelessness and other forms of social exclusion. Two focus group sessions were held to reflect on the survey results and wider policy context, the outputs of which are presented in commentary boxes throughout the report.

This report was produced with support from Specsavers as part of their commitment to supporting people experiencing homelessness to access healthcare. As such, this year's survey included several questions focusing on vision and hearing care in inclusion health to support Specsavers's work.

Key findings

The Labour government's proposed 'shifts' for the NHS (from analogue to digital, hospitals to community, sickness to prevention) can benefit people in inclusion health groups but run the risk of further excluding them if their specific needs and circumstances are not considered.

While the Government has not yet fleshed out these shifts with concrete policy proposals, survey respondents felt positively about the possible impact of s**hifting care from hospitals to the community (57% thought this would have a positive impact for inclusion health groups)** and **shifting from sickness to prevention (68% positive** impact). As poor access to primary, community and preventative health services, along with inadequate hospital discharges, are fundamental to the poor health outcomes and overreliance on urgent and emergency care that are typical for people in inclusion health groups, improving care in these areas has long been central to the inclusion health agenda (as outlined in the NICE Guidelines NG214)[2]. While these shifts represent a significant opportunity to get things right for people who have been historically excluded from services and society, survey respondents cautioned that unless existing barriers to primary and community services are removed, and hospital care and discharges are significantly improved, these shifts will be hard to realise for people in inclusion health groups (see Chapter 4).

Contrastingly, **61% of survey respondents felt that the shift from an analogue to a more digital NHS would have a negative impact on people in inclusion health groups,** as it runs the risk of deepening the digital exclusion that many people in these groups already face, further preventing them from accessing vital services. However, the potential improvements in information sharing between services that this shift could realise would be extremely beneficial for often-transient inclusion health populations and could possibly minimise the re-traumatisation associated with repeatedly sharing difficult personal information with services.

> **"Unless there is specific provision for and focus on the above shifts being tailored to include inclusion health groups then these groups are likely to be largely unaffected or could be negatively impacted"**
>
> *Nurse, Specialist GP Practice, London*

The growing awareness and reach of the inclusion health agenda is driving some improvements in service delivery, integration, education, commissioning and data. However, further reform is still needed, along with significant improvements in the availability of housing and other forms of accommodation.

Faculty members reported that the NHS inclusion health framework[3] has helped to raise awareness of the inclusion health agenda within Integrated Care Systems (ICSs), and health inequalities funding provided through Core20Plus5[4] has been useful in some areas for improving integration and specialist service commissioning. Survey respondents reported seeing improvements in **collaborative working between health, housing and social care (46% saw some improvement), Lived Experience input into service design and delivery (44%), trauma-informed care (40%), local ICS inclusion health strategy (39%)** and the **availability and use of data for inclusion health (37%)** in their local areas, all central aspects of the NICE Guidelines 214[2].

Despite these positive signs, **40% of survey respondents felt that health outcomes for people in inclusion health groups would worsen over the next three years, 32% that they would stay the same** and just **20% that they would improve.** Ongoing pressure on the NHS, issues around adequate funding for services and integration and the ongoing housing crisis were highlighted as central barriers to improvement.

Because of the often complex and overlapping care and support needs that people in inclusion health groups experience, improvements in the availability of basic housing must be accompanied by improved provision of specialist and supported types of accommodation (such as Housing First and care homes for younger people). Respondents were clear that, without improved access to adequate housing, preventing and treating health conditions is extremely challenging.

> **"As a hospital team, time and time again we see people admitted with preventable conditions that permanent housing would solve. We are also very concerned about how many people are now coming to A&E for solely housing concerns as they cannot approach housing in a timely manner."**
>
> *Social Worker, Specialist Inclusion Health Hospital Team, London*

> **"Preventative healthcare becomes a higher priority when someone has a stable base to work from. Housing needs to be seen as prevention."**
>
> *Doctor, Specialist GP Practice, North West*

A lack of safety and missed opportunities for intervention are causing harm to people in inclusion health groups and driving avoidable future pressures on the health system. Hospital discharges, support for people with a dual diagnosis of mental health and addictions, and access to primary care and general practice are all areas where improvement is crucially needed.

Following the NHS definition of patient safety as ***"the avoidance of unintended or unexpected harm to people during the provision of healthcare"*** [5], **60% of survey respondents felt that the health system was unsafe for people in inclusion health groups,** and just **11% felt that it was safe**, with a range of examples of unsafe practices provided (see Chapter 1.4). Unsafe practice was also identified as common across other statutory services (safeguarding, Social Care, housing), with the inability of Local Authority housing teams to provide basic accommodation being highlighted as particularly unsafe.

Lived Experiences contributors detailed how, despite being somewhere you are supposed to receive care and support, a lack of understanding, poor communication, and a lack of respect can all make healthcare settings feel extremely unsafe. Failing to make people feel safe when accessing services is a missed opportunity to engage them and provide much-needed support.

> **"As well as being actively harmful to people, it [a lack of safety] also makes people stop trusting and engaging with the health, housing and care system."**
>
> *Lived Experience group member*

These unsafe practices represent missed opportunities to provide the care and support that people in inclusion health groups severely need - overall, 92% of survey respondents felt that missed opportunities to provide safe and effective care causes avoidable harm to people in inclusion health groups, and 89% felt that the same missed opportunities cause avoidable future pressures on health services.

The poor access to primary care and general practice that people in inclusion health groups typically face is a missed opportunity to provide secondary and tertiary preventative healthcare, which in turn contributes to health deterioration and an overreliance on costly urgent and emergency care. When people are admitted to hospital, poor hospital care and discharges represent missed opportunities to provide support at a crucial transition point, by identifying people at risk and preventing them from being discharged into homelessness – survey respondents said that people in inclusion health groups are commonly **discharged to the street (58% all the time or often), to unsuitable temporary accommodation (71%)** and with

unmet health needs (79%). The inability of the housing system to provide a safe place to recover following hospital admissions is central to the 'revolving door' in and out of secondary care, an expensive and inefficient way of delivering healthcare, on top of the significant human cost.

> **"There are multiple missed opportunities to provide care. If services could flex to take these opportunities, health outcomes would be much improved, crises averted, and money saved."**
>
> *Local Authority Manager, Yorkshire & The Humber*

Despite many positive examples of initiatives to improve the accessibility of health services, access to mainstream NHS services continues to be extremely challenging for people in inclusion health groups.

Survey respondents and members of Pathway's Lived Experience programme identified several effective approaches that have helped to improve access to health services in their local areas, including extra support from care navigators and peer advocates, co-located service hubs, collaborations with local third sector organisations, drop-in clinics with flexible opening hours and joint-working between mainstream and specialist health services (see Chapter 1.1.4). Research presented in Chapter 1.1.4 also shows how Quality Improvement approaches can drive improvements in care through collaboration, knowledge exchange and Lived Experience involvement.

However, mainstream services were again perceived to be very difficult for people in inclusion health groups to access – according to respondents, Urgent and Emergency care is the most accessible, but even here just **31% said that it was easy to access,** with **45% seeing it as difficult or very difficult to access.** Results paint an even more challenging picture for other services, in particular **mental health (92% difficult or very difficult), dentistry (87%)** and **general practice (69%).**

A range of barriers were identified as being common, with poor understanding of peoples' needs (88% said this was a barrier in their local area), stigma and discrimination (86%), digital exclusion (86%) and inflexible appointments (85%) being the most common. As well as these common cross-cutting barriers across all inclusion health groups, survey respondents identified barriers faced by specific groups such as sex workers, Gypsy/Roma/Traveller communities and migrants (see Chapter 1.1.3)

Workforce development across the NHS, Adult Social Care and Local Authority services is a fundamental cross-cutting enabler to drive improvements for people in inclusion health groups. Education, trauma-informed care, staff support and job security are all areas where improvements are severely needed.

With poor understandings of the needs of people in inclusion health groups and stigma highlighted as key barriers, there is a need for improved training and education and the widespread implementation of trauma-informed environments across the health and care system. Lived experience contributors to this report highlighted how a lack of understanding, empathy and compassion from health service staff stands out as a fundamental barrier, pushing people away from services and preventing their needs from being heard and addressed (see Chapter 2.1).

Although **33% of survey respondents reported seeing improvements in training and education relevant to inclusion health over the past year,** and 4**0% reported improvements in trauma-informed care,** there are still clearly large gaps - **less than half (42%) of staff working in mainstream health services felt that they had enough training to effectively support people in inclusion health groups,** along with **63% of those working in specialist services.** Improvements in staff support are essential, as just **42% of all respondents felt that they had enough support and supervision to effectively provide care** for people in inclusion health groups.

> **"Unless stigma [is addressed], and specialist staff support and training is introduced, nothing will change - both staff and patients will be subject to traumatizing systems, procedures and cultures, creating 'moral injury' amongst staff and re-traumatization amongst patients."** -
>
> *Psychotherapist, Specialist GP Practice, London*

Specialist inclusion health services continue to operate under significant pressure, with resources and funding lagging behind rising demand and complexity in an increasingly challenging context. Short-term funding poses a challenge to retaining skilled staff in specialist services.

As the numbers of people experiencing homelessness[1,2,8,9] and migrants being pushed into social exclusion continue to increase, demand on specialist inclusion health services is rising, with **76% of survey respondents who work in such settings reporting rising demand on their service over the past year.** Overall, the level of provision of specialist services remains far below the level of need, with particular gaps reported to exist for specialist mental health and community nursing services (see Chapter 1.2).

Specialist services remain challenged by inadequate, unstable and non-recurrent funding, which drives severe issues in retaining skilled and experienced staff who are pushed to leave by a chronic lack of job security. This is extremely inefficient, as resources are wasted in re-recruitment processes, and knowledge and collaborative working relationships have to be rebuilt. Overall, **just 28% of staff working in specialist services said that their service had secure, long-term funding,** and **just 19% said that they had enough resources and staff** to effectively support people from inclusion health groups.

While specialist services are doubtless essential in meeting the needs of, and improving outcomes for, people in inclusion health groups, the rising demand for these services and the reported increasing complexity of the patients they support (see Chapter 3) means that they cannot do so alone. Effective responses to the needs of people in these groups are dependent on both the improved commissioning and provision of specialist services and significant improvements in access to and support from mainstream services.

> **“There is a big difference between specialist inclusion health services and general services in terms of ease of access and understanding of client group, however I've noticed even specialist services struggling to maintain flexibility when faced with severe pressures.”**
>
> *VCSE worker providing direct care, South East*

Approaches to improve the visibility of inclusion health groups within health data have been proposed – now action is needed

With the **NHS’s Emergency Care Dataset (ECDS)**[i] and **Mental Health Services Dataset (MHSDS)**[ii] both adopting revised and improved sets of housing status fields, there is a way forward to improving the visibility of inclusion health groups in NHS data. Leadership is now needed from central government and NHS England to drive system-wide recording and analysis of housing status fields, to support improved service delivery, commissioning and policy development for inclusion health (see Chapter 3.1).

> **“Homelessness is poorly defined in NHS IT - there are suitable categories in the mental health minimum dataset but they are often not used. If you are not counted, you don't count.”**
>
> *Doctor, National Psychosis Service*

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[i] The Emergency Care Data Set (ECDS) collects information about why people attend emergency departments and the treatment they receive. Available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/emergency-care-data-set-ecds

[ii] The Mental Health Services Data Set (MHSDS) collects data from the health records of individual children, young people and adults who are in contact with mental health services. Available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set

Recommendations

Together, Pathway and Crisis call on the Westminster government, through the NHS 10-year plan, ending homelessness strategy and long-term housing plan, to take action on the following urgent priorities:

1. Improve the quality of care during hospital admissions and ensure that every person experiencing homelessness has a safe place to recover afterwards by funding and implementing a national safe discharge programme

Scale up the provision of cost-effective specialist intermediate care services to meet the level of national need, to ensure that people experiencing homelessness have a safe place to recover and prevent them being avoidably readmitted to hospital.

Ensure that all hospitals seeing over 200 people experiencing homelessness per year establish a multi-disciplinary Pathway team[iii], so that people in inclusion health groups receive holistic and compassionate care whilst in hospital and are provided with effective multi-disciplinary discharge planning.

2. Improve opportunities for prevention by improving access to primary care for people in inclusion health groups

Encourage and incentivise General Practice to provide longer, more flexible appointments and multi-disciplinary care for people in inclusion health groups, through a reformed GP finance incentive system, backed by improved accountability. This will help to create a blueprint for working with other complex, multi-morbid and frail populations.

Establish multi-disciplinary neighbourhood hubs where people in inclusion health groups can access care for physical health, addictions and mental health, along with housing and welfare support where needed.

Require services to carry out impact assessments for digital inclusion and ensure that they retain analogue routes to accessing services for multi-morbid and complex patients.

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iii. Pathway Teams are clinically-led, multi-disciplinary Teams that provide holistic support for patients experiencing homelessness and other vulnerable groups within acute and mental health hospital settings.

3. Drive health and housing integration to achieve better homes and better care for people in inclusion health groups

Provide a single longer-term pooled budget, using learning from similar integrated budgets such as the Better Care Fund, to integrate NHS spend with spend directed to local government, and drive integration across relevant programmes such as those targeted towards rough sleepers.

4. Address the invisibility of people in inclusion groups in NHS data

Drive reform to routinely capture patients' housing status in NHS data. The first step is to fund and implement a national pilot of revised housing status fields within the Emergency Care Data Set and the Mental Health Data Set. The Government, working with NHS England, ICSs and relevant national teams that support the ECDS/MHDS, should promote the use of housing status field at ICS level, supported by an evaluation. This should then inform a national programme which drives the routine recording and analysis of housing status across all NHS care settings.

5. Provide people with the safe and secure housing they need to both recover and improve health outcomes

Strategically align the homelessness strategy with the forthcoming with the forthcoming long-term housing strategy, and NHS plan to include a shared outcome of ending homelessness.

This must include investing in building 90,000 social rented homes a year and ensuring that local delivery meets need, including specific targets for social rented homes, Housing First units and supported housing.

The welfare system must ensure homes are affordable over the short, medium and long term. This requires investment in Local Housing Allowance so it covers at least the 30th percentile rent and exploring the abolition of the Shared Accommodation Rate, as well as household benefit cap and Spare Room Subsidy, both of which make even social homes unaffordable.

6. Develop the NHS workforce for inclusion health

The Government and NHS England, working with the relevant Royal Colleges, should established a national inclusion health workforce programme that is co-produced by people with lived experience- listening to and learning from their perspectives is essential to getting workforce development right for these populations.

The programme should ensure minimum levels of clinical knowledge and cultural competence to support inclusion health populations, widespread adoption of the principles of trauma-informed care and awareness of roles and responsibilities with regards to safeguarding, in particular self-neglect.

7. Drive ICBs' progress and accountability on inclusion health

Set explicit improvement targets for inclusion health through future iterations of the NHS operational planning guidance and NHS 10-Year Plan

Targets could include reducing the rate of self-discharges from hospital by people experiencing homelessness to the 4% seen in the general population, ending discharges from acute and mental health hospitals to homelessness, increasing GP registration rates among people in inclusion health groups, and regular reporting of the size of the mortality gap between inclusion health groups and the general population.

8. Ensure that people experiencing and at risk of homelessness can access support for mental health issues and addictions

Promote early intervention by working with ICBs to ensure the provision of assertive outreach teams, in order to prevent mental health deterioration and prevent those at risk of homelessness from losing their accommodation

Improve support for people with dual diagnosis by ensuring that addictions services are funded and able to assess and treat less complex mental health conditions, and that mental health teams are able to assess substance misuse disorder and deliver brief interventions where necessary.

We also highlight a number of recommendations for ICBs who wish to proactively address the needs of their local inclusion health populations;

Conduct a local inclusion health needs assessment which strongly involves people with lived experience, and develop a local inclusion health strategy to ensure that local service delivery meets the NICE Guidelines NG214.

Assess the extent to which local services deliver care in a trauma-informed way and make improvement plans.

Commission evidence-based specialist inclusion health services, in line with NICE Guidelines, to meet local need in acute, mental health, primary care and community settings.

Conduct audits of all discharges to the street from acute and mental health hospitals, and make improvement plans.

Ensure that locally commissioned specialist inclusion health services can access legal advice services as needed.

Ensure that specialist inclusion health services are commissioned with long-term and stable funding to improve staff retention and service quality.

Improve local inclusion health data by promoting and evaluating the use of existing housing status fields with the Emergency Care Dataset and the Mental Health Services Dataset.

Introduction

About

This report is the second in Pathway and Crisis' 'Homeless and Inclusion Health Barometer' series. The 'Barometer' series provides an independent account of the state of homeless and inclusion health in England, exploring key issues such as access to and experience of health services, patient safety, health outcomes, housing and the wider policy context. The Barometer series draws on a range of sources – original survey data, published research, grey literature and publicly available statistics – with the following aims;

- Synthesise new, existing and emerging evidence into a comprehensive picture to inform and educate policymakers, academics, commissioners, clinicians and others with an interest in this area.
- Annually monitor progress across a number of key domains
- Identify priority areas, challenges and opportunities to improve the health of society's most excluded groups
- Put forward actionable recommendations for different actors at various system levels
- Identify gaps in evidence and research

This year's report was proudly supported by Specsavers, as part of their commitment to helping people experiencing homelessness to access eye and hearing care more easily. People experiencing homelessness face unnecessary barriers to NHS-funded sight tests and glasses, due to administrative obstacles in the national General Ophthalmic Services contract, which can make it even harder to look for accommodation, build up skills, apply for benefits or find a job.

Specsavers drives change by working with charity partners and the wider sector, to influence policy and systems, as well as developing new clinical delivery models to provide eye and hearing care for people experiencing homelessness via their stores. In addition, they use their platform to raise awareness of the broader needs of homeless populations and advocate for improvements in inclusion health.

This edition of the Barometer draws upon the following sources of evidence:

Faculty for Homeless and Inclusion Health survey

The Faculty for Homeless and Inclusion Health is a national membership body for NHS professionals, local authority staff, NHS commissioners, third sector employees, civil servants, system leaders and other professionals involved in the care and support of inclusion health groups[iv]. The annual survey captures the views and perspectives of this group on a range of important inclusion health topics. By tracking responses to certain questions year-on-year, the Barometer series also aims to provide an indicator of whether progress is being made in key areas.

Overall, 44% of survey respondents were working in specialist homeless/inclusion health services, 17% in third sector organisations, 17% in mainstream health services and 11% in Local Authority services. We received responses from across England, with London (29%), South East (17%) and Yorkshire & The Humber (11%) being the most common.

A note on comparison - while this report does compare survey results between years, any differences should be seen as indicators of possible change rather than concrete evidence of year-to-year differences.

Lived Experience Commentary

Involving and listening to the perspectives of people with lived experience of homelessness and other forms of social exclusion is essential to improving health for these groups. This report includes several commentary boxes, co-produced by six members of Pathway's Lived Experience Programme and the report author. Two focus group sessions were held to reflect on the survey design, results and wider policy context, the outputs of which are presented in commentary boxes throughout the report. Two members of the focus groups were also members of the project steering group, giving advice and input into key elements of the project, such as survey design. The authors of this report are extremely grateful for the contributions of all the members of the Pathway's Lived Experience Programme to the production of this report.

New Research

While this report does not include a comprehensive literature review, we highlight several pieces of new research that are of relevance to the primary themes and findings of this report.

[iv] To become a member of the Faculty for Homeless and Inclusion Health, please follow the link here: https://www.pathway.org.uk/the-faculty/support-the-faculty/

Policy Context 2025

Last year's Barometer focused heavily on the policy context of the previous 14 years, and it is clear from this year's findings that the effects of those choices are still rippling across health, housing and social care. The new Government's reforms still exist only in outline, with changes via the NHS 10-Year Plan and cross-Government homelessness strategy on the horizon, but little in the way of detail. Significant and bold policy changes are now needed to drive improvements for inclusion health groups.

Housing policy choices over the past decade and a half continue to drive up homelessness, which manifests in the rising demand our survey respondents have seen in their services this year. The most recent official figures show that the number of households facing homelessness exceeded 320,000 between 2023 and 2024, the highest on record[9]. Across July and September 2024, 126,000 households were living in temporary accommodation, a record high and an increase of 16% on the same period the previous year[2], while 4,667 people were sleeping rough across England on a given night in Autumn 2024, an increase of 20% on the previous year and 91% higher than three years ago[1].

Mounting NHS pressures in recent years continue to make it more challenging for people facing homelessness to access the care they need; mainstream services that are stressed and stretched cannot offer the flexible, trauma-informed care that the evidence shows is effective for people facing homelessness and in other inclusion health groups[2].

As a result, specialist inclusion health services continue to face a rising tide of demand and complexity[9], but the current policy framework, including incentives and accountability arrangements, allows them to be treated by local decision makers as optional extras. This results in a pattern of short-term funding and contracting, with some promising practice in certain ICSs but no sustainable provision of services elsewhere. The previous Government took no steps to address this, reserving sharp incentives to drive change in the NHS for high volume, mainstream political pressures such as elective recovery and A&E waiting times[10]. The hostile immigration environment forms the backdrop to this. The ongoing policy of 'no recourse to public funds', which denies access to certain health services and housing for many migrants, continues to trap thousands in an intractable situation, with no solution to their interwoven health and housing problems. Pathway's first 'Homeless and Inclusion Health Barometer'[9], published last year, pointed to positive policy developments, such as NHS England's first Inclusion Health Policy Framework[3] and the potential of Integrated Care Systems to create joined-up, holistic services that can meet the needs of medically and socially complex people. We know from our work with Integrated Care Systems[11], echoed by this year's survey respondents, that the Framework is helping to raise the profile of healthcare for people facing homelessness and other excluded groups in their systems.

But as our respondents point out, these positive developments do not go far enough in driving the long-term, sustainable reform needed to address the extremely poor health of people facing homelessness and other forms of severe social exclusion. This Government therefore has a major opportunity to achieve this, and the three shifts it has proposed for the NHS, through its 10-Year Plan, are a good starting point. In turn, a focus on inclusion health can and should be part of the solution to make the three shifts a reality, paving the way for solutions and progress for other medically and socially complex groups of patients.

Shifting care from hospital to the community

Shifting care from hospital to the community will be harder to achieve for people facing homelessness and for other inclusion health groups. Their access to care in the community is poor, leading to intensive use of hospital-based services. People experiencing homelessness attend emergency departments six times as often as housed people, are admitted four times as often, and stay on average twice as long[12]. Hospitals will realistically continue to be a significant part of the care the NHS provides to people facing homelessness and other inclusion health groups for the foreseeable future. Making a reality of this shift for people facing homelessness, therefore, relies in part on driving up the quality of their hospital stays, to set people on a trajectory towards better health and connect them to community-based services. Specialist services, such as Pathway teams, can play an integral role in driving improvements in this area.

Providing safe places for people to recover after a hospital admission, to improve health and prevent readmissions, is another key enabler of this shift. The combination of pressures to free up hospital beds, a dearth of suitable accommodation, a policy and legal framework that drives unsafe discharges for people facing homelessness, and a lack of specialist intermediate care beds combine to cause more than 4,200 patients every year to be discharged from hospital to no fixed abode[13]. This leads to further admissions and addressing it through a national programme of cost-effective specialist intermediate care9 will be an important part of shifting care from hospital to the community – currently just 3% of respondents said that there was enough provision to meet demand in their local areas.

Shifting care from analogue to digital

People experiencing homelessness and other inclusion health groups face significant digital exclusion[9], locking them out from tech-enabled health care. Requirements from many mainstream services to book appointments and conduct consultations online limit some people's access, given that many people in inclusion health groups have difficulties with phone and internet access, while there is also a lack of support for people who struggle with digital literacy, such as some people with brain injuries or acquired brain damage. It is essential that we develop policy measures to retain analogue and human contact options for people who need them.

Shifting from sickness to prevention

Fixing people's health problems earlier and ensuring great GP access is a major strategic priority for the Government for the whole population. It must also be at the heart of efforts to get upstream of the significant multi-morbidity that affects people in inclusion health groups, who typically have the worst GP access of all.

This is driven in part by the policy and funding landscape. The structural barriers to providing adequate care for inclusion health groups in general practice are significant. There are no mechanisms that incentivise a health inequalities approach or monitoring to ensure progress is made systematically. Under the Quality Outcomes Framework (QOF), working with more complex patients brings no additional funding and makes practices less likely to achieve full QOF renumeration. Practices in deprived areas, which are more likely to serve people in inclusion health groups, receive up to 7% less funding and care for 10% more patients[14]. Without funding to match need, delivering the aspirations of the inclusion health framework, such as longer, more flexible appointments, delivering continuity of care in a trauma informed environment, and acting on social determinants will remain a fantasy.

Reforming GP funding and incentives through the NHS 10-Year Plan to improve access will not only shift care from sickness to prevention for people experiencing homelessness, but the lessons will show the way for treatment for other multi-morbid and socially complex patients.

Mission-led approach

Beyond the 10-Year Plan, a mission-led approach to Government, and a cross-Government homelessness strategy hold huge promise in resolving the complex, entrenched social and clinical issues that this report describes.

As evidence continues to mount about the link between health and the housing crisis[15], providing the 90,000 social homes a year that England needs must be a priority, along with ensuring that there is coherence between the 10-Year Plan, new homelessness strategy and long-term housing plan.

Reforms to drive integration locally to ensure that joined up, holistic services are sustained are also needed. A good first step would be the creation of a single budget to achieve the outcomes of better homes and better care for people in inclusion health groups, with a view to improving their health and wellbeing, and to reduce health inequality. While the Government has provided a welcome cash injection for homelessness through the Autumn Budget, the longer-term opportunity is for more sustainable, joined-up funding.

The ongoing hostile environment has left too many people with no options for sustainable access to healthcare, so reforming policies around no recourse to public funds will be critical in addressing the needs of a substantial minority of people, particularly in London.

Chapter 1. Delivering integrated and accessible services for inclusion health

Last year, our report highlighted how pressures on the NHS, and a lack of policy action on extreme health inequalities, are creating significant barriers to care for people in inclusion health groups[9]. Services are increasingly unable to support patients with complex needs and in response to limited capacity and resources, people in inclusion health groups are often the first to be excluded. In a challenging context, health services were found to be increasingly unable and unwilling to provide the kind of flexible support that we know is needed.

1.1 Access to mainstream health services

Responses to this year's survey show that mainstream health services continue to be extremely challenging for people in inclusion health groups to access, across the board. As with last year's results, mental health and dentistry were perceived to be the hardest to access, followed by general practice.

This pattern of poor access to primary and community health services is a central driver of the disproportionate use of urgent and emergency care seen amongst people in inclusion health groups, as opportunities for early intervention and preventative healthcare are missed. Perceived improvements in access were not seen for any mainstream service type, while substance misuse services were perceived to be more difficult to access than previously **– 16% said they were easy to access in 2025, compared to 26% in 2024.**

As with last year, a range of barriers were identified as being common, with poor understanding of peoples' needs, stigma and discrimination, digital exclusion and inflexible appointment processes standing out.

Figure 1.1 Ease of access to mainstream health services for people in inclusion health groups

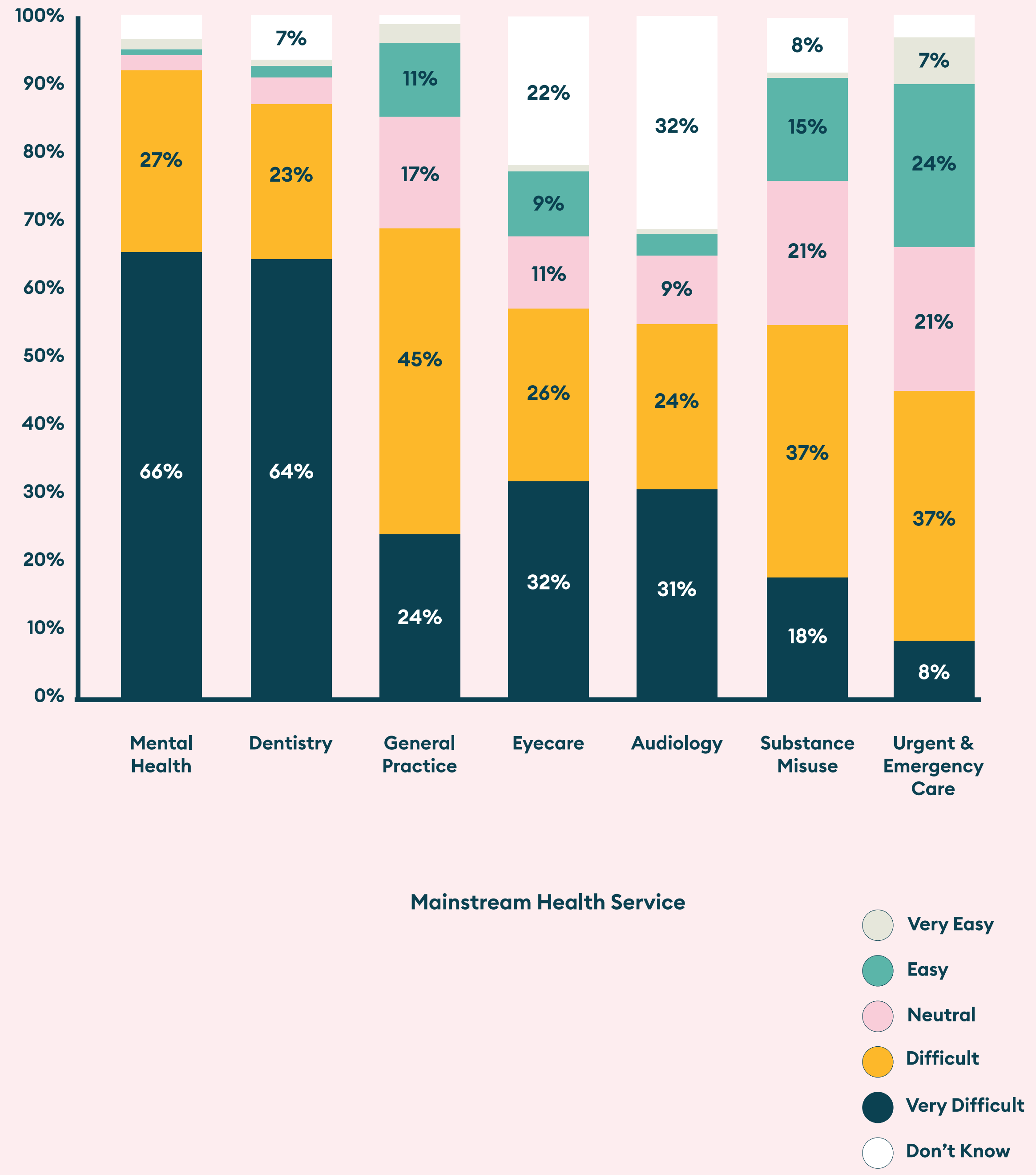
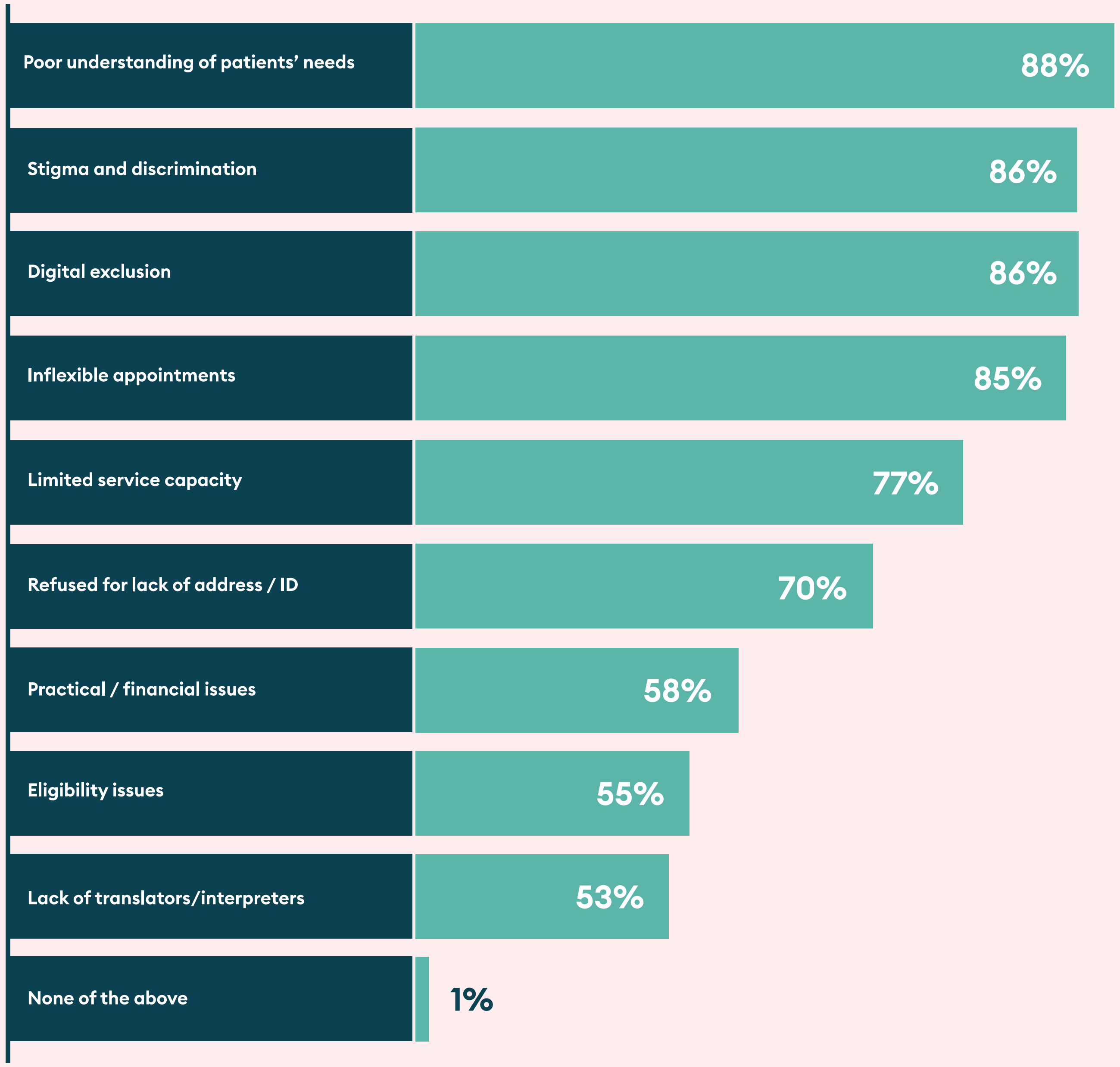


Figure 1.2 Common barriers to accessing mainstream health services for people in inclusion health groups



Members of Pathway's Lived Experience Programme said;

There are so many reasons why services can be hard to access, but the biggest barriers are the lack of empathy and compassion you often get from staff. Having to explain that you are homeless can be very difficult, especially with the lack of privacy in health service settings, and you feel like you need to prove that you are human to get treated with respect and actually supported. First impressions are so important, and if someone is treated badly, they won't want to come back and engage.

The health system can often feel extremely complicated to navigate, and this is especially true for people who face communication barriers, such as people with learning difficulties, neurodiversity, or brain injuries, or whose first language isn't English. There is a lack of extra support to help these people, which means they are not able to properly communicate their needs to professionals and may not properly understand the information and advice they are given.

This can be extremely unsafe and stops people from engaging with services and getting the support they need. Support such as interpreters, peer advocates and care navigators are extremely important to helping people access healthcare – they might seem like small things, but they can make a huge difference.

Digital exclusion is also such a big issue – for some people, it is about not being able to access a phone that has credit, charge or data for the internet. For others, such as some people with learning difficulties, it is about digital literacy and the lack of support and alternative options to communicate with services. Digital processes aren't explained to people.

1.1.1 Access to vision and hearing care

Eyecare and audiology services, which often receive less focus than other services, were included in this year's survey questions on access. Notably, these services received a much higher proportion of 'Don't Know' responses than any other service type, indicating that respondents may have less knowledge and awareness about the pathways to access support for vision and hearing problems. Excluding 'Don't Know' responses, both eyecare **(74% difficult or very difficult)** and audiology **(80% difficult or very difficult)** were perceived to be very challenging to access.

Access to these services was seen to be limited by familiar problems such as poor GP access, issues receiving letters/phone calls about appointments due to a lack of phone or address, stigma from staff and communication challenges such as a lack of interpreters. However, respondents also identified several specific barriers to accessing these services; 'high street' opticians/shops can be intimidating, a lack of awareness amongst patients and staff about legal entitlements to support, issues accessing benefits in order to establish these entitlements to statutory support, a lack of inreach/outreach services focusing on eye and ear care, and a lack of priority given to vision and hearing problems by both staff and patients.

> **"Insufficient NHS drop-in care leads to people needing an address and a working phone with a consistent phone number to access care. Also, it's hard for people to prioritise things like this when in survival mode."**
>
> *Psychologist, Specialist Mental Health Service, Yorkshire & The Humber*

> **"Our NHS contracts for eye care are only available for people on benefits. We need this to change and people experiencing homelessness should have an automatic right to NHS eyecare and glasses. Even people on benefits do not know their entitlement."**
>
> *Optometrist, Vision Care for Homeless People, National Role*

Members of Pathway's Lived Experience Programme said;

Untreated eye problems can make things very difficult when you are experiencing homelessness. It's very easy to lose or break your glasses, you can't afford to buy new ones and there is a two year wait for a new eye test. Not having glasses can make it really hard to do things like reading important letters and can make you feel unsafe. The whole process of getting an appointment for an optician and getting to the appointment can be very challenging. We need more early diagnosis for eye-related health issues for people who are experiencing homelessness, as this isn't often prioritised for people, but can make such a big difference. Support from vision, hearing and dental services are all more neglected when you are homeless.

1.1.2 Stigma and discrimination

In addition to removing the many practical barriers that exist for people in inclusion health groups, survey respondents and Lived Experience contributors felt strongly that reducing stigma and improving the attitudes and understanding of staff towards inclusion health groups is fundamental to improving access across all types of services (explored further in Chapter 2).

> **"Many of these barriers can be overcome with persistence and advocacy, but the stigma, discrimination, and poor understanding of people's needs by healthcare staff are particularly pervasive and remain the most difficult challenges to address."**
>
> *Psychologist, Specialist Mental Health Service, London*

> **"Services do not offer flexible or outreach support and are quick to label clients as "too complex" or "not ready" instead of adapting their ways of working to meet client needs. There is also a lot of ignorance about these clients making "poor lifestyle choices" because services are not trauma-informed and have limited understanding of addiction, alcohol-related brain injury, mental capacity. There is also a lot of discrimination in statutory services; professionals are quick to dismiss these clients as troublesome and deny them appropriate care."**
>
> *VCSE Staff providing direct care, London*

While the attitudes and behavior of staff are certainly a central part of how stigma is expressed and experienced, it is also essential that we understand how stigma and stigmatising behavior can be systematically produced and embedded through policy, commissioning decisions, service design and eligibility criteria. For example, the separated commissioning and delivery of mental health and addictions services may contribute to the stigmatising attitudes towards drug and alcohol use that respondents have identified as present in mental health services (see Chapter 1.4.2). While improving the understanding and attitudes of staff through education and training is no doubt crucial, responses to stigma must also aim to address these systemic elements.

Research overview 1: Social responses to stigma

Andrew Guise, River Újhadbor and Simone Helleren, King's College London, 2025

Stigma and discrimination are recognised as problems that limit services and responses to homelessness and health. The Social Responses to Stigma study aims to understand how stigma is experienced and then explore how this stigma is produced, mediated or challenged by the many systems that people need to engage with. The study then aims to develop new responses that tackle the social complexity of stigma.

Method and approach

The study is using a long-term ethnographic approach in south London. Interviews with people with past or current experience of homelessness, and those who work in services or who manage them, are being combined with observation and documentary analysis. The study is ongoing.

Key findings

The study has generated multiple findings. A foundational finding is that across the sectors and experiences studied, there are very different understandings of stigma. Some people we interviewed, whether working in or using services, understood stigma in a 'flat' way, either seeing the problem as resulting from individuals or as a problem for individuals. Others we interviewed viewed stigma in a 'deep' way: stigma here is understood as a result of inequalities in power and social position.

Implications

Variations in our understanding of stigma are a problem as this limits the potential for collective responses. The issues we describe here are not just a problem of language or definitions. The issues these results relate to are of profoundly different assumptions and worldviews of what stigma is. Currently, the more dominant perspectives in policy responses to stigma are the 'flat' view, that doesn't fully engage with history and inequities. Research and evidence on stigma and health are increasingly focused on how stigma results from social inequalities. The development of services and policy needs to respond more to this 'deep' view of stigma that acknowledges power and inequalities.

The ongoing Social Responses to Stigma study will be exploring how this can be done and developing a local systems response in South London.

1.1.3 Barriers for different inclusion health groups

While the common barriers identified above cut across all inclusion health groups, survey respondents also identified several barriers that are faced by particular groups of people. For those people who have No Recourse to Public funds, there can be significant barriers to accessing services, as detailed in last year's Barometer report[9]; concerns over being charged for NHS services, accessing palliative care services, access to detox, rehab and other substance misuse services and housing provision (e.g. asylum accommodation) which limits ability to access essential health services.

For people whose first language isn't English – which includes many migrants and some people from Gypsy, Roma and Traveller backgrounds – a lack of translating and interpreting services presents a significant challenge to engaging with health services. The communication challenges that this causes can make it difficult for people to fully express their needs and circumstances and can limit their ability to engage with and understand the health system and care processes.

> **"We have seen several issues of individuals being assessed in GP and hospital settings without translators and having key things missed."**
>
> *Nurse, Specialist Inclusion Health Service, London*

Migrants and people from Gypsy, Roma and Traveller backgrounds may also face stigma that is compounded by racist attitudes and stereotypes, and a particular lack of understanding due to their varied and different cultural backgrounds. While a lack of cultural competence amongst healthcare staff does affect all inclusion health groups, it may be particularly acute for people from diverse cultural backgrounds.

> **"Many of the communities I work with (Irish, Irish Traveller & Gypsy Traveller communities) have intersectionalities that cut across most of the barriers; so it's not as easy as removing only one, they compound each other."**
>
> *Partnerships and Safeguarding Lead, North West*

> **"Work with travelling Showpeople has indicated that work pressures; high rates of travel and lack of flexibility over appointment time can create a significant barrier despite higher levels of literacy than are often found amongst IH populations. Roma populations in particular report experiences of being stigmatised, fear of engagement with health care providers"**
>
> *Researcher, National Role*

For people who are sex working, accessing specialist sexual health services (which can provide flexible and drop-in care) can be especially challenging, as the commissioning of such services may not prioritised in the context of limited funding for specialist services. Further, people who are sex working at night can face further barriers in accessing services during normal daytime hours. Respondents highlighted the need to improve out-of-hours outreach services to effectively reach people who are sex working. Stigma towards sex work and people who are sex working is also a significant problem and can prevent people from identifying themselves as such to services for fear of the responses from staff.

> **"Sex workers who work at night struggle to access daytime services. Funding a vehicle to go round out of hours might be a good option, especially for this group."**
>
> *Mental Health Practitioner, Specialist GP Practice, South East*

1.1.4 Improving access

Despite these challenges, respondents provided numerous examples of how to improve access and care for people in inclusion health groups, such as collaborative working between specialist and mainstream services, assertive outreach approaches, offering drop-in services with appointment flexibility, co-located service hubs, support from peer advocates and care navigators and collaborations with local charities. While funding and resourcing remains a central challenge to pushing forwards many of these improvements, it is encouraging to see good practice and innovation taking place in the face of systemic obstacles.

> **"In terms of dental care, we have no NHS dentists taking on adult clients. As a consequence, we have worked with Dentaid to provide 8 clinics a year for referred clients."**
>
> *Addictions Specialist, VCSE Service, North West*

> **"Drop-in appointments and longer appointment times, plus more care-coordinator support for accessing referral appointments, can be really helpful in helping people engage"**
>
> *Public Health Officer, Local Authority, London*

> **"The discharge services in our local hospital manages inclusion health groups really well. They have built close links with our local Specialist GP service and work collaboratively together very well."**
>
> *Doctor, Specialist GP Practice, North West*

Research Overview 2: Improving diabetes care for people experiencing homelessness: a quality improvement project

Samantha Dorney-Smith (2024)

People experiencing homelessness with diabetes have very poor health outcomes. There are numerous barriers to good care – e.g. a lack of access to a fridge to store insulin, cooking facilities, and/or good quality healthy food. Multiple health appointments are needed, and these can be hard to understand and access. As a result, poor control of the condition is common, and people are at a much higher risk of serious complications such as amputations and death.

A Diabetes Specialist Nurse and the Homeless Vulnerable Adults Team (HVAT) in Bolton have been working to improve care since 2020. Their work inspired a 15-month Burdett Trust for Nursing funded project aimed at sharing learning and best practice across the country. Method/approach - The project comprised a literature review, a review of five safeguarding adult reviews, two practitioner and Expert by Experience workshops, a University of Plymouth led practitioner survey, five good practice area visits, and thirteen nurse-led local quality improvement projects. Three expert patients were also interviewed in depth, and two were supported to provide both video and audio content to training materials.

Key insights from the project

Common approaches to successful care were found to be:

- Strong partnerships between diabetes and homeless and inclusion health services
- Outreach from diabetes specialists to homelessness settings
- Robust audits of clinical care
- Training of homeless hostel, day centre and outreach staff
- Proactive use of Continuous Glucose Monitoring (CGM) technology
- Partnership working with eye screening and podiatry services
- Pro-active HBA1c screening
- Personalised safeguarding approaches

There were multiple clinical insights related to e.g. the clinical prevalence and treatment of Type 3 Diabetes, the use of insulin in people with addictions, diabetes related mental health issues like eating disorders and insulin-related suicidality, and how to promote and manage good nutrition when a person is homeless. The outputs of the project including a report, leaflets, guidance and crib sheets can be accessed via the Pathway website . An E Learning has been produced that has already been undertaken by 92 people (launched September 2024).

Implications

This project clearly demonstrated the benefit and power of clinical networks in improving care. Many new outreach initiatives have commenced as a result of the project. The project also showed the clear benefit of specialists actively outreaching to homeless populations, in partnership with inclusion health services. This approach could be easily applied to other areas of care e.g. respiratory care and epilepsy. In an ideal world, NHS funding would support such national quality improvement work, focused on reducing extreme health inequalities.

Research Overview 3:
GP access for inclusion health groups: perspectives and recommendations

Aaminah Verity and Victoria Tzortziou Brown (2024)

People in inclusion health groups typically face multiple barriers to accessing general practice, with post-COVID remote consulting and triage processes potentially creating new challenges for registration and appointment booking. However, there is a lack of evidence exploring how inclusion health populations have been impacted by this transformation.

Method

We undertook a mixed methods study exploring the direct experiences of people from inclusion health groups trying to access GP care in 13 practices in east London. A mystery shopper exercise involving 39 in-person practice visits and 13 phone calls was undertaken. The findings were reflected upon by a multidisciplinary stakeholder group, which identified recommendations for improvements.

Results

Only 31% of the mystery shopper visits (n=8) resulted in registration and the offer of an appointment to see a GP for an urgent problem. None of the mystery shoppers were able to book an appointment over the phone but 10/13 felt that they would be able to register and make an appointment if they followed the receptionist's instructions. Most mystery shoppers felt respected, listened to and understood the information provided to them. Just under half of the practices (46%, n=6) received positive comments on how accessible and supportive their spaces felt.

Implications

The study identified significant barriers to GP access, including confirmation of the lack of ID for registration and new challenges with triage systems. Recommendations included:

Practice-Level

Communication to Patients
Psychologically informed waiting rooms, clear and consistent signage – walk in, triage, easy access interpreters at every stage.

Training for practice staff
Professionalising of receptionists to care navigators, helping people understand the human cost of refused registrations.

Digital inclusion
Devices and free WiFi in waiting rooms, links to local organisations providing digital inclusion support, reviewing online consultation tools to check fit for purpose and easy to navigate

Tailored options to care
Identifying and flagging individual needs, walk-in options available, continuity of care promoted, and providing additional access support through advocates

System Level

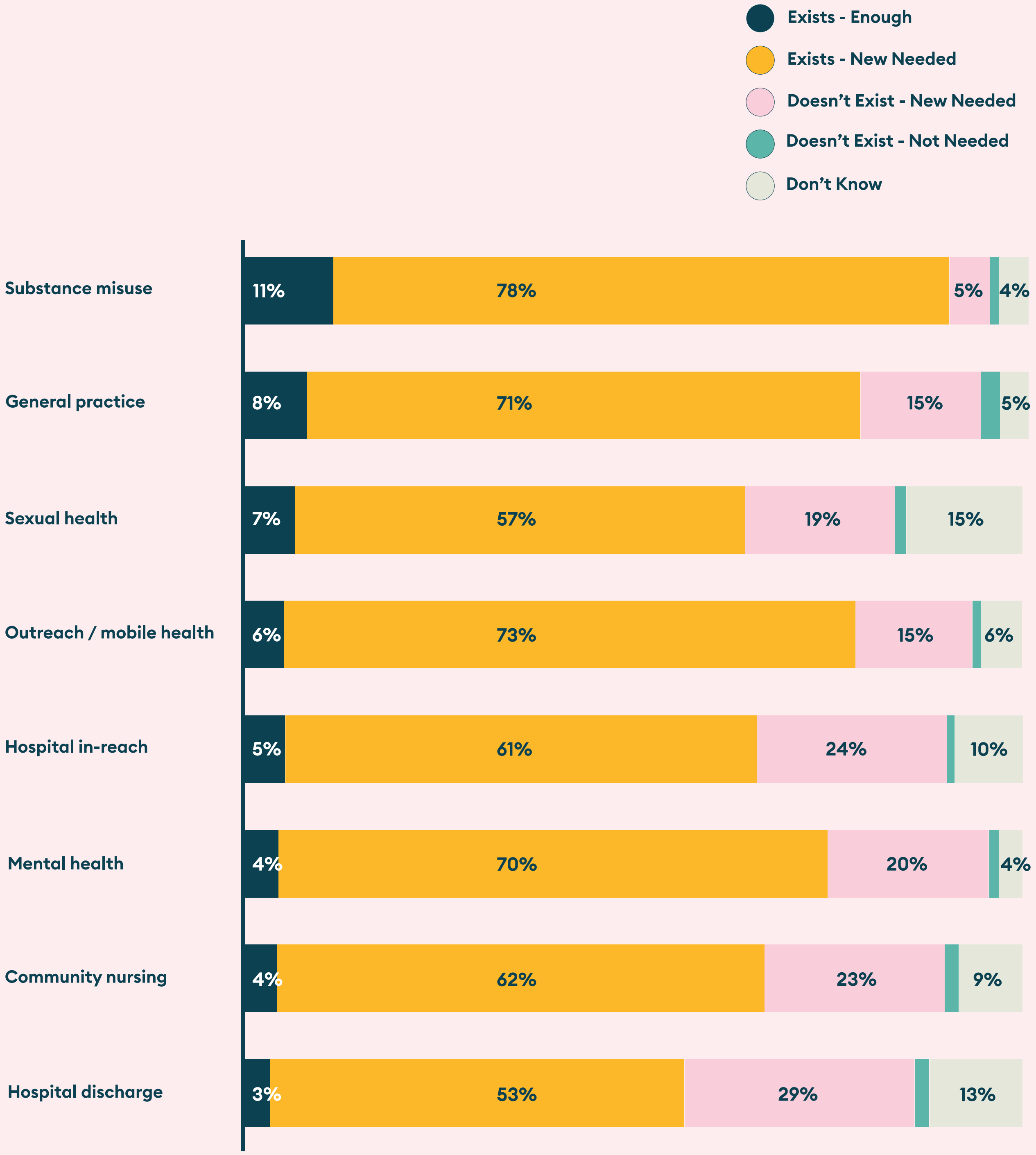
- Developing a centralised online registration tool that does not require proof of address or ID, clarifying the role of general practice and what are appropriate waiting times
- Provide additional resources and funding for practices that are registering and caring for inclusion health patients, nationally defining and coding these groups, and developing quality indicators that promote access and care for people in inclusion health groups
- Improve inclusion health training for practice staff, disseminate resources to practices and provide national training opportunities for trauma-informed care and developing psychologically informed clinical environments.

1.2 Specialist inclusion health services

There is a substantial body of evidence showing the effectiveness and cost-effectiveness of various types of specialist inclusion health services[9]. Despite this, such services continue to operate under extreme pressure, with resources and funding lagging behind rising demand, complexity and an increasingly challenging context.

As with last year, survey responses indicate large gaps between the level of specialist service provision and the level of local need for these services. While the results show that a range of specialist services do exist, **none of the types of specialist service we asked about had more than 11% of respondents saying that there was enough provision to meet demand,** with particularly low levels for **specialist mental health (4% enough)** and **community nursing (4% enough)** services. **Although 26% of respondents did report improvements in local specialist service commissioning over the past year,** this was the lowest of the possible improvements we asked about, and 11% said that it worsened.

Figure 1.3 Perceived level of provision for specialist inclusion health services



For each type of specialist service, a higher percentage of respondents in 2025 said that the service type exists, compared to 2024. However, for each, a lower percentage said that there was enough provision to meet demand. This may be reflective of the rising demand for these services, as levels of homelessness and migration continue to increase; overall, **76% of respondents working in specialist services reported that demand on their service from people in inclusion health groups had increased over the past year.**

> **"I think the point is, it's a postcode lottery that doesn't necessarily relate to need. In London, some boroughs have good provision and some less so. The level of service tends to depend on the amount of commissioning interest, and power of lobbying voices rather than the need per se"**
>
> *Nurse, VCSE Policy/ Research/ Communications, National Role*

> **"I've been quite generous with saying that most of these exist in some way. Some of the above - e.g. sexual health - exists as a single drop-in once a fortnight in a sex workers' organisation. Most of them are slightly more than that but still incredibly inadequate and staffed by people who are desperately trying to provide far more than they have capacity for"**
>
> *Psychologist, Specialist Mental Health Service, Yorkshire & The Humber*

> **"There are pockets of really good practice but we all struggle for sustainable funding and these [funding opportunities] seem to be decreasing instead of increasing as they should."**
>
> *VCSE Inclusion Health Service Trustee, London*

Members of Pathway's Lived Experience Programme said;

Specialist inclusion health services are so important, but there are just not enough of them. They can provide the kind of person-centered, compassionate support that really helps people to engage with their healthcare. Seeing the right people at the right time can be so important for recovery and ultimately, for getting out of homelessness. But specialist services can't do everything – while we do need more of them, we need to make sure that we are also improving things across the whole of the health system.

On top of rising demand, specialist services continue to face a range of systemic and structural challenges, operating in extremely difficult contexts. **Just 28% of specialist service staff said that their service had long-term, stable funding** and **19% said that their service had adequate resources and staff levels to effectively provide care for people in inclusion health groups.** As well as limiting the support that these services can provide, short-term funding and inadequate resources drive inefficiencies by making staff retention very difficult (see Chapter 2).

Just **10% of specialist service staff said that their service** had access to enough legal advice services for patients in need of legal support. Increasingly, staff working in specialist services report needing to use legal advice services to challenge local authority housing decisions, as well as supporting people with No Recourse to Public Funds or uncertain immigration statuses.

> **"There is a big difference between specialist inclusion health services and general services in terms of ease of access and understanding of client group, however I've noticed even specialist services struggling to maintain flexibility when faced with severe pressures."**
>
> *VCSE Worker providing direct care, South East*

> **"We have faced for nearly 5 years lack of funding, lack of support, prejudice, lack of understanding, stigma from management who are far too empowered to make decisions without any consultation with patients and frontline staff. It is a travesty."**
>
> *Doctor, Specialist Inclusion Health Service, South East*

While specialist services will remain essential in improving outcomes for people in inclusion health groups, the rising demand and systemic challenges that they face mean that they cannot do so alone. As people in inclusion health groups continue to struggle to access mainstream health, social care and housing services, their health and support needs continue to increase in complexity (see Chapter 3). As a result, by the time they come to access specialist services, their needs are at a level of complexity that puts huge pressure on these services and makes it very challenging to achieve positive outcomes. The ability of specialist services to achieve positive outcomes is therefore highly dependent on the effective input of other NHS, Adult Social Care, safeguarding and housing services.

> **"Specialist services work well and could do more with greater remit and capacity. They need partners to work with, internal to primary and secondary care, in hospitals and in mental health services. This would provide the organisational drive to deliver services and work in partnership. Investment is needed and would save money for housing and health services by supporting people to keep tenancies, manage their physical and mental health and not reach physical or mental health crisis point."**
>
> *Specialist Inclusion Health Service Manager, Yorkshire & The Humber*

1.3 Integration and collaboration

As well as improving access to mainstream services and the provision of specialist services, strengthening collaborative and integrated working across ICSs is essential to improving outcomes for people in inclusion health groups[4], and is a fundamental feature of the 2022 Health and Care Act[17]. Overall, **46% of respondents reported improvements in integrated working between health, housing, social care and safeguarding over the past year**, with comments highlighting the positive impact of national programmes and funding opportunities such as the Core20Plus5 framework[6], the Changing Futures programme[18] and Rough Sleeper Initiative[19] funding. However, effective integration and improved service delivery was seen to be constrained by limited budgets and the fact that much funding is either non-recurrent or not ring-fenced for inclusion health (or even health inequalities more widely).

> **“The lack of ringfenced Health Inequalities budget within Integrated Care Boards (ICBs) means a lack of opportunity to support innovative practice & improvement projects”**
>
> *Local Authority Service Manager, South East*

> **“CORE20PLUS5 investment has supported some changes but this is not ring-fenced in the future and mainstreamed, and recurrent funding is needed to prevent the end of services which are currently performing excellently in this area. Further investment is needed to improve services more, as CORE20PLUS5 could not fund all of the services which would improve health for inclusion health groups”**
>
> *Public Health, Local Authority, Yorkshire & The Humber*

Effective service integration and delivery for inclusion health is also contingent on ICSs having a clear and defined strategy for inclusion health– **37% of respondents reported improvements in local ICS inclusion health strategy over the past year.** In particular, the NHS inclusion health framework was identified as being useful in pushing inclusion health up the agenda with ICS leadership, although this was not a universal perspective.

> **“I think the Inclusion Health Framework has been useful in raising knowledge of the inclusion health issue at ICS leadership level. There has been some improvement in inclusion health strategy and leadership, and it is moving up the agenda and getting more focus”**
>
> *Nurse, National Inclusion Health Role*

> **“There is no desire for local ICB boards to fund effectively and for the long-term for these vulnerable groups. Where I work, the people with the least knowledge and experience are the decision makers holding the purse strings and they are failing this group of patients at every level.”**
>
> *Doctor, Specialist Inclusion Health Service, South East*

Members of Pathway’s Lived Experience Programme said;

While it is good to see things such as the NHS Framework on Inclusion Health, we need concrete action. We need legislation that makes these changes mandatory, as guidelines and frameworks are too easy to ignore, especially when the health system is under so much pressure. While the big structural changes are really important, there are also lots of small adjustments that can really help people, such as care navigators/advocates, small improvements in communication, and interpreters. There are lots of bottom-up actions that services can be proactive with, as well as bigger structural changes.

1.4 Missed opportunities and a lack of safety

These challenges around service accessibility, specialist service provision and integration – along with the significant pressure that health, care and housing systems are operating under – are causing missed opportunities for intervention and unsafe practices. Overall, **92% of survey respondents agreed that missed opportunities to provide safe, effective and high-quality care are causing harm to patients,** and **89% agreed that these same missed opportunities are causing preventable future pressures on healthcare services.** Later in this chapter, we highlight three important areas of care – hospital admissions, General Practice/ primary care and mental health/addictions services - where missed opportunities to deliver support and preventative care are particularly prevalent.

> **"Every missed opportunity to meet the needs of a patient who already mistrusts health and social care services leads to further alienation from those services and reduces the likelihood that they will seek support when they really need it. This is turn exacerbates health problems and increases pressure on urgent care."**
>
> *Psychologist, Specialist Mental Health Service, London*

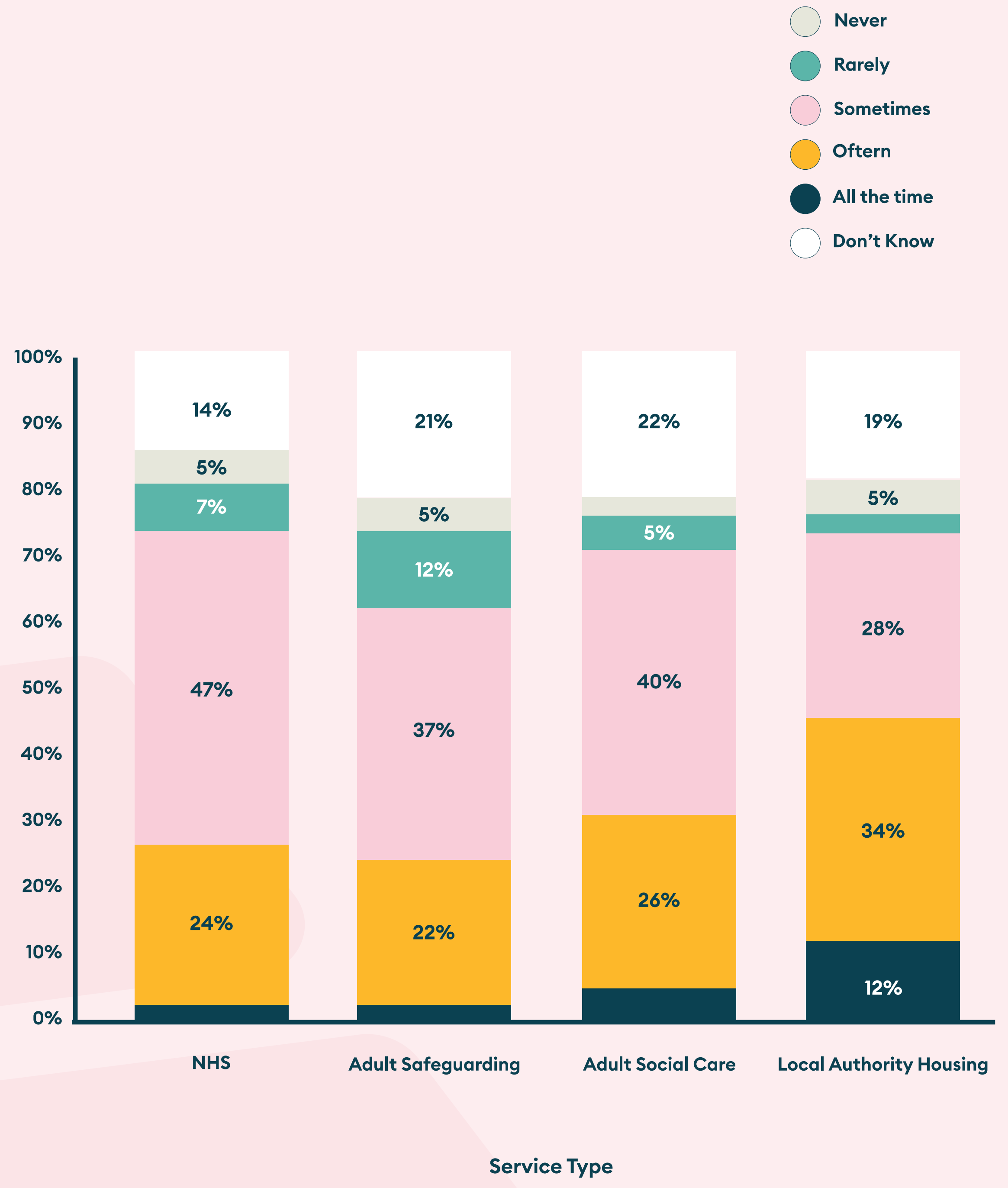
> **"There are multiple missed opportunities to provide care. If services could flex to take these opportunities, health outcomes would be much improved, crises averted and money saved."**
>
> *Local Authority Manager, Yorkshire & The Humber*

As a result of these missed opportunities, healthcare delivery for people in inclusion health groups is characterised by a lack of safety. Following the NHS definition of patient safety as 'the avoidance of unintended or unexpected harm to people during the provision of healthcare'[7], **60% of survey respondents felt that the health system was unsafe for people from inclusion health groups,** and **just 11% felt that it was safe.** While patient safety is a growing concern across the NHS[20], the precarious social situations and vulnerabilities of people in inclusion health groups, combined with their need for support from multiple services, make safety an even more pressing issue here.

> **"Clients are left in limbo between housing, NHS and social services. It feels like this has worsened in the past 12 months as services' budgets are stretched and therefore services just want to pass to another service. It feels like the client at the center is forgotten, especially in the case where they are experiencing homelessness and already have negative experiences with services."**
>
> *VCSE Service Manager, South East*

As shown below, unsafe practices with regards to the care and support of people in inclusion health groups were perceived to happen commonly across health, housing, social care and safeguarding services. In particular, the inability of Local Authority housing teams to provide access to even basic forms of temporary and emergency accommodation was thought to be particularly unsafe, as reflected in the responses below.

Figure 1.4. Perceived frequency of unsafe practice across statutory services



> **“Local authority housing services have become almost completely inaccessible to many groups and even professional advocacy is limited. We've had to engage legal aid support to challenge unlawful practice on almost every occasion we've supported someone to make homeless applications in the past 12 months and, even then, people have been forced to sleep rough and put through retraumatising experiences repeatedly when there is a duty owed”**
>
> *Nurse, Specialist Inclusion Health Service, London*

> **“I think unsafe practice is happening because there is no other choice - put simply, there is not enough housing and radical change is required to ensure that there is more affordable housing available - particularly disability adapted properties. Front-line staff are trying to do their best for inclusion health groups but often don't have any resources to facilitate a solution.”**
>
> *Social Worker, London*

While these missed opportunities and unsafe practices are seen to be present across the whole health, housing and care system, we highlight three key areas where they are particularly prevalent.

Members of Pathway’s Lived Experience Programme said;

There are so many examples where people are treated in a way that isn’t safe – not being able to get accommodation when you are sick, not being able to get support for mental health problems, being turned away from the GP because you don’t have an address, being discharged to the streets. As well as being actively harmful to people, it also makes people stop trusting and engaging with the health, housing and care system.

Despite being a place where you are supposed to be cared for, healthcare settings can often feel very unsafe – not feeling seen and cared for, not feeling understood, and not feeling respected.

A&E in particular feels very unsafe – it is very intense, and little attention is paid to your needs. Good communication is really important and can make people feel safer within the health system – ensuring that adjustments are made to help people communicate is a really important part of improving safety. Trauma-informed principles also help to make the system safer and should be implemented in healthcare settings, social care, safeguarding and housing teams.

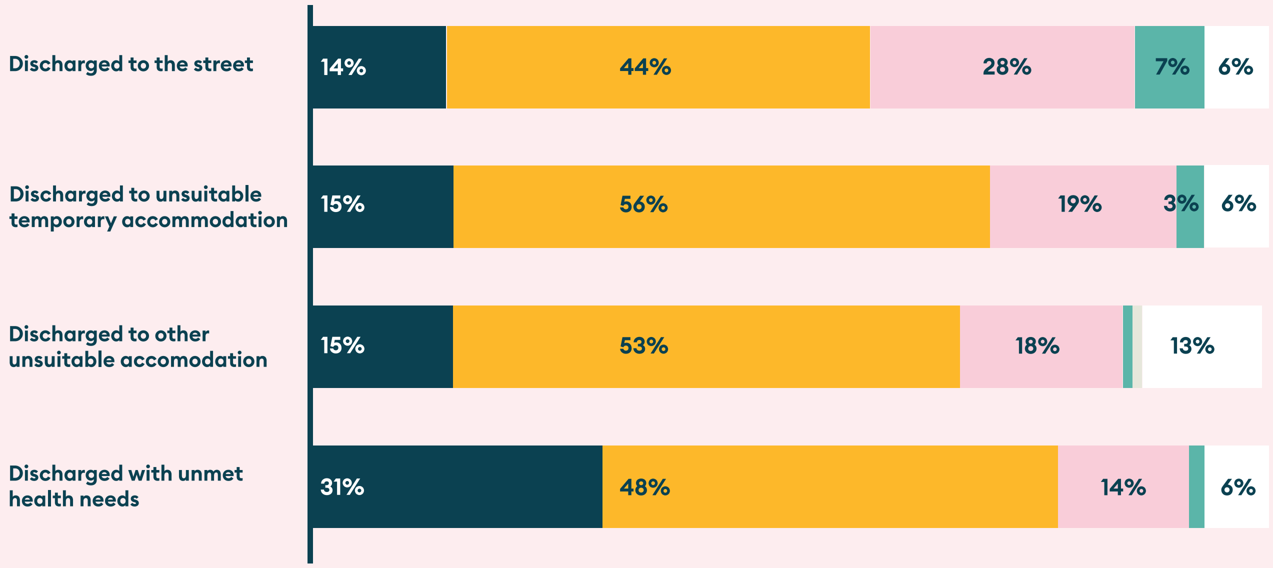
1.4.1 Hospital Discharges

Because of the access issues that people in inclusion health groups face in accessing general practice and primary care, hospital attendances and admissions are an important opportunity to holistically assess their needs and provide health and housing support. However, the possible benefits of these admissions are often undone by poor quality inpatient care, and extremely inadequate discharges in which people are discharged from hospital to locations that are not suitable for recovery - the most extreme example being discharges to the street - and without adequate support from health, safeguarding and social care services. A Freedom of Information request revealed that at least 4200 people were discharged to the street from hospitals in England in 2022/23, although this figure likely underestimates the true number by around half, given that only half of Trusts responded to the request[14].

While the survey responses presented here cannot show the scale of street discharges, **it is notable that a higher proportion of survey respondents felt that they occur ‘all the time’ or ‘often’ in 2025 (58%) than in 2024 (46%).**

Although this does not concretely show that street discharges are becoming more common, it does highlight that they continue to be a significant problem. Responses also show that discharges to unsuitable temporary accommodation and other unsuitable accommodation (such as wet hostels for those with alcohol issues) continue to be common and that patients are frequently discharged with unmet health needs.

Figure 1.5 - Perceived frequency of hospital discharge outcomes for people experiencing homelessness



In addition to being extremely unsafe, causing harm to patients and preventing recovery, inadequate discharges drive pressures on hospitals - **94% of survey respondents said that a lack of appropriate discharge options causes avoidable reattendances and readmissions,** and **86% said that the same factors can cause hospital discharge delays.**

> **“Research I've been involved in suggests the homeless population often experience multiple admissions to hospital and can then be discharged to unsuitable accommodation. A lack of understanding of the needs of the homeless and their circumstances means these people are readmitted a short time afterwards.”**
>
> *University Researcher, North West*

> **“I have seen several instances of delayed discharges due to lack of suitable temporary accommodation. However, there is also concerns around housing questions being asked in A&E and therefore patients being discharged quickly and homeless, without suitable signposting, leading to reattendances.”**
>
> *Nurse, Specialist Substance Misuse Service, London*

Specialist intermediate care provision has an extremely strong body of evidence showing that it improves outcomes for patients, reduces repeated reattendances and readmissions to hospital and generates significant cost-savings across the health and criminal justice systems [21] [22]. However, just **3% of survey respondents said that there is enough provision to meet demand in their local area, lower than the 6% in 2024.**

Because effective hospital discharges often require input from health, housing, social care and safeguarding services, the continued failure of the system to discharge people to a place of safety is indicative of ongoing failures in collaborative and integrated working. In particular, survey respondents have highlighted how a lack of understanding in NHS, safeguarding and adult social care services around the interactions between mental capacity, self-neglect and substance misuse leads to inadequate assessments and offers of support.

> **“Despite a progressive approach to multi-disciplinary team working there is gulf between what is needed and what is assessed as needed by Adults Social Care who are making capacity assessments which do not show insight into the impact of trauma and executive dysfunction amongst the population or consider capability only in the moment and without context from trusted and experienced housing and medical professionals.”**
>
> *Local Authority Manager, South West*

> **“Lack of safeguarding pathways for self-neglect and lack of trained expertise in assessing patients with care needs and mental capacity issues, especially in context of addiction, brain injury, cognitive impairment and non-psychotic mental illness.”**
>
> *Doctor, Specialist Inclusion Health Service, London*

1.4.2. Dual Diagnosis and Mental Health Support

In the context of an overstretched and under-resourced mental health system, people in inclusion health groups continue to face significant issues in accessing mental health support. The issue is particularly pressing for those who also suffer from concurrent addictions issues (dual diagnosis), as mental health services frequently refuse support for these patients. Because poor mental health and substance misuse can both contribute heavily to keeping people stuck in homelessness, the inability of the system to support dual diagnosis patients is a missed opportunity not only to improve their health and wellbeing, but to help end their homelessness. While this issue is far from new, it is still one of the most significant areas where improvement is needed.

> **“People experiencing homelessness face a lack of safety when denied services based on concurrent addictions and mental health issues. Lack of joined-up services also mean patients have to retell stories leading to retraumatisation and burn out/ fatigue and disengagement from support.”**
>
> *University Researcher, North East*

It is notable that, across both years of the survey, respondents’ comments have focused on mental health services when discussing the barriers to care that people with a dual diagnosis face. While access to substance misuse services is still challenging (in particular access to detox and rehabilitation facilities), respondents across both years have perceived mainstream mental health services as being more difficult to access than substance misuse services, and specialist mental health services as having a lower level of provision, relative to demand, than specialist substance misuse services.

> **“Within the London Borough I work in the funding lies particularly with addictions services, although this is fantastic and needed, there is a lack of funding for specialist outreach homeless mental health service.”**
>
> *Nurse, Specialist Inclusion Health Service, London*

Across both years of our survey, respondents have emphasised how stigma towards substance misuse plays a central role in preventing access to support from mental health services. In particular, a failure to appreciate the psychological drivers of substance misuse, despite significant evidence, leaves people unable to access the support they desperately need.

> **“Mental health services in hospital settings predictably say any mental health diagnosis is 'drug-induced' - seeing all substance issues as ‘misuse’, opposed to the client self-medicating to numb their prior trauma which most presentations reveal to us”**
>
> *Addictions Specialist, North West*

> **"It is incredibly frustrating and sad when, for example, we are seeing someone experience a psychosis episode and thus refer them for mental health support, then are told they don't meet criteria or have to focus on their substance use first, to then witness them decline to the point they require inpatient care. Where is the preventative support? People have shared with me that they feel they need to be at complete crisis point, on the edge of a cliff, before anyone will accept that they need help and even then the quality of care is often questionable or lacking."**
>
> *Psychologist, Specialist Substance Misuse Service, London*

Despite multiple guidelines[23] calling for the joined-up commissioning and delivery of these services, recommendations have been poorly implemented: many drug and alcohol services are now run by third sector organisations and are therefore entirely separate from local NHS mental health Trusts, making joining up care even harder.

1.4.3. General Practice and Primary Care

The challenges that inclusion health groups face in accessing primary care and general practice are a missed opportunity to provide essential healthcare in the community, stop peoples' health deteriorating to crisis point, prevent hospital admissions and offer essential preventative healthcare. Numerous pieces of research have outlined the barriers that inclusion health groups face when trying to access general practice and primary care[10]; being refused registration for lack of address/ID, being excluded by digital communication processes, inflexible appointment schedules, stigmatising attitudes and difficulties travelling to services and appointments.

Despite these challenges, there are many examples of research and practice, such as that presented above, which provide a roadmap to improving access to general practice and primary care, as well as strong evidence showing the effectiveness of specialist primary care services[24]. As discussed further in Chapter 4, the new Government's plans plans to shift care out of hospitals into the community, and to shift from sickness to prevention, will only be successful for people in inclusion health groups if access to these services is drastically improved. Developing our understanding of why people struggle to access and engage with these services, such as through the research presented below, is essential to implementing effective interventions and improvements.

Research overview 4: Understanding the causes of missingness in primary care: a realist review

Dr Calum Lindsay et al (2024)

Context

A recent study of more than half a million GP records in Scotland found that people who missed multiple GP appointments were more likely to have multiple long-term health conditions, experience social adversity and were at much greater risk of dying too young. This led us to define missingness as 'the repeated tendency not to take up opportunities for care, such that it has a negative impact on the person and their life chances.'. We wanted to do further research to find out why people experienced missingness and what could be done to address it.

Method/approach

We used a 'realist' approach, which aims to find out 'what works for who and in what circumstances.' This involved pulling together the results from almost 200 papers, interviews with 61 people, and stakeholder workshops with 16 people. Participants included professionals and people with lived experience of missingness from a range of clinical, social and inclusion health contexts.

Key findings

There are lots of possible causes of multiple missed appointments, and they occur at different points in patients' journeys through healthcare, through complex interactions between patients' circumstances and the ways in which services are designed and delivered. Patients may feel that the service is not for them – not needed, not able to improve their health, not appropriate, or unsafe. This may be influenced by past experiences of mistreatment, conflicting understandings of health, poor communication, and offers of care in the NHS that do not 'fit.' Some may experience issues physically getting to appointments because of travel costs and difficulties, poor health impeding mobility, and concerns about safety. Primary care services have specific, inflexible rules for how they are used, making it hard for patients to arrange the right appointment for them. 'Missing' patients may be subject to a host of competing demands with limited resources to manage or meet them, including work, other appointments, caring responsibilities, or urgent and pressing needs or crises caused by precarious circumstances such as experiencing homelessness. Finally, a lifetime's worth of experiences of stigma, hostility, trauma, and difficult relationships with care may act as a deterrent against accessing care

Implications

This work has implications for the whole NHS and for all patients at risk of missingness. By viewing the issue through a 'missingness' lens, and seeking to embed this throughout the NHS, services can better meet the needs of patients with diverse overlapping health and social needs. More detail about the interventions will be available soon.

Chapter 2. Developing the workforce for inclusion health

Workforce development is a central issue facing the whole of the NHS, with staff satisfaction and retention falling and staff levels that are below what is needed to effectively care for the general population[25]. With regards to inclusion health, these challenges sit alongside and are compounded by specific issues with stigma, clinical and cultural understanding and chronic job insecurity.

In this context, it is important not to distinguish too strongly between 'the inclusion health workforce' and the 'general workforce'. While there is no doubt a need for people with specialist skills, knowledge and experience to work in specialist inclusion health services, developing the workforce for inclusion health also means ensuring a minimum level of cultural understanding, trauma-informed approaches, compassionate care, clinical knowledge and staff support, across the whole NHS workforce, along with safeguarding, social care and housing service staff.

> **"Unless stigma [is addressed], and specialist staff support and training is introduced, nothing will change - both staff and patients will be subject to traumatizing systems, procedures and cultures, creating 'moral injury' amongst staff and re-traumatisation amongst patients - nothing will change. All will be swept under the carpet under a sea of administrative language and bureaucratic procedures, mainly computerized and further excluding already multiply excluded vulnerable populations."**
>
> *Psychotherapist, Specialist GP Practice, London*

2.1 Education, understanding, stigma and trauma-informed care

As outlined in Chapter 1, poor understandings of peoples' needs, stigma and a lack of empathy are among the most significant barriers to accessing care for people in inclusion health groups. Survey respondents described how this lack of understanding drives poor care processes and leads to stigmatising attitudes;

> **"Having a poor understanding of patients needs and circumstances seems to me to be the biggest cross cutting barrier to good health for these groups. For example, a failure to understand the social circumstances into which patients are discharged, and the inflexibility of primary care, leads to a revolving door into ED."**
>
> *Sexual Health Specialist, Yorkshire & The Humber*

> **"Poor understanding of needs, poor tolerance and stereotyping leads to poor services, poor listening/ communication, assumptions of issues rather than true understanding and provision of care and interventions. The lack of understanding of the interactions and challenges of homelessness, mental health issues and addiction."**
>
> *Social Worker, East of England*

Members of Pathway's Lived Experience Programme said;

One of the biggest barriers to getting help is the lack of empathy and understanding you often get from healthcare professionals. There is such a lack of understanding about people's circumstances, issues and needs, and healthcare staff often do not understand the full picture of the patient. Even when staff want to be understanding and compassionate, they are under so much stress and pressure that it can be difficult for them. You have to fight to prove that you are human. This makes people not want to engage with services and can also mean that staff don't try to fully assess, understand and meet peoples' needs. We need to make sure that all staff are trained in trauma-informed care, so that they can meet people with understanding, patience and empathy.

While **33% of survey respondents reported seeing improvements in training and education relevant to inclusion health over the past year,** there are still large gaps; **less than half (42%) of staff working in mainstream NHS services felt that they had enough training** to effectively support people in inclusion health groups, compared to **63% of those working in specialist inclusion health services.**

However, an improved understanding and awareness of the issues facing people in inclusion health groups is needed across the whole social sector – adult social care, adult safeguarding and housing services – not just the NHS. As highlighted in Chapter 1, a lack of understanding around the interactions between mental capacity, addictions, brain injury and safeguarding issues is particularly pressing.

> **“Lack of safeguarding pathways for self-neglect and lack of trained expertise in assessing patients with care needs and mental capacity issues, especially in context of addiction, brain injury, cognitive impairment and non-psychotic mental illness.”**
>
> *Doctor, Specialist Inclusion Health Service, London*

> **“I have seen challenges in supporting alcohol dependent patients who are homeless and severely self-neglecting falling through the gaps due to failure [of staff] to spend additional time appropriately assessing capacity. I feel that there is a lack of understanding overall within housing and adult social care services around the complexity of assessing capacity in these individuals.”**
>
> *Nurse, Specialist Substance Misuse Service, London*

Fundamentally, there need to be substantial improvements in trauma-informed care across the health and care system – despite **40% of respondents reporting improvements in trauma-informed care locally,** responses also showed that too many staff and services still fail to appreciate and accommodate the impact of trauma on individuals when providing care and support.

> **“There is also a lot of ignorance about these clients making "poor lifestyle choices" because services are not trauma-informed and have limited understanding of addiction, alcohol-related brain injury, mental capacity. There is also a lot of discrimination in statutory services; professionals are quick to dismiss these clients as troublesome and deny them appropriate care.”**
>
> *VCSE Staff providing direct care, London*

2.2 Staff support, recruitment and retention

Although staff retention is an issue for the NHS workforce in general[26], the issue is particularly pressing for specialist inclusion health services. The systemic challenges that exist when trying to support people from inclusion health groups means that specialist service staff may be more likely to experience burnout, compassion fatigue and moral injury than those working in mainstream services - although these issues are by no means unique to inclusion health service staff. Overall, **less than half (42%) of survey respondents who worked in NHS services agreed that they had enough support and supervision** to effectively provide care for people in inclusion health groups, although this figure was higher amongst s**pecialist service staff (48% agreed) compared to mainstream staff (32% agreed).**

> **“Services which are specialist can be overworked and have high caseloads and lack of experienced workers due to the high pressure of the job picking up on many societal shortfalls, meaning there is little support for employees which can lead to high staff turnover.”**
>
> *Social Worker, NHS Health Service, West Midlands*

Many specialist services also struggle to retain skilled and experienced staff because of the non-recurrent and limited budgets through which these services are typically funded – just **28% of specialist service staff said that their service had secure, long-term funding.** Because of the lack of job security that this causes, staff lose motivation and end up leaving for more secure positions.

The result is that resources are wasted in re-recruitment processes, and a significant amount of knowledge, skills, experience and relationships are lost. Ensuring that specialist services can access long-term and stable funding is essential to ensuring that these services can successfully recruit and retain skilled staff, improving the quality of services and preventing inefficiencies.

> **“Funding has been available for the last few years...but it continues to be non-recurrent which has resulted in vacancies and difficulties recruiting staff and sustainable transformation.”**
>
> *ICB Commissioner, London*

> **“Lack of substantial investment into the patient group impacts any meaningful progress - all short-term contracts. Staff need to feel engaged in trying to support patients and not worrying that they need to find a job every year.”**
>
> *Nurse, Specialist Mental Health Service, South West*

Chapter 3. Evidencing and understanding the characteristics, needs and health outcomes of inclusion health groups

3.1 Improving the visibility of people from inclusion health groups in health data

The difficulty of identifying people from inclusion health groups in routine NHS data continues to frustrate good commissioning, service planning and fair resource allocation for these groups[27][28]. There is widespread inconsistency in the coding and recording of homelessness, migration status, Gypsy/Roma/Traveler ethnicity codes and other key indicators in NHS settings, which could identify people as belonging to inclusion health groups.

> **“Homelessness is poorly defined in NHS IT - there are suitable categories in the mental health minimum dataset, but they are often not used. If you are not counted, you don't count.”**
>
> *Doctor, National Psychosis Service*

At a local, regional and national level, the lack of real-time, good quality and accessible NHS inclusion health data poses significant challenges to; improving care by recording and targeting people at risk of extreme health inequalities, conducting strategic needs assessments at Integrated Care System level, commissioning and designing services to meet the needs of local inclusion health populations, holding systems accountable by setting and monitoring targets for inclusion health, and developing and evaluating policy improvements at a national level.

Members of Pathway’s Lived Experience Programme said;

People in inclusion health groups are too often excluded from society and services, and being invisible within NHS data is yet another example of this. We live in a time where technological improvements have huge potential to improve healthcare delivery and services, but without data improvements, such as better recording of housing status, these technologies will not benefit people in inclusion health groups. Once again, they will be left behind. But as well as improving the technical capacity of data systems and training staff to ask the right questions, healthcare settings need to feel safer and more inclusive, so that people are comfortable disclosing sensitive information, such as their housing status – this depends on services implementing trauma-informed and compassionate approaches.

Despite these challenges, there is a growing recognition of this issue and some movement in a positive direction - overall, **37% of survey respondents reported seeing improvements in the availability and use of data for inclusion health groups in their local area** over the past year, with comments also highlighting the need to understand patient experiences and outcomes through qualitative investigation.

> **“We have some multi-disciplinary team activity - NICE NG214 informed activity, we have better evidence and insight too - we need to strive to influence leaders to deploy budgets towards this population group in a collaborative way, understanding that outcome measures may not be effective measures, but client feedback regarding compassion and care can be.”**
>
> *Local Authority Manager, South West*

An important development is that both the NHS’s Emergency Care Dataset (ECDS) and Mental Health Services Dataset (MHSDS) have implemented revised sets of housing status fields, with corresponding SNOMED codes, which should help to make people from inclusion health groups more visible if used accurately. Because there are questions around data quality and accuracy, Pathway has called for a centrally funded pilot investigation of the use of these housing fields, with the results and learning to be disseminated nationally. These codes are ready for use within any acute hospital or mental health setting, and this is an important area where ICS and ICBs should be proactive and drive best practice and improvement.

3.2 Health Needs and Outcomes

Overall, health outcomes continue to be extremely poor for people in inclusion health groups. As in last year's report, we must highlight that the reported number of deaths of people experiencing homelessness continues to rise annually, reflecting the growing numbers of people falling into homelessness, and the continued failure of the health, housing and social system to effectively support them. While the Office for National Statistics, following pressure from various sources, ultimately decided to continue publishing statistics on deaths of people experiencing homelessness[29], there has not been a release of figures since 2022, and the uncertain commitment to continuing and improving this data is a cause for concern. In this context, projects such as the Dying Homeless Project are essential tools to help us all hold the system to account.

Members of Pathway's Lived Experience Programme said;

Sadly, this report is crucial in understanding the many preventable deaths of people experiencing homelessness. For too long addiction has not been tackled with the same focus as other killer illnesses and people/professionals still see it as a lifestyle choice. In addiction there is no choice, yet it still remains the biggest catalyst for people ending up without a home.

The death of someone who is experiencing homelessness often does not come with the same compassion as is given to those with a home. Friends and family members are not given the same grieving process as others, because of the homeless tag. Those who appallingly struggle in our society pay with their lives, and this is made clear throughout the report.

It is shocking that reports such as this are so needed to hold the system accountable. It brings to the forefront trying to find the person in the statistic – these are people not numbers and we need to remember that.

Research Overview 5: Dying Homeless Project

The Museum of Homelessness (2024)

Method/approach

The Dying Homeless Project aims to document and remember every person who dies whilst homeless in the United Kingdom. The project publishes an annual report presenting our findings from the previous year and shares ongoing attempts to galvanize action to prevent future losses of life.

The project collects information year-round using a mixed methodology. An FOI request is sent to every local authority and relevant housing authority in the UK, which is supplemented by desktop research examining media reports, coronial inquiries, tributes and memorials, and statutory reviews. Employing the same methodology over multiple years means that multi-year comparisons can be made to identify trends confidently.

Key findings

In 2023, the investigation recorded that 1,474 people died whilst homeless in the United Kingdom - one person every six hours. We documented a 12.2% increase in the total number of deaths across the UK compared with 2022, and a 42% increase in the number of people who died whilst rough sleeping compared with 2022.

The increase was highest in Wales. London had the highest number of deaths (309) and the region with the most significant change was Yorkshire and the Humber, with a 93% increase in the number of identified deaths.

Women made up 26% of deaths reported to us, much higher than ONS data (12.7%). Women appear to be more likely to die by suicide and men by accidents, cardiac causes and cancer. Drug and alcohol related deaths (including overdose) make up 37% of all deaths where we know the cause. Overdose deaths have increased by 37%, and cardiac-related deaths by 47%, since 2022.

Implications

The findings about the causes, locations and geographies of homeless deaths tell an important story about the impact of cuts in public spending, hostile immigration and welfare policies and unequal distribution of resources between and across the four nations.

Importantly, the Dying Homeless Project provides crucial insights for inclusion health policy and practice development. Although data on the causes of death is only partial, it is evident that attention should be paid to improving access to cancer screening, frailty pathways, suicide prevention and harm reduction support. It is also clear that inclusion health services and local strategists can play a key role in recording and reviewing and also in contributing to decision-making that champions the discrete needs of inclusion health groups.

Whilst housing precarity is certainly a fundamental cross-cutting issue faced by many people in inclusion health groups, it is important that our efforts to improve our understanding and evidence base also focus on other inclusion health groups such as migrants, Gypsy, Roma and Traveller communities and people who are sex working, alongside people who are experiencing homelessness.

When survey respondents were asked to rate the high-level health outcomes of different inclusion health groups, sex workers and Gypsy, Roma and Traveller groups received a much higher proportion of 'Don't Know' responses – this may indicate that staff are less likely to come into contact with people from these groups, or less able to identify when they are working with people from these groups.

Alongside rating overall health outcomes, survey respondents were asked to describe any changes they had noticed in the needs and characteristics of the people from inclusion health groups they had worked with over the past year. Some of the changes reported were;

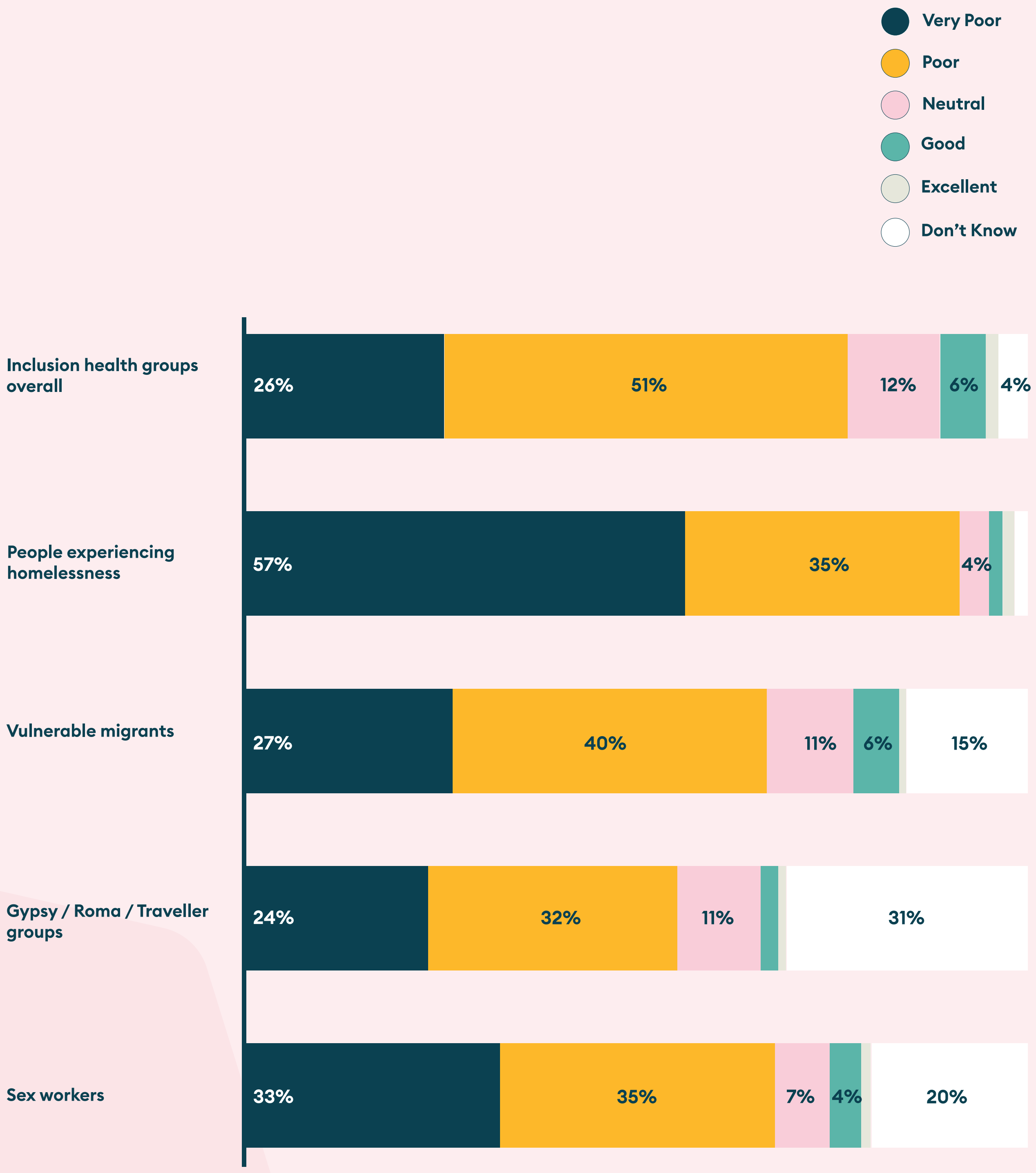
- Increased complexity of care and support needs
- Greater complexity amongst younger people
- Increasing levels of frailty, multiple long-term conditions and mental capacity issues
- More people with autism spectrum disorder, personality disorders, ADHD and other forms of neurodiversity
- More asylum seekers experiencing addictions issues
- Greater use of nitazines, gabapentin, spice and synthetic opioids
- More people presenting with mental health conditions, drug and alcohol use and a dual diagnosis.

Survey respondents' comments around increasing levels of mental health and substance misuse needs are partially supported by data collected by Pathway Partnership teams (multi-disciplinary homelessness hospital teams), which show an increase in the proportion of people with mental health and substance misuse needs from 2022/23 to 2023/24. Of all patients seen by these teams in 2023/24, 62% had substance misuse needs, 60% mental health needs and 38% had a dual diagnosis[30].

As shown in the research presented below, frailty is also a significant and often overlooked issue for people in inclusion health groups. Because the onset of frailty for these people occurs much earlier than in the general population, there are challenges in being eligible for and accessing the appropriate support and accommodation.

> **"It is difficult to get people to appreciate that many of the people we are working with have the same level of frailty (and therefore vulnerability) as people much much older. There would be a huge reluctance to discharge an 85-year-old to the street, but it regularly happens to people experiencing homelessness with the same level of frailty"**
>
> *VCSE Service Manager, London*

Figure 3.1 Perceived health outcomes for people in inclusion health groups



Research overview 6:
Understanding frailty in people experiencing homelessness

Jo Dawes et al. (2025)

Context

People who are frail are more likely to become unwell, take longer to recover from illness or need hospital care. The previously estimated prevalence of frailty in people experiencing homelessness found wide-ranging results (16–55%). However, small sample sizes (n=33–250) and varied methods for measuring frailty potentially affect results. Evidence suggests that frailty levels amongst people experiencing homelessness to be high, but the current picture is unclear. Our research addresses this evidence gap by using a methodologically robust approach to calculate the prevalence of frailty and explore associated sociodemographic characteristics in a large sample of people experiencing homelessness (n=2,288).

Method/approach

Using cross-sectional observational health needs audit data collected in England, we created a Frailty Index (FI) to identify frailty and pre-frailty in the population. Regression analysis illustrates the relationships between frailty and population sociodemographic characteristics.

Key findings

In people experiencing homelessness (majority aged 18–59 years), the prevalence of frailty was 41.5%, however, frailty prevalence is estimated to be just 10.0% amongst the general population aged <65 years, suggesting people experiencing homelessness have a four-fold greater prevalence of frailty than their housed contemporaries. Our study identified frailty in 26.6%, and pre-frailty in 50.1% of people experiencing homelessness aged 18–29 years, suggesting that even young people experiencing homelessness have multiple and cumulative health problems in substantial proportions.

We identified an eight-fold increased risk of frailty in older people experiencing homelessness (50–59 years) compared with younger people experiencing homelessness (18–29-years). Homeless women had double the risk of frailty compared to homeless men. Not being in employment, education or volunteering conferred a three-fold greater risk of frailty compared to those who were working.

Implications

We cannot ignore that in people experiencing homelessness, the prevalence of frailty is high, and onset far younger than in the general population. Many NHS frailty services include a referral criterion of ≥65 years of age, meaning most frail people experiencing homelessness (who are largely younger than this) would be unable to access these services. If addressed early, frailty is reversable, so frailty services must address meeting the needs of this currently underserved population. Exercise and nutrition interventions are well evidenced for improving frailty in older adults- so they must be explored for effectiveness in younger people experiencing homelessness. This study is important because it included people living in various homelessness settings and proactively reached “hidden” homeless (e.g. staying with family/ friends, sofa surfing or unsustainable situations). The new understanding of frailty in people experiencing homelessness that our research provides can steer improvements to fill current gaps in frailty services.

Research overview 7:
Nutrition status of people experiencing homelessness living in temporary accommodation

Hannah Style et al (2025)

Given the rise in food insecurity nationally, it is surmised that people experiencing homelessness are at risk of malnutrition. However, evidence is limited, and diet is often overlooked when providing care for this population, despite being intrinsically linked to different facets of trimorbidity. This study examined dietary health inequalities faced by people experiencing homelessness in temporary accommodation (TA) across London. The research sought to understand the prevalence of nutritional risks and complications for this population and to develop actionable recommendations for diverse stakeholders to address these challenges. The research was funded by the British Dietetic Association and conducted in partnership between University College London and FEAST .

Method

18 TAs were visited across seven London boroughs, and 40-minute interviews with 200 residents were conducted, utilising standardised questionnaires, equipment and screening tools to assess prevalence and severity of:

- Malnutrition by using the Malnutrition Universal Screening Tool, BioImpedence Scales, and Handgrip Strength (HGS)
- Food insecurity by using the Household Food Security Survey
- Dietary quality and nutrient intake by using the Short Form Food Frequency Questionnaire and the single-pass 24 hour dietary recall

Key Findings

Malnutrition was prevalent amongst 60% of the participants and was predominantly disease-related, being predicted by age, mental illness and food security. 19% of participants had low HGS, comparable with that of frail 89-year-olds. Over 50% of participants reported low to very-low food security, which is concerning given that 44% participants were in catered TA. Participants had low dietary quality, with low energy, protein, fibre, fruit and vegetable, vitamin and mineral intakes, and disproportionately high sugar intakes. Overall, nutritional status of people experiencing homelessness living in temporary accommodation was poor.

Implications:

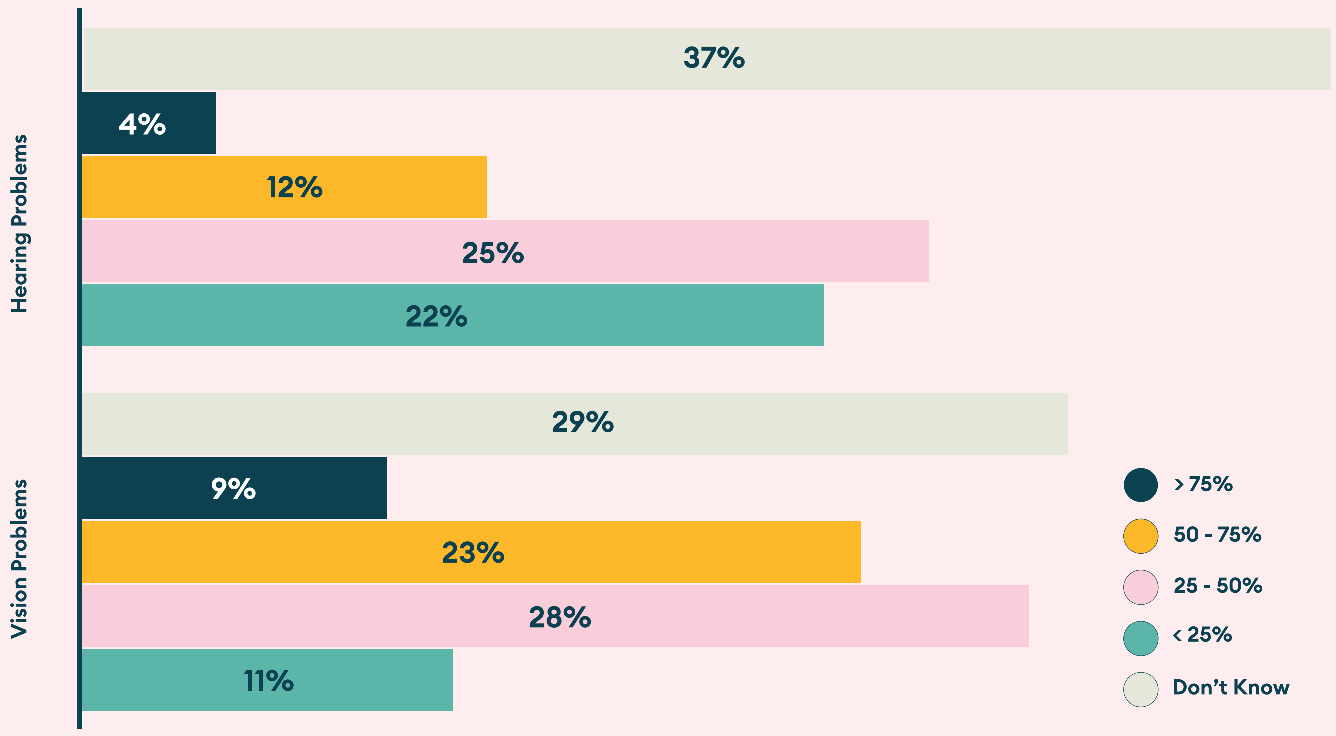
Our results reveal staggering dietary health inequalities for people experiencing homelessness, highlighting inadequate nutrition practices and poor-quality dietary provision. The findings support related work, such as studies by Ghislaine Swinburn, Primary Care Dietitian working in Bristol, and demonstrate the need to deliver interventions to improve diet and nutrition amongst people experiencing homelessness. After connecting at the Pathway Symposium 2024, we partnered with Ghislaine to establish the Pathway Nutrition Committee, the first of its kind network of stakeholders dedicated to improving dietary outcomes for people experiencing homelessness. We are currently researching and co-developing population-specific nutritional screening tools for people experiencing homelessness, funded by British Association Parenteral and Enteral Nutrition .

Following this report's focus on vision and hearing problems amongst people experiencing homelessness, survey respondents were asked to estimate the prevalence of vision and hearing problems for this population, based on their professional experiences. While this data does not provide concrete evidence to this point, the responses certainly indicate these issues may be common amongst people experiencing homelessness.

> **“It's hard for people and staff to prioritise things like [vision and hearing problems] when the patients are in survival mode.”**
>
> *Nurse, Specialist Inclusion Health Service, Yorkshire & The Humber*

Notably however, this question received a large proportion of ‘Don't Know’ responses, with responses indicating that services may be less likely to focus on these issues in the context of the multiple health and social problems that people experiencing homelessness typically face. Respondents working in relevant specialist and mainstream healthcare services were asked if their service routinely considers vision and hearing problems when assessing newly referred services: for vision problems, **55% said that their service does consider these issues, and for hearing problems, 46% considered these issues.**

Figure 3.2 - Perceived prevalence of vision and hearing problems amongst people experiencing homelessness



Chapter 4. Looking to the future – inclusion health in a shifting NHS

The evidence considered in this report paints a picture in which good practice and improvement is often happening in the face of broader systemic challenges. Given this context, respondents were generally pessimistic about the extent to which health outcomes for inclusion health groups would improve over the next three years, **with 72% expecting them to worsen or stay the same and just 20% expecting improvement.**

For those expecting improvement, their outlooks were based on the growing awareness and reach of the inclusion health agenda, a more empathetic political environment and a greater focus on homelessness within central Government;

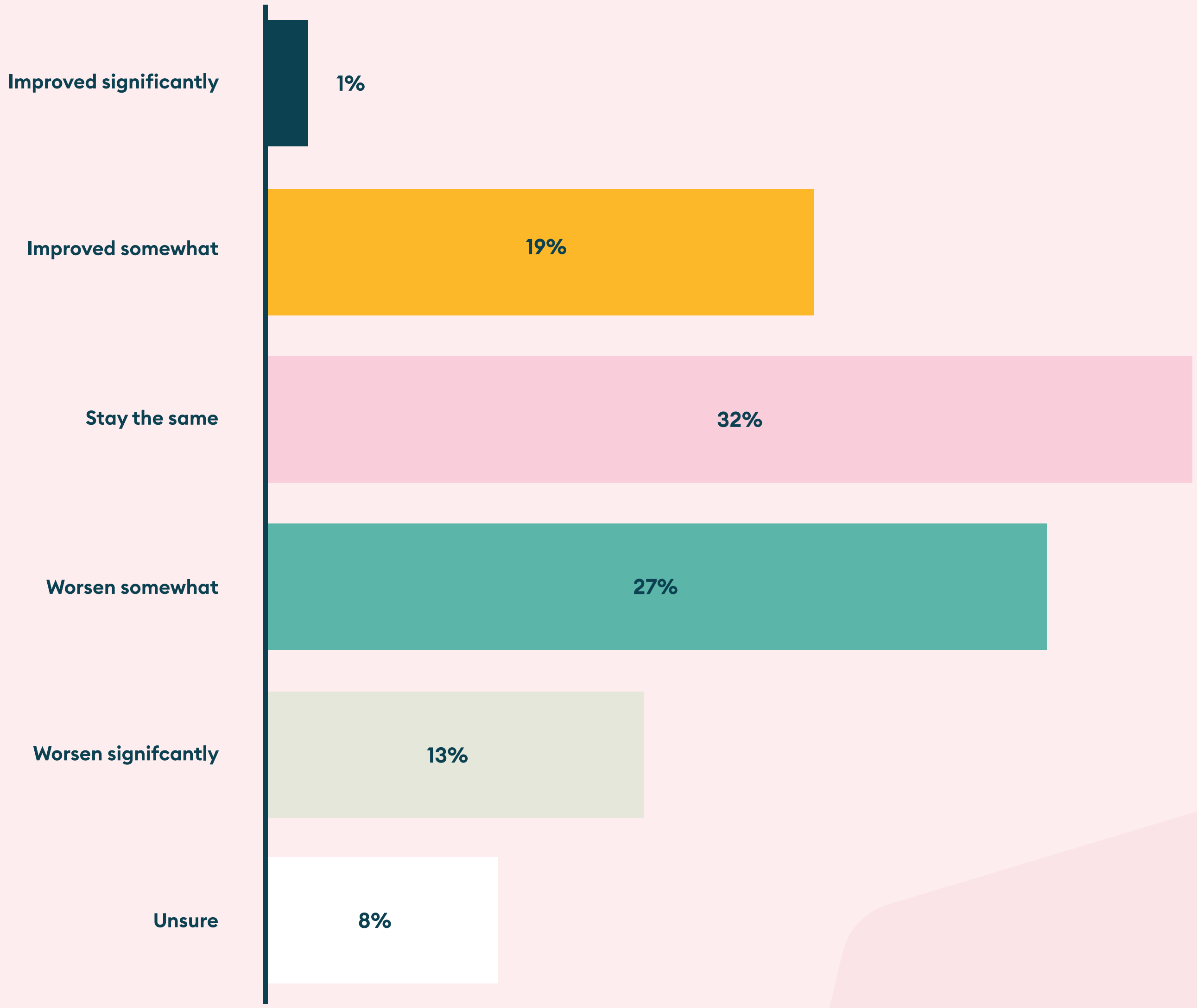
> **"The Inclusion Health agenda is live, people are talking about it outside specific Inclusion Health events and communications so it must be having an impact and, eternal optimist as I am, I believe that will lead to change."**
>
> *VCSE Service Manager, Yorkshire & The Humber*

However, for those respondents who expected outcomes to stay the same or to worsen, they noted the scale of the challenge faced by the Labour government in terms of improving the NHS and resolving the ongoing housing crisis.

> **"I think that the impact of 14 years of austerity will continue to take its toll, even if more resources are put into care for inclusion health groups. I think that health outcomes can get better, but it will take longer than 3 years for benefits to start to show."**
>
> *ICB Manager, London*

> **"There is no indication that spending decisions now are considering the public health sphere to include justice, housing, social care, education and health systems together; no commitment to invest into a sustainable social infrastructure that focuses on our most vulnerable populations, the need for multiple systems to work effectively together with a joined-up understanding of the issues that individuals face, for which currently there is no process/ structure to support."**
>
> *Nurse, Community Palliative Care Service, London*

Figure 4.1 Expected change in health outcomes for people in inclusion health groups over the next three years



4.1 The Labour Government’s ‘three shifts’

At the center of its planning for the future of the NHS, the Labour government has proposed three ‘shifts’ for the health system: moving care out of hospitals into the community, moving from treating to preventing sickness, and moving from an analogue to a more digital NHS. While each of these ‘shifts’ certainly holds promise for improving services and outcomes for people in inclusion health groups, any changes must explicitly consider the specific needs and circumstances of such patients, to minimise the risk of deepening existing exclusion and inequalities.

> **“These shifts are often aimed at improving things for the majority but result in a worse situation for some minorities. I think people experiencing homelessness may be worse off with some of these shifts. The shifts will all improve the health of inclusion health groups if implemented with them in mind”**
>
> *Physiotherapist, University Research, London*

> **“Unless there is specific provision for, and focus on the above shifts being tailored to include inclusion health groups, then these groups are likely to be largely unaffected or could be negatively impacted”**
>
> *Nurse, Specialist GP Practice, London*

As shown in the chart below, survey respondents had mixed feelings on the capacity of these ‘shifts’ to drive improvements in service provision and outcomes for people in inclusion health groups.

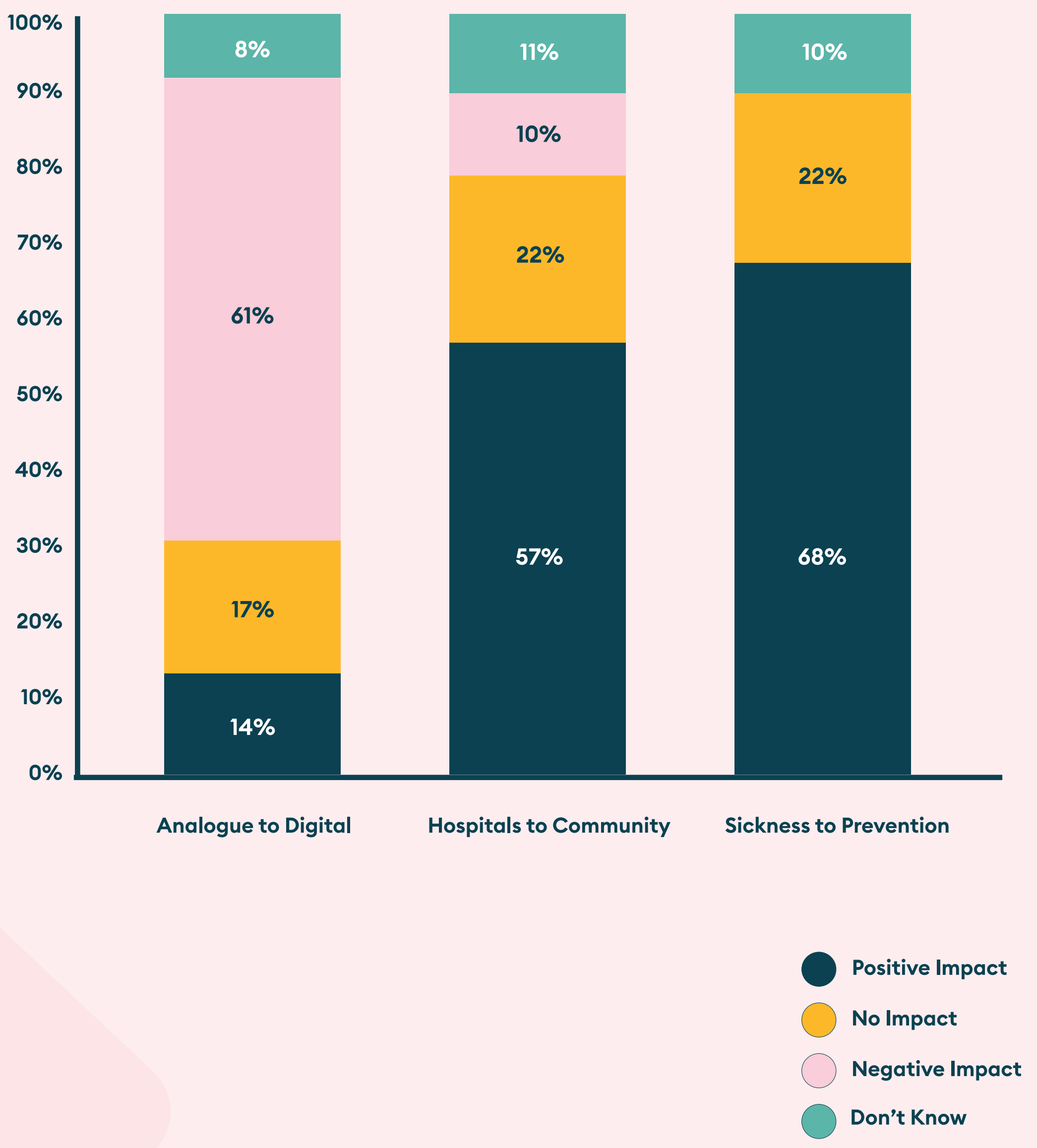
Members of Pathway’s Lived Experience Programme said;

Improving care in the community for people in inclusion health groups is so important because access at the moment is so bad.

We need to be taking services to where people are, with in-reach teams into different types of accommodation, outreach services and hubs that bring services together under one roof to make them easier to access. Things like health checks in hostels for early detection and prevention can be really effective and encourage people to get support before their conditions get really bad.

If community care, primary care and GPs are compassionate and holistic, then they can also be preventative. Digital exclusion is already such a massive issue that it is hard to see how a more digital NHS will benefit people in inclusion health groups.

Figure 4.2 Expected impact of the ‘three shifts’ on health service provision for people in inclusion health groups



4.2.1 Analogue to digital

As highlighted in Chapter 1, digital exclusion continues to be a significant problem for people in inclusion health groups. It is unsurprising then that 61% of respondents thought that shifting to a more digital NHS would have a negative impact on service provision for these groups, citing familiar issues around access to internet/data/credit, keeping devices safe, and the lack of support for those who struggle with digital literacy. Without adjustments such as retaining and improving analogue routes to accessing services, a more digital NHS is likely to deepen the digital exclusion from services faced by many people in inclusion health groups.

> **“Digital barriers are already huge for [people experiencing homelessness and rough sleeping] and prevent access to services [for people] who rely solely on electronic means of accessing appointments or healthcare.”**
>
> *Nurse, Specialist Mental Health Service, South West*

> **“Many people that I come into contact with are unable to read or write. Shifting to digital access, i.e. the booking of appointments and receiving appointments digitally may prevent them from accessing appropriate services. Also, the lack of technology, such as not having the funds to own a smartphone, computer may again reduce the ability for people to access care.”**
>
> *Mental Health Practitioner, Community Mental Health Service, East Midlands*

However, the shift to a more digital NHS could also realise much-needed improvements in information sharing between services. This would be extremely beneficial for often transient inclusion health populations and could avoid the re-traumatization associated with repeatedly sharing difficult personal information with services.

> **“[A more] digital NHS could be positive if it allows for more record sharing between trusts, as information and continuity of care can be lost when people are transient and access different services. However, if it means a transition to more digital access to NHS services at the exclusion of face-to-face/phone calls, that will negatively impact health inclusion groups who are often digitally excluded”**
>
> *VCSE Staff, London*

> **“An accessible and detailed patient record, viewable by GP's regardless of surgery/PCN, Outreach Nursing and Hospitals, is essential if we are to make significant inroads to delivering the right care at the right time [for inclusion health groups] and avoid retraumatizing patients having to explain their circumstances and needs”**
>
> *Local Authority Manager, South West*

As well as increasing the role of digital technologies in the delivery of services, Labour’s digital shift also refers to improvements in the analysis and use of health data by leaning into AI-driven analytics. As discussed in Chapter 3, the issues around identifying people in inclusion health groups within NHS data mean that these developments will fail to benefit inclusion health groups. However, if we see improvements in basic data recording, such as improved recording of housing status, then these developments will also be able to bring benefit to people in inclusion health groups.

4.2.2 Hospitals to community

Making health services more accessible in the community – through (e.g.) outreach teams, drop-in services, specialist primary care and inreach services – is a central part of the inclusion health agenda, reflected by the **57% of respondents who felt that this shift would benefit people in inclusion health groups.** As outlined in Chapter 1, there are significant barriers to accessing primary care, general practice and community health services for inclusion health groups, and this is a significant contributing factor to their over reliance on secondary care. Shifting care to the community will only be meaningful for inclusion health groups if changes are implemented to remove the typical barriers that get in the way of accessing these services. Specialist inclusion health services – such as specialist general practice – are often exemplary models of accessible and good quality community care, which will be essential in realising this shift for people in inclusion health groups.

In the short and medium term, the potential benefits of this shift for inclusion health groups are also dependent on improving the quality of care during hospital admissions (for example, through specialist in-reach Pathway teams) and drastically improving discharges through specialist intermediate care provision, improved safeguarding procedures, improvements in the availability of other safe and secure forms of accommodation, and an end to street discharges.

> **“Accessible community services tailored to all could prevent hospitals being the first point people go to for everything. If they are easier to access things may get treated earlier or even prevented.”**
>
> *Nurse, Specialist GP Practice, London*

4.2.3 Sickness to prevention

While people in inclusion health groups typically already experience complex health needs and multi-morbidity, meaning that opportunities for primary prevention may have been missed, there is always the possibility of preventing their conditions from getting worse. However, for preventative healthcare to be delivered effectively for these groups, there needs to be better access to primary and community services that can meet people where they are and deliver care in a flexible, compassionate and person-centered way.

Of particular concern is the fact that many people in inclusion health groups are unlawfully refused registration from registering with general practice due to a lack of proof of address and/or ID - **70% of survey respondents said that being refused for lack of ID/address was a barrier for people in inclusion health groups, in the area they worked in** - alongside the digital exclusion resulting from increasingly digitised registration and appointment booking processes.

Another area of concern is poor access to early intervention for mental health problems. As discussed in Chapter 1, access to mental health services is extremely challenging, and especially so for people in inclusion health groups. Because mental health problems can play a significant role in pushing and keeping people into homelessness and other forms of social exclusion, improving early access to mental health services should also be prioritised as a form of preventing homelessness and the complex health problems that are caused by it.

Respondents also highlighted that improving the capacity of the system to provide preventative healthcare for people in inclusion health groups goes beyond the health system and requires drastic improvement in the wider determinants of health, in particular, housing.

> **“Prevention becomes a higher priority when someone has a stable base to work from. Housing needs to be seen as prevention.”**
>
> *Doctor, Specialist GP Practice, North West*

> **“Preventative healthcare is a culture change, it's a huge job so any progress won't be seen immediately and also it's a socioeconomic issue, as people who experience co-morbidities, multiple disadvantage and complex trauma require services that are not just healthcare”**
>
> *Psychotherapist, Specialist Mental Health Service, Yorkshire & The Humber*

Conclusion and Recommendations

With a new NHS 10-Year Plan, a cross-governmental strategy on ending homelessness and the long-term housing strategy on the horizon, the political backdrop to this report holds significantly more cause for optimism than in previous years.

The new Labour government's stated focus on driving improvements in healthcare delivery through the three shifts holds promise for improving outcomes for people in inclusion health groups, and the NHS framework on inclusion health has helped to push these issues up the national agenda. As such, there is a firm base to continue advocating for the changes in policy, practice, commissioning and education that are crucially needed.

As this report has shown, the hard work and dedication of staff across the health, care and housing system, combined with the improved recognition of inclusion health at system level, has driven improvements in important areas such as collaborative working between services, lived experience input, trauma-informed care and ICS inclusion health strategy. Building on the NICE Guidelines 214, the body of evidence around improving outcomes for people in inclusion health groups continues to grow and provides a clear roadmap for future improvements.

However, despite these positive signs, the broader context remains challenging. Driven by pressure on the NHS, stigmatising attitudes, digital exclusion and a lack of understanding, access to and experience of mainstream health services continues to be poor for people in inclusion health groups. Across key services, opportunities to provide holistic and compassionate care and support are being missed, causing significant harm to people, preventing their recovery and driving future pressure on services. These missed opportunities are driving an endemic lack of safety for people in inclusion health groups -hospital discharges, access to primary care and support for dual diagnosis patients are areas where improvements are particularly needed.

While specialist inclusion health services have been consistently shown to generate positive outcomes, we need to find a balance between improving the funding and commissioning of such services and pushing forward improvements in the quality and safety of mainstream healthcare for people in inclusion health groups. Specialist services cannot, and should not be expected to, carry the burden and risk alone supporting complex and vulnerable people – a whole system approach is needed. Ensuring that staff working in both specialist and mainstream services across the health, housing and care sectors have the resources and support that they need to provide effective care for people in inclusion health groups is essential.

While the Labour government's proposed shifts for the health system hold promise for improvement, their implementation must consider the specific needs and circumstances of people in inclusion health groups. The poor access to primary and community services and the resulting overreliance on secondary care that people in inclusion health groups face is an extreme version of the pattern of healthcare delivery that the new government is proposing to move away from. If we are able to get things right – shifting from hospital to community care and preventing sickness - for the most excluded and clinically complex people in our society, we will have laid an effective groundwork to improve the health system for the wider population.

Finally, improvements in the wider determinants of health, in particular housing, are absolutely fundamental to improving outcomes for people in inclusion health groups. Without the greater provision of quality housing (including supported and specialist accommodation) the potential benefits of any improvement in health service delivery will be severely limited and more people will be pushed into housing precarity and extreme health inequalities.

Recommendations

Together, Pathway and Crisis call on the Westminster government, through the NHS 10-year plan, ending homelessness strategy and long-term housing plan, to take action on the following urgent priorities:

1. Improve the quality of care during hospital admissions and ensure that every person experiencing homelessness has a safe place to recover afterwards by funding and implementing a national safe discharge programme

Scale up the provision of cost-effective specialist intermediate care services to meet the level of national need, to ensure that people experiencing homelessness have a safe place to recover and prevent them being avoidably readmitted to hospital.

Ensure that all hospitals seeing over 200 people experiencing homelessness per year establish a multi-disciplinary Pathway team[iii], so that people in inclusion health groups receive holistic and compassionate care whilst in hospital and are provided with effective multi-disciplinary discharge planning.

2. Improve opportunities for prevention by improving access to primary care for people in inclusion health groups

Encourage and incentivise General Practice to provide longer, more flexible appointments and multi-disciplinary care for people in inclusion health groups, through a reformed GP finance incentive system, backed by improved accountability. This will help to create a blueprint for working with other complex, multi-morbid and frail populations.

Establish multi-disciplinary neighbourhood hubs where people in inclusion health groups can access care for physical health, addictions and mental health, along with housing and welfare support where needed.

Require services to carry out impact assessments for digital inclusion and ensure that they retain analogue routes to accessing services for multi-morbid and complex patients.

[iii] Pathway Teams are clinically-led, multi-disciplinary Teams that provide holistic support for patients experiencing homelessness and other vulnerable groups within acute and mental health hospital settings.

3. Drive health and housing integration to achieve better homes and better care for people in inclusion health groups

Provide a single longer-term pooled budget, using learning from similar integrated budgets such as the Better Care Fund, to integrate NHS spend with spend directed to local government, and drive integration across relevant programmes such as those targeted towards rough sleepers.

4. Address the invisibility of people in inclusion groups in NHS data

Drive reform to routinely capture patients' housing status in NHS data. The first step is to fund and implement a national pilot of revised housing status fields within the Emergency Care Data Set and the Mental Health Data Set. The Government, working with NHS England, ICSs and relevant national teams that support the ECDS/MHDS, should promote the use of housing status field at ICS level, supported by an evaluation. This should then inform a national programme which drives the routine recording and analysis of housing status across all NHS care settings.

5. Provide people with the safe and secure housing they need to both recover and improve health outcomes

Strategically align the homelessness strategy with the forthcoming with the forthcoming long-term housing strategy, and NHS plan to include a shared outcome of ending homelessness.

This must include investing in building 90,000 social rented homes a year and ensuring that local delivery meets need, including specific targets for social rented homes, Housing First units and supported housing.

The welfare system must ensure homes are affordable over the short, medium and long term. This requires investment in Local Housing Allowance so it covers at least the 30th percentile rent and exploring the abolition of the Shared Accommodation Rate, as well as household benefit cap and Spare Room Subsidy, both of which make even social homes unaffordable.

6. Develop the NHS workforce for inclusion health

The Government and NHS England, working with the relevant Royal Colleges, should established a national inclusion health workforce programme that is co-produced by people with lived experience- listening to and learning from their perspectives is essential to getting workforce development right for these populations.

The programme should ensure minimum levels of clinical knowledge and cultural competence to support inclusion health populations, widespread adoption of the principles of trauma-informed care and awareness of roles and responsibilities with regards to safeguarding, in particular self-neglect.

7. Drive ICBs' progress and accountability on inclusion health

Set explicit improvement targets for inclusion health through future iterations of the NHS operational planning guidance and NHS 10-Year Plan

Targets could include reducing the rate of self-discharges from hospital by people experiencing homelessness to the 4% seen in the general population, ending discharges from acute and mental health hospitals to homelessness, increasing GP registration rates among people in inclusion health groups, and regular reporting of the size of the mortality gap between inclusion health groups and the general population.

8. Ensure that people experiencing and at risk of homelessness can access support for mental health issues and addictions

Promote early intervention by working with ICBs to ensure the provision of assertive outreach teams, in order to prevent mental health deterioration and prevent those at risk of homelessness from losing their accommodation

Improve support for people with dual diagnosis by ensuring that addictions services are funded and able to assess and treat less complex mental health conditions, and that mental health teams are able to assess substance misuse disorder and deliver brief interventions where necessary.

We also highlight a number of recommendations for ICBs who wish to proactively address the needs of their local inclusion health populations;

Conduct a local inclusion health needs assessment which strongly involves people with lived experience, and develop a local inclusion health strategy to ensure that local service delivery meets the NICE Guidelines NG214.

Assess the extent to which local services deliver care in a trauma-informed way and make improvement plans.

Commission evidence-based specialist inclusion health services, in line with NICE Guidelines, to meet local need in acute, mental health, primary care and community settings.

Conduct audits of all discharges to the street from acute and mental health hospitals, and make improvement plans.

Ensure that locally commissioned specialist inclusion health services can access legal advice services as needed.

Ensure that specialist inclusion health services are commissioned with long-term and stable funding to improve staff retention and service quality.

Improve local inclusion health data by promoting and evaluating the use of existing housing status fields with the Emergency Care Dataset and the Mental Health Services Dataset.

References

1. ‘Rough sleeping snaphot in England: autumn 2024’ (2025) GOV.UK. Available at: *https://www.gov.uk/government/statistics/rough-sleeping-snapshot-in-england-autumn-2024/rough-sleeping-snapshot-in-england-autumn-2024*

2. Statutory homelessness in England: July to September 2024 (2025) GOV.UK. Available at: *https://www.gov.uk/government/statistics/statutory-homelessness-in-england-july-to-september-2024/statutory-homelessness-in-england-july-to-september-2024*

3. ‘Independent Investigation of the National Health Service in England’ (2024). Avaiable at: *https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf*

4. ‘NICE Guidelines NG214: Integrated health and social care for people experiencing homelessness’ (2022), NICE. Available at: *https://www.nice.org.uk/guidance/ng214*

5. ‘A national framework for NHS – action on inclusion health’ (2023), NHS England. Available at: *https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/*

6. ‘Core20PLUS5 – an approach to reducing healthcare inequalities’ - NHS England. Available at: *https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/*

7. ‘Patient safety’ NHSE. Available at: *https://www.england.nhs.uk/patient-safety/*

8. ‘The homelessness monitor: England 2023’ (2023), Crisis. Available at: *https://www.crisis.org.uk/media/utehvxat/homelessness-monitor-england_report-2023_v11.pdf*

9. Statutory homelessness in England: financial year 2023-24 (2024), GOV.UK. Available at: *https://www.gov.uk/government/statistics/statutory-homelessness-in-england-financial-year-2023-24/statutory-homelessness-in-england-financial-year-2023-24*

10. Always at the Bottom of the Pile: The Homeless and Inclusion Heath Barometer (2024), Pathway. Available at: *https://www.pathway.org.uk/resources/barometer2024/*

11. Urgent and Emergency Care Recovery Plan Year 2 (2024), NHSE. Available at: *https://www.england.nhs.uk/wp-content/uploads/2024/05/PRN01288_i_Urgent-and-emergency-care-recovery-plan-year-2-building-on-learning-from-2023-24-May-2024.pdf*

12. ICS Learning Programme. Report forthcoming, Pathway

13. Promoting compassionate healthcare for homeless people, The Health Foundation. Available at: *https://www.health.org.uk/funding-and-fellowships/projects/promoting-compassionate-health-care-for-homeless-people*

14. Cancer and stroke NHS patients among thousands discharged with nowhere to live (2024), The Independent. Available at: *https://www.independent.co.uk/news/uk/home-news/homelessness-hospital-patient-bed-nhs-b2513414.html*

15. 'Levelling up' general practice in England (2021), The Health Foundation. Avaiable at: *https://www.health.org.uk/reports-and-analysis/briefings/levelling-up-general-practice-in-england*

16. Building Health Equity: The Role of The Property Sector in Improving Health (2024), The Intitutude for Health Equity. Available at: *https://www.instituteofhealthequity.org/resources-reports/building-health-equity-the-role-of-the-property-sector-in-improving-health*

17. Health and Care Act 2022, GOV.UK. Available at: *https://www.legislation.gov.uk/ukpga/2022/31/contents*

18. Changing Futures Programme. Available at: *https://www.gov.uk/government/collections/changing-futures*

19. Rough Sleeper Initiative. Available at: *https://www.gov.uk/government/publications/rough-sleeping-initiative-2022-to-2025-funding-allocations*

20. We are not getting safer: Patient safety and the NHS staff survey results (2024), Patient Safety Learning. Available at: *https://d2z1laakrytay6.cloudfront.net/Report_Wearenotgettingsafer_PatientsafetyandtheNHSstaffsurveyresults_Issued_2024-03-25-170020_djqc.pdf*

21. Cornes, M., Tinelli, M., Clark, M., Coombes, J., Harris, J., Burridge, S., Robinson, J., & Wittenberg, R. (2024) Evaluation of the Out-of-Hospital Care Models Programme for People Experiencing Homelessness. London: NIHR Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London.

22. Intermediate Care for People Experiencing Homelessness: Cost-benefit Analysis (2024), Alma Economics/Pathway. Available at: *https://www.pathway.org.uk/resources/intermediate-care-for-people-experiencing-homelessness-cost-benefit-analysis/*

23. Coexisting severe mental illness and substance misuse (2019), NICE. Available at: *https://www.nice.org.uk/guidance/qs188*

24. Crane, M., Joly, L., Daly, B.J., Gage, H., Manthorpe, J., Cetrano, G., Ford, C. and Williams, P. (2023). Integration, effectiveness and costs of different models of primary health care provision for people who are homeless: an evaluation study. National Institute for Health and Care Research; 2023 Oct. (Health and Social Care Delivery Research, No. 11.16.) Available from: *https://www.ncbi.nlm.nih.gov/books/NBK596135/ doi: 10.3310/WXUW5103*

25. NHS workforce in a nutshell (2024), The King’s Fund. Available at: *https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/nhs-workforce-nutshell*

26. Staff shortage (2024), The King’s Fund. Available at: *https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/staff-shortages*

27. The unseen struggle: the invisibility of homelessness in NHS data (2024), Carnall Farrar. Available at: *https://www.carnallfarrar.com/the-unseen-struggle-the-invisibility-of-homelessness-in-nhs-data-cf/*

28. Tackling Extreme Health Inequalities Using Health Data: The Case for the Development of Routine Housing Status Recording (2024), S. Dorney-Smith, Pathway. Available at: *https://www.pathway.org.uk/app/uploads/2024/12/Tackling-extreme-health-inequalities-using-health-data-The-case-for-the-development-of-routine-housing-status-recording.pdf*

29. ONS U-turns on plan to stop publishing data on deaths of homeless people after furious outcry (2024), The Big Issue. Available at: *https://www.bigissue.com/news/housing/homeless-deaths-ons-mortality-data/*

30. 30. “Delivering Against the Odds”: Pathway Partnership Programme Annual Review 2025 (Pathway) - forthcoming

Appendix A. Research Overview Citations

1. Guise A, Újhadbor A., Helleren, S. (2025) Social responses to stigma, King's College London, publications forthcoming
2. Dorney-Smith, S., Jackson, T., & Dr Oehring, D. (2024), 'Don't tell us off: Examining ways to improve the health care of people experiencing homelessness with diabetes', Pathway/ University of Plymouth. Available at: *https://www.pathway.org.uk/app/uploads/2024/09/Dont-Tell-Us-Off-Examining-Ways-to-Improve-the-Health-Care-of-People-Experiencing-Homelessness-with-Diabetes-1.pdf*
3. Verity, A., & Tzortziou Brown, V. (2024) GP access for inclusion health groups: perspectives and recommendations, BJGP Open. *Available at: https://bjgpopen.org/content/8/3/BJGPO.2024.0021*
4. Lindsay, C., Baruffati, D., Mackenzie, M., Ellis, D. A., Major, M., O'Donnell, C., Simpson, S. A., Williamson, A. E. & Wong, G (2024) Understanding the causes of missingness in primary care: a realist review, BMC medicine, 22(1), 235. Available at: *https://link.springer.com/content/pdf/10.1186/s12916-024-03456-2.pdf*
5. Taylor, G., Vale, J., Turtle, J. & Turtle, M. (2024) Dying Homeless Project 2023, Museum of Homelessness, London. Available at: *https://museumofhomelessness.org/dhp*
6. Dawes, J., Bagkeris, E., Walters, K., Burton, A., Hertzberg, D., Frost, R., Palipane, N. & Hayward, A (2025) Prevalence of frailty and associated socioeconomic factors in people experiencing homelessness in England: cross-sectional analysis of health needs survey data – paper forthcoming
7. Style, H., Vickerstaff, V., & Brown, A. (2025) Nutrition Status of People Experiencing Homelessness Residing in Temporary Accommodation in London. Journal of Human Nutrition and Dietetics, 38(1), e70024. Available at: *https://onlinelibrary.wiley.com/doi/pdf/10.1111/jhn.70024*

Appendix B. Faculty for Homeless and Inclusion Health Survey

Section A – Background Information

1. Which type of role do you currently work in?

	Total	%
Specialist homeless / inclusion health service - healthcare practitioner providing direct care	68	38%
Other healthcare service = healthcare practitioner providing direct care	22	12%
Local authority - manager / other	16	9%
Voluntary & community sector - staff providing direct care / support	13	7%
Voluntary & community sector - service manager	11	6%
University - research / teaching	11	6%
Voluntary & community sector - policy, research, communications	7	4%
Specialist homeless / inclusion health service - healthcare service manager	7	4%
Specialist homeless / inclusion health service - NHS employed allied worker (e.g. housing worker / social worker)	5	3%
Other healthcare service - NHS employed allied worker (e.g. housing worker / social worker)	4	2%
Other healthcare service - healthcare service manager	4	2%
Housing association	3	2%
Other (please specify)	3	2%
Healthcare commissioner	2	1%
Local authority - social worker	2	1%
Civil service - policy / research / data / communications	1	1%
Local authority - housing authority	1	1%
Total	180	

2. What is your professional background? You may select more than one if applicable

	Total	%
Medical Doctor	36	27%
Nurse	38	29%
Psychotherapist/counsellor	11	8%
Psychologist	11	8%
Mental health practitioner	7	5%
Occupational therapist	7	5%
Physiotherapist	2	2%
Addictions specialist	5	4%
Sexual health specialist	2	2%
Paramedic	3	2%
Dietician	1	1%
Podiatrist/chiropodist	1	1%
Pharmacist	1	1%
Optician/opthamologist/optometrist	2	2%
Healthcare assistant	3	2%
Social worker	5	4%
Other	14	11%
None	49	37%
Total	**198**	

3. Which region of England do you work in?

Region of work	Total	%
England - London	52	28.9%
England - South East	30	16.7%
England - Yorkshire & The Humber	19	10.6%
England - South West	18	10%
England - North West	18	10%
England - East of England	13	7.2%
England - East Midlands	8	4.4%
England - National Role	8	4.4%
England - West Midlands	8	4.4%
England - North East	6	3.3

Section B – Access to healthcare services

1. In general, how easy do you think it is for people in inclusion health groups to access the following types of mainstream healthcare service?

	Very difficult	Difficult	Neutral	Easy	Very easy	Don't know	Total
General practice	43	81	30	19	5	2	180
Urgent & emergency	15	66	38	43	13	5	180
Mental health	118	48	4	1	3	6	180
Substance misuse	32	67	38	27	2	14	180
Dentistry	116	41	7	3	1	12	180
Eyecare	57	46	19	17	1	40	180
Audiology	56	43	17	6	1	57	180

2. Which of the following barriers do you think that people in inclusion health groups tend to face when accessing mainstream healthcare services. Please select all that apply

Poor understanding of patient needs	159
Digital exclusion	155
Stigma and discrimination	155
Inflexible appointments	153
Limited service capacity	139
Refused for lack of address/ID	126
Practical/financial issues	105
Eligibility issues	99
Lack of translation	96
None of the above	1

Section C – Patient Safety

1. The NHS defines patient safety as "the avoidance of unintended or unexpected harm to people during the provision of health care."In general, how safe do you think that the healthcare system is for people in inclusion health groups?

Extremely unsafe	16	10%
Unsafe	83	50%
Neither safe nor unsafe	44	26%
Safe	19	11%
Extremely safe	0	0
Don't know	5	3%
Total	167	

2. Over the past 12 months, how often have you seen unsafe practices in the following statutory services, in relation to the care and support of people in inclusion health groups?

	NHS	Safeguarding	Adult social care	LA housing
All the time	4	4	8	20
Often	40	37	44	56
Sometimes	79	62	67	47
Rarely	12	20	8	5
Never	8	9	4	8
Don't Know	24	35	36	31
Total	167	167	167	167

3. To what extent do you agree or disagree that missed opportunities to provide safe, effective and high quality care for patients in inclusion health groups causes;

	Preventable future harm to patients	Preventable future pressures on health-care services
All the time	82	89
Often	72	60
Sometimes	6	8
Rarely	1	2
Never	3	4
Don't Know	3	4
Total	167	167

4. Please elaborate on your above responses, if you wish to do so. For example, if you think there are any inclusion health groups/service types that are particularly unsafe, or experience especially poor-quality care, please briefly describe below (free text).

Section D – Health Outcomes

1. In general, how would you rate the health outcomes of the following inclusion health groups?

	Very poor	Poor	Neutral	Good	Excellent	Don't know	Total
Overall	42	82	19	10	1	7	161
People experiencing homelessness	92	56	7	3	1	2	161
Migrants	43	65	18	9	2	24	161
Gypsy/Roma/ Travellers	38	51	17	4	1	50	161
Sex Workers	53	57	12	6	1	32	161
People in contact with the criminal justice system	37	74	24	6	1	19	161

2. Thinking ahead to the next three years, do you expect that health outcomes of inclusion health groups in general will improve, worsen or stay the same?

Worsen significantly	21	13%
Worsen somewhat	43	27%
Stay the same	52	32%
Improve somewhat	31	19%
Improve significantly	1	1%
Don't know	13	8%
Total	161	

3. Please elaborate on your answers, if you feel able to do so (free text).

4. Based on your experience of working with people who are experiencing homelessness, what proportion do you estimate have;

	Vision problems	Hearing problems
< 25%	17	34
25-50%	44	40
50-75%	37	19
> 75%	14	6
Don't Know	46	58
Total	158	157

5. Please describe any barriers that you think exist for people experiencing homelessness when trying to access NHS eyecare services (free text).

6. Please describe any barriers that you think exist for people experiencing homelessness when trying to access NHS audiology services (free text).

Section E – Specialist Service provision

11. For the following types of specialist service, please select the response that best describes the area that you work in.

	Enough	Exists - more needed	Doesn't exist - new needed	Doesn't exist - not needed	Don't know	Total
Specialist GP	12	111	24	2	8	157
Specialist hospital	8	95	37	2	15	157
Specialist community nursing	6	98	36	3	14	157
Specialist mental health	7	110	32	2	6	157
Specialist substance misuse	18	123	8	1	7	157
Specialist sexual health	11	90	30	2	24	157
Specialist hospital discharge	5	83	46	3	20	157
Outreach/mobile health	9	114	24	1	9	157

2. Please elaborate on your responses, if you wish to do so (free text).

Section F – Hospital Discharge

1. Following hospital admissions, how often do you think that people experiencing homelessness are discharged;

	To the street	To unsuitable temporary accommodation	To other unsuitable forms of accommodation	With unmet health needs
All the time	22	23	23	47
Often	68	87	82	73
Sometimes	43	30	27	21
Rarely	11	4	1	3
Never	0	0	1	0
Don't Know	10	10	20	9
Total	154	154	154	153

3. Please indicate the extent to which you agree or disagree with the following statements

	Strongly agree	Agree	Neutral	Disagree	Strongly agree	Don't know	Total
A lack of appropriate discharge options for patients experiencing homelessness prevents recovery following hospital visits	83	64	1	1	0	5	154
A lack of appropriate discharge options for patients experiencing homelessness causes hospital delays and reduces hospital capacity	78	55	7	2	0	12	154
A lack of appropriate discharge options for patients experiencing homelessness causes preventable reattendances and readmissions to hospital	92	53	1	1	0	7	154

4. Please elaborate on your answers, if you wish to do so (free text)

Section G – Improvement and Development

1. Over the past year, have you noticed improvements in any of the following, in the area that you work in?

	Availability and use of data	Collab-orative working	ICS Inclusion Health strategy	Specialist service commis-sioning	Training and education	Trauma informed care	Lived experience input
Substantial improvement	2	9	4	5	4	6	9
Substantial improvement	53	59	53	33	44	53	55
No change - future improvement expected	10	7	10	10	11	10	11
No change	55	52	48	68	65	53	51
Worsened	5	10	5	16	8	9	5
Don't Know	24	12	28	17	17	18	16
Total	149	149	148	149	149	149	147

2. Following Lord Darzi's review of the NHS, the Government has said that its 10-year plan for the NHS will focus on three big 'shifts'. What impact, if any, do you think these shifts will have on healthcare provision for people in inclusion health groups?

	Analogue to digital	Hospitals to community	Sickness to prevention
Positive impact	21	84	101
No impact	25	33	33
Negative impact	91	15	0
Don't Know	12	16	15
Total	149	149	149

3. Please elaborate on your responses above, if you wish to do so. For example, if you feel that these approaches will/won't improve healthcare for inclusion health groups, please briefly tell us why (free text)

Section H – Healthcare Staff

1. Over the past 12 months, have you experienced any changes in the numbers of people from different inclusion health groups needing to access your service?

	Overall	People experiencing homelessness	Migrants	Sex workers	Gypsy/ Roma/ Travellers	People in contact with CJS
Increased significantly	25	35	30	5	6	15
Increased somewhat	42	34	32	16	6	34
Stayed the same	16	15	15	49	38	30
Decreased somewhat	3	1	1	0	3	1
Decreased significantly	3	0	1	0	0	0
Don't work with this group	0	1	4	4	9	1
Don't Know	7	8	21	21	22	14
Total	93	94	95	95	95	95

2. Have you noticed any changes in the needs or characteristics of people in inclusion groups who are accessing your service? For example, more people with substance misuse issues, increasing complexity of need, younger/older patients. Please briefly describe below, if you wish to do so (free text).

3. Please indicate the extent to which you agree or disagree with the following statements about your service.

	Strongly agree	Agree	Neutral	Disagree	Strongly agree	Don't know	Total
My service has the funding, resources and staff levels needed to effectively provide care for patients in inclusion health groups	3	12	16	29	23	3	86
I have the support and supervision (including psychological support) needed to effectively provide care for patients in inclusion health groups	6	32	9	21	15	3	86
My service has secure, long-term funding	4	22	10	22	22	6	86
I have access to enough training that allows me to effectively provide care for people in inclusion health groups	8	42	14	13	6	3	86
My service has sufficient access to legal advice services to support those patients who need legal support	1	9	11	28	24	13	86
My service is able to work collaboratively with other relevant services to achieve positive outcomes for patients	14	45	19	6	0	2	86
My service is able to work effectively with people who have lived experience to improve service design and delivery	6	31	24	17	5	3	86

Pathway
Homeless & Inclusion Health

Crisis
Together
we will end
homelessness

Specsavers