“Always at the bottom of the pile”: The Homeless and Inclusion Health Barometer 2024

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Pathway
Homeless & Inclusion Health

Crisis
Together we will end homelessness

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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 in-patients 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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Right now we're facing a national crisis across our health and housing systems.

In response to rising levels of need, increasing demand for services and reductions in funding, the NHS, housing and social care services are becoming less and less flexible while at the same time raising their thresholds; people have to be sicker, more vulnerable or more distressed before they can get any help at all. For people facing homelessness, in contact with the criminal justice or immigration systems, or experiencing other forms of multiple exclusion, this crisis is a threat to life.

At Pathway and Crisis, we see first-hand the impact homelessness and insecure housing have on people's health. The Homeless and Inclusion Health Barometer 2024 is the first report of its kind to document an independent account of the state of homeless and inclusion health in England.

The report lays bare how some of us are more likely to face stigma and exclusion from health services. Not only is this discriminatory in practice but it stops preventable and treatable diseases being addressed before they get worse. For people facing this exclusion it is downright dangerous and leads to premature death, while for health services it simply drives more pressure towards the most costly parts of the system: urgent and emergency care and hospitals.

Despite strong evidence for what works to improve care and wider outcomes, our report highlights the inadequacy of funding for specialist services for people from inclusion health groups. 64% of health and care professionals responding to our survey cited lack of resources as a barrier to providing effective care and nearly 6 in 10 described uncertainty of funding as a challenge to their service.

We can and must do better than this. Our report also shows there are amazing examples of good practice right across the country. Thousands of people working in inclusion health and the wider health service already play a vital role in meeting patients' needs and providing the individual and specialist support that can make a tangible difference. From multi-disciplinary teams supporting patients facing homelessness during a hospital admission, to specialist primary care and step-down support and accommodation, the evidence of what to do to improve the health of people in inclusion health groups is there. What is needed now is bold action to reverse the trend of people with the worst health receiving the poorest quality care.

But improving health and longer-term outcomes for people excluded from our health and housing systems will not be achieved unless we look at the wider policy changes needed: across health, housing, welfare and immigration. We have an opportunity to take action and fix the problems outlined in this report.

This must start with the Westminster Government, working with NHS England and Integrated Care Systems to increase the availability of specialist primary care, specialist hospital teams and community-based services to meet the needs of people in inclusion health groups, and to put in place reforms to make mainstream services both more accessible and better trained to respond to their needs. But we also desperately need a long-term plan to increase housing supply. Good quality, secure and truly affordable homes are fundamental to the health and wellbeing of us all. Building the 90,000 social rented homes a year we need will provide a foundation where everyone can thrive.

Alex Bax
Chief Executive of Pathway

Matt Downie
Chief Executive of Crisis

Terms

Acute care	Short–term treatment, usually in a hospital, for patients with any kind of illness or injury.
Care Act Assessment	An assessment under the Care Act 2014, which assesses a person's needs for care and support (including transition assessments), or an assessment of a carer's needs for support.
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	Changing Futures is 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.
Co-morbidity	Having two or more conditions at the same time.
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.
Discharge to Assess	The 'discharge to assess' (or D2A) model involves providing short-term care, rehabilitation and reablement, where needed, and then assessing people's longer-term needs for care and support once they've reached a point of optimal recovery.
Dual diagnosis	When a person has both a substance use disorder (alcohol or drugs) and a mental health condition.
Duty to Refer	Statutory duty on specified public bodies to refer anyone who they think is homeless, or being threatened with homelessness, to local authority housing departments.
Floating/wrap-around support	Community support that aims to support people to live independently, including support around housing and benefits, social integration, employment and use of health services.

Intermediate care	Services that provide support for people who have healthcare needs that cannot be safely managed in the community, but who do not need inpatient hospital care.
Mainstream services	NHS provided healthcare services which are available to the general population.
Multi-agency working	Collaborative working from professionals who work for different agencies, such as healthcare organisations, social care, housing and safeguarding.
Multi-disciplinary teams	Teams that are comprised of professionals from a range of disciplines and backgrounds, including various forms of healthcare professionals, social workers and housing workers.
Multimorbidity	The presence of two or more long-term health conditions, which can include: defined physical and mental health conditions, such as diabetes or schizophrenia, ongoing conditions, such as learning disabilities, or symptom complexes, such as frailty or chronic pain.
No Recourse to Public Funds (NRPF)	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.
Out of Hospital Care Models Programme (OOHCM)	DHSC-funded programme for specialist homelessness discharge services, including specialist hospital in-reach teams and specialist intermediate care services. Included 17 sites and ran from 2020 to 2022.
Palliative care	An approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-limiting illness, usually progressive. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems whether physical, psychosocial or spiritual.
Primary care	Usually a patient's first point of contact and includes general practice, community pharmacies, dentistry and eyecare.
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.
Showmen	Members of a group organised for the purpose of holding fairs, circuses or shows (whether or not travelling together as such). This includes such persons who on the grounds of their family's or dependents' more localised pattern of trading, educational or health needs, or old age, have ceased to travel temporarily or permanently, but excludes Gypsies and Travellers.
Specialist services	Services which are designed specifically to provide healthcare to people in inclusion health groups.
Step-down	Intermediate care services for people following discharges from hospital.
Urgent & Emergency Care	Includes A&E, ambulances and urgent treatment centres.

Glossary

A&E	Accident & Emergency
B&B	Bed and breakfast accommodation
CQC	Care Quality Commission
DHSC	Department for Health and Social Care
ICB	Integrated Care Board - 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
ICS	Integrated Care System - 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
LHA	Local Housing Allowance
NHSE	National Health Service England
NICE	National Institute for Care Excellence
NIHR	National Institute of Health and Care Research
OHID	Office for Health Improvement and Disparities
OST	Opioid Substitution Treatment
PCN	Primary Care Network
SARs	Safeguarding Adults Reviews

Executive Summary

Introduction

This report provides an account of the state of homeless and inclusion health in England, considering access to and experience of healthcare, health outcomes and the wider social and economic determinants of health.

Inclusion health groups generally 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.

While the NHS and some parts of wider Government policy have sought to address health inequalities through initiatives such as Core20PLUS5, other deliberate policy decisions and policy inaction across the landscape, including migration, housing and welfare, are actively working against the progress made, ultimately deepening disparities.

This is compounded by the NHS facing some of the most severe pressures in its history.[1,2] Around 6.39 million people are currently waiting for treatment because of the backlog in secondary care,[1] while the UK has a very low total number of hospital beds relative to its population (2.4 per 1,000 people, well below the average of 5 per 1,000 people in OECD EU nations.[3]

There is a lot of evidence on how we can improve services and outcomes for people in inclusion health groups. The chapters that follow highlight current and emerging evidence and opportunities for change. We hope they help to point the way for decision-makers who want to take action to respond to the otherwise bleak picture presented in this report. Many dedicated professionals and services are already working hard to improve their patients’ lives alongside leaders in Integrated Care Systems who can see the potential for improvement through integration. There is a long way to go, but the way ahead is clear.

We analysed four sources of evidence for this report:

Literature
We conducted a rapid scoping review of recent literature on inclusion health, identifying 85 UK-based research reports from the previous two years.

Spotlight
We analysed the data presented in this analytical tool developed by the Office for Health Improvement and Disparities (OHID), which shares key public health statistics on inclusion health groups.

Pathway Needs Assessments
We analysed 16 health needs assessment reports carried out by Pathway, covering 23 NHS Trusts. These studies employed mixed methods approaches to examine how hospital systems provide care for, manage, and discharge people experiencing homelessness.

Faculty for Homeless and Inclusion Health Survey
We conducted a cross-sectional, mixed methods online survey to capture the perspectives of the Faculty of Homeless and Inclusion Health, a membership organisation for people involved in health care for inclusion health groups. 156 people in England completed the survey, representing people working in mainstream and specialist health services, and those in commissioning and managerial roles.

Key findings

NHS pressures are creating barriers to care for people in inclusion health groups

Pressures on healthcare services are driving inflexibility, lack of integration and high service thresholds, all the antithesis of what people in inclusion health groups need. It also undermines services' abilities to meet complex needs.

> **"Pressures on the NHS means services are even less flexible when people don't attend, arrive late, or exhibit difficult behaviour."**
>
> *GP, Specialist Practice*

Many services increased their access thresholds in the context of reduced capacity within the healthcare system, driving people to seek care only when they have become very unwell and at times of crisis. One Faculty respondent said;

> **"The deterioration of NHS services overall means that our clients are always at the bottom of the pile and left out."**
>
> *Psychologist, Specialist Mental Health Service*

Stigma and discrimination can exacerbate these barriers

There is clear evidence that inclusion health groups face stigma and discrimination in health service contexts. This is often underpinned and compounded by a lack of understanding of peoples' needs amongst staff.[4,5] For Gypsies, Roma and Travellers, as well as many migrants, racist attitudes, are also a key factor.[6]

> **"Stigma affects people in inclusion health groups confidence to approach service providers. Being more likely to be judged due to possible issues with hygiene, literacy, language barriers or stigma means people in inclusion health may not always be offered the help they need."**
>
> *Nurse, Specialist Hospital Team, London*

People in inclusion health groups have poor experiences across all major aspects of healthcare

Patients in inclusion health groups are at the sharp end of the problems in general practice. Two-thirds of our Faculty respondents said that people in inclusion health groups were being refused access to general practice because of lack of ID or proof of address. Dentistry services for people in inclusion health groups were described as "non-existent" by Faculty respondents, with the Homeless Health Needs assessments showing just over half of people facing homelessness were registered with a dentist, compared to 80% of the general population.[7]

Lack of access to primary care drives an intensive use of hospitals, particularly A&E, among people facing homelessness. Faculty survey respondents noted multiple barriers to hospital care, including long wait times, issues with addiction withdrawal and the stressful nature of A&E spaces. Lengths of hospital stay for people facing homelessness are usually longer than for people who are housed due to the complexity of their needs and the lack of intermediate care and other appropriate accommodation where people can be discharged safely.[8]

There are major barriers to accessing help for mental health problems, with high service thresholds, long waiting lists and a general lack of capacity and resources in services, according to evidence and our Faculty respondents.[9,6,10] This is especially the case for people who use substances alongside experiencing mental health problems. Less than one in five receive appropriate support for both conditions,[7] especially problematic given that many people experiencing homelessness 'self-medicate' with drugs and alcohol.

Migrants in vulnerable circumstances face particular issues. Government policy that restricts access to free healthcare for people with insecure immigration status or other restrictions on entitlement to support exacerbates an already challenging situation for people with language and literacy challenges and a poor understanding of how to navigate the UK health system. For people seeking asylum and facing vulnerable circumstances, the evidence shows a significant lack of access to medical care[11] for acute and chronic conditions,[12,13] especially for children and pregnant women.[14]

The manner in which these problems exist across all services shows that this is not an isolated issue, but one that requires systemic reform to address.

Many current practices present a threat to the safety of people from inclusion health groups

These problems can lead to deterioration of people's health and even risk to life. Hospital staff may not recognise when people are in withdrawal, or do not treat symptoms appropriately.[15] Pressures to discharge patients to free up beds are intense, compounded by a lack of appropriate accommodation in the community.

Homeless Health Needs Assessment[15b] data shows that, for people experiencing homelessness who had been admitted to hospital, 24% were discharged to the street and 21% to unsuitable accommodation, while three-quarters of Faculty survey respondents felt that people experiencing homelessness are discharged from hospital with unmet health needs often (47%) or all the time (28%).

Faculty survey respondents said the adult safeguarding system regularly fails properly to protect people in inclusion health groups, despite the widespread need. Incidences of death and abuse among people facing homelessness are often due to practitioners' lack of understanding or even recognition of self-neglect as a safeguarding risk, usually due to the assumption that a person is making 'lifestyle choices'.[16,17]

Lack of access to primary care means that vital prevention opportunities, such as vaccinations and cancer screenings, are missed, a further knock-on effect of lack of access to primary care.

Intermediate care offers safety after hospital discharge

Substantial evidence has highlighted how intermediate care can have positive outcomes for people on discharge from hospital, as reflected in the National Institute for Care Excellence (NICE) Guideline for homelessness.[18] As well as reducing delayed discharges and improving follow-on care, intermediate care is more cost-effective than standard discharge procedures and helps prevent unplanned hospital reattendances.[19,20]

Specialist intermediate care provision remains far below what is required. Faculty survey responses highlighted significant gaps in provision for patients in inclusion health groups, with just one in seventeen respondents saying there was enough to meet the level of need in their local area and less still for patients with no recourse to public funds. Specialist services improve outcomes but rely on mainstream services playing their part too.

Specialist services can play a vital role in providing the flexibility to meet patient needs; for example, recent research found that specialist general practice is better able than mainstream to meet the needs of single adults facing homelessness[10]. However, too few of these services meet patients' needs, and they are especially vulnerable to being cut. 64% of Faculty respondents cite inadequate resources as a barrier to providing effective care, and 59% cite funding uncertainty. This drives a pattern of time-limited and patchy service provision, which cannot fulfil its potential to meet patients' needs.

> **"We do our best and have things to celebrate but we are simply tinkering with the shop window. There is very little in the shop itself."**
>
> *GP, Specialist GP Practice, South West*

These services' ability to achieve positive outcomes is also constrained by the challenges patients face when accessing support from mainstream health, housing and social care services.[21,22,23] For example, specialist hospital teams can struggle to improve health outcomes without adequate housing support and effective engagement from mainstream mental health and substance misuse services. This points to the need for a system-wide response to the health of people in inclusion health groups rather than a false dichotomy between mainstream and specialist services.

Housing is a foundation of health

While the poor access to healthcare services experienced by inclusion health groups is a central driver of the health inequity they experience, it is also driven by a range of wider social determinants.[24] Housing availability and quality are foundational to health,[24] and housing precarity is a key common feature across the inclusion health population. A lack of, or poor-quality housing actively contributes to worse health and makes it harder to access healthcare, while recovery from illness following treatment is extremely difficult without somewhere safe and stable to live.[24]

Alongside the crisis within the NHS, the UK is experiencing a housing and homelessness crisis, sharply rising costs of living and rising levels of destitution.[25] Rising rents and Local Housing Allowance reductions have drastically reduced the affordability of renting, compounded by the increasing cost of living. There is a significant lack of social and affordable housing.

In this context, securing housing for inclusion health groups is extremely difficult. 80% of Faculty respondents disagreed or strongly disagreed with the statement that ***"people in inclusion health groups with housing needs get these met in a timely and effective manner".***

In addition to basic housing, there is a need for more specialist and supported accommodation, such as single-sex supported accommodation for women, Housing First models and long-term care placements.

People in inclusion health groups experience the worst health outcomes in society – and they are getting worse

People in inclusion health groups experience very poor health outcomes, including for preventable and treatable diseases. For these people, more than half of Faculty survey respondents felt that health outcomes had worsened over the past three years, while three-quarters felt that the complexity of need had increased. People in Gypsy, Roma and Traveller communities are facing increasingly poor health outcomes, with musculoskeletal problems being a particular issue, along with other chronic conditions.

Mortality is increasing for people experiencing homelessness, with the estimated number of deaths per year rising from 482 in 2013 to 741 in 2021 in England and Wales, though this may well be an under-estimate.[26] Against this backdrop, the Office for National Statistics should work towards raising the quality of homelessness deaths data to the level of National Statistics rather than cease their publication.

Asylum seekers in vulnerable circumstances have poor health compared to the general population and high physical health, mental health and safeguarding risks.[12,13,27] As with other people in inclusion health groups, these poor outcomes are avoidable and rooted in policy choices. Along with significant material deprivation and uncertainty, asylum seekers housed in contingency accommodations, such as repurposed barracks and hotels, are suffering from social isolation. This has a considerable impact on their mental health, with some instances of suicide.

Invisible in the data, invisible to decision-makers

Notwithstanding the evidence presented in this report, inclusion health groups are too often still invisible within health system data. This prevents needs from being accurately identified and outcomes from being monitored and is a barrier to effective service commissioning. Improved recording of housing status in health settings would improve the visibility of people experiencing homelessness within health data. Despite a growing evidence base, there are still important gaps in research and evidence for several key topics, including broad questions about the role of health and care in homelessness prevention and effective interventions to challenge stigma.

Recommendations

The very poor experiences and outcomes described in this report, therefore, require fundamental and systemic reform driven by clear and joined-up leadership at the national level. This reform must span funding, accountability, data, and workforce development within the health service, in tandem with a further drive towards integrating services with housing and social care and national action to address the housing crisis. This will require political commitment and the engagement of partners across multiple sectors, but for now, we highlight some urgent priorities for action.

Together, Crisis and Pathway are calling for:

1. The current and next Westminster Government, working with NHSE and ICSs, to increase the availability of specialist primary care, acute hospital, and community services to better meet the needs of inclusion health populations. Most urgently, this should include a National Safe Discharge programme to end the unsafe practice of discharging patients from the hospital to the street.
2. NHS England to set out clear expectations in its next Operational Planning and Contracting guidance with regards to addressing the extremely poor experiences and outcomes of inclusion health groups.
3. Integrated Care Systems to assess themselves against the NICE Homelessness Guideline (NG214) and the NHSE Inclusion Health Framework, and take action on their findings in their planning and funding of services.
4. The CQC to specifically assess for action on inclusion health groups in its ICS inspection regime.
5. All NHS hospital trusts and GP practices to assess how far their frontline services deliver trauma-informed care and put improvement plans in place.
6. Over the long term, the Westminster Government to put in place a plan capable of increasing the supply of social rent homes to meet current and future need – 90,000 new social rented homes in England per year for the next 15 years, coupled with significant investment in Housing First at scale nationally and supported housing, to prevent people with complex support and health needs from cycling in and out of homelessness and rough sleeping.

Chapter 1. Introduction

This Health Barometer is the first joint Crisis and Pathway 'Homeless and Inclusion Health Barometer', a new report that shines a light on challenges and progress in homeless and inclusion health. It provides an independent account of the state of homelessness and inclusion health in England, considering access to and experience of healthcare, health outcomes and the wider social and economic determinants of health.

Crisis and Pathway entered into a formal partnership in 2021 to tackle the health inequalities impacting people who are homeless and ensure that the health and care system plays its part in ending homelessness. Both organisations share a commitment to evidence-based solutions to bring about a world without homelessness. There exists considerable and growing evidence about homeless and inclusion health, but until now, no comprehensive digest has synthesised this into a picture to inform policy-makers, academics, commissioners, clinicians and others with an interest in this area.

This report draws on a range of evidence – described in more detail below – to set out recent research on what good looks like in inclusion health and to provide an assessment of the challenges and opportunities facing the system. While it presents a challenging picture overall, it also sounds a note of hope, describing significant evidence of what works, and signposting many helpful tools and guidance available to those wishing to bring about change in their area or clinical practice. It also draws heavily on the accounts of people working in healthcare and related fields through our major survey of members of the Faculty for Homeless and Inclusion Health.

1.1 The evidence and methods used for this report

This Homeless and Inclusion Health Barometer provides an overview of current and emergent evidence as well as new evidence generated specifically for this report. The sources of evidence used for this report are summarised below (see *Appendix A* for a more detailed description).

1. Literature

We conducted a rapid scoping review of recent literature on inclusion health, encompassing 85 UK-based publications from the previous two years. We identified papers through a public call for evidence via Pathway's networks.

2. Spotlight

Spotlight is an analytical tool developed by the Office for Health Improvement and Disparities (OHID) that shares key public statistics on inclusion health groups. Spotlight draws upon a range of existing data sources, including healthcare datasets, statutory homelessness data and survey research. Further detail on these sources is given as they appear in the text. (See *Appendix B* for a complete list of data sources presented in Spotlight.)

3. Pathway Needs Assessments

Pathway frequently carries out needs assessments for hospital Trusts or ICSs who wish to better understand the homeless healthcare needs in their area. This report draws on an analysis of 16 needs assessment reports covering 23 NHS Trusts. These reports employ mixed methods approaches to examine how hospital systems provide care, manage, and discharge people experiencing homelessness. (See *Appendix C* for a detailed analysis of the Pathway Needs Assessments.)

4. Faculty for Homeless and Inclusion Health Survey

A new cross-sectional, mixed methods online survey was developed to capture the perspectives of the Faculty, a membership organisation for people involved in healthcare for inclusion health groups. This is the first such survey of this body and gives new insights from the frontline of homeless and inclusion healthcare. This report analyses 156 complete responses from Faculty members based in England. (See *Appendix D* for detailed results and the full list of questions contained in the survey.)

Analysis

We conducted a high-level analysis of the three existing sources of evidence, drawing out key themes and identifying areas where the evidence supported or contradicted each other. We then synthesised the results with the results of the Faculty survey to identify further salient points as well as identify key gaps in the available evidence.

Lived Experience

Drawing mostly on published evidence from the last two years, a key limitation of our approach is the lack of information collected directly from those with lived experience of the challenges facing inclusion health populations. Although much of the new and existing evidence reviewed for this report speaks to the experiences of inclusion health groups, it is often second-hand evidence. While lived experience perspectives were included in the planning and design of the report, we hope for future editions of the Barometer to include lived experience voices as a key source of evidence.

1.2 What is inclusion health?

Inclusion health has been growing as a clinical, policy and research agenda for over a decade. People in inclusion health groups generally include people facing homelessness, people engaged in sex work, migrants in vulnerable circumstances, Gypsy, Roma, Travellers, and those in contact with the criminal justice system. People in inclusion health groups often share the experience of housing precarity, if not actual homelessness, trauma and deep social exclusion.

This combination of groups seems uneasy to some people; some of these groups are defined by inherent characteristics while others are defined by life circumstances at particular points in time. It is axiomatic that some people will be in more than one of these groups at once. Homelessness dominates the discourse of inclusion health, sometimes at the apparent expense of other groups. This report is not immune from this, drawing as it does so heavily on existing research in which homelessness features so predominantly.

Despite these complexities, the stark levels of health inequality suffered by people in inclusion health groups means the term is still a useful definition to draw attention to the distinct effects of social exclusion and disadvantage on health and on access to and experience of healthcare and highlight the need for a better approach. People in inclusion health groups have much worse health outcomes than the general population, even in comparison to the most deprived populations.

The impact of structural exclusion leads to people's needs and the ways in which they try to access care exceeding the capacity and capability of standard service models to respond. When they do access services, people can experience being further labelled (as difficult or complex) and then again excluded for being too hard to help. This, in turn, sets up further cycles of stigma, alienation and feelings of shame for the individual: again, these are common shared experiences of inclusion health groups. This combination of profound marginalisation and service failure underpins the shocking mortality rates and life expectancy deficits which also define inclusion health groups.

Concerted and bold action is needed to address this profound injustice. The Marmot Review states, ***"To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism."***[28] In response, as the first Joint Statement of The Academy of Medical Royal Colleges and the Faculty for Homeless and Inclusion Health put it in 2017, ***"Those who are living on the margins of society are too often poorly served. We believe that care must be tailored to reflect the particular needs of each patient, with clinicians addressing the patient's total health, care and social needs"***.[29]

Despite this challenging backdrop, we can draw considerable hope from the significant evidence on what makes a difference in improving the access, outcomes and experience of people in inclusion health groups when they seek health services. Some of this evidence is outside the two-year scope we have set for this report but merits inclusion here as major contributions that helped to define the field of inclusion health.

The 2022 National Institute for Health and Care Excellence (NICE) homelessness guideline contains evidence-based principles that apply widely to people in all inclusion health groups.[18]

These include:

- Involving people with lived experience in the planning, commissioning and design of services;
- The importance of longer contact times in establishing and maintaining trusting relationships;
- A long-term commitment to care to promote recovery, stability and lasting positive outcomes;
- Ensuring that resources are allocated according to need and level of disadvantage and take into account the social determinants of health;
- The provision of care through specialist homelessness multidisciplinary teams across sectors and levels of care, tailored according to local needs;
- Providing intermediate care services with intensive, multidisciplinary team support for people experiencing homelessness who have health needs that cannot be safely managed in the community but who do not need inpatient hospital care.

In 2017, a landmark paper in a special issue of The Lancet set out principles that drew on a large number of systematic reviews to determine what works in inclusion health.[30]

It highlighted the value of:

- Multicomponent interventions with coordinated care, along with partnership working and services designed around the whole person;
- Opioid replacement therapy and, given the prevalence of dual diagnosis, found that long-acting injectable antipsychotics are effective for people with schizophrenia and substance use disorders;
- Case management to support planning and linking across services;
- Housing-led models, such as Housing First, are focused on certain outcomes, such as housing stability and quality of life;
- Programmes tailored to women, especially those that are trauma-informed;
- Services that go ‘above and beyond’, taking the time to build relationships, and offering flexibility and personalised care.

The authors pointed out that a review of such evidence inevitably contains gaps, particularly around ***“interventions to improve upstream determinants of social inclusion, such as child poverty, employment and education, which are also instrumental to long-term recovery from social exclusion”.***[29]

They highlight that other systematic reviews have particularly established the effectiveness of housing for improving health and social outcomes. Sir Michael Marmot echoes this view, saying, ***“Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age… taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society.”***[28]

The evidence this report draws on, including responses from our Faculty members, concurs with this view that the importance of wider social determinants of health is indivisible from access to healthcare itself.

1.3 Policy background and context

Inclusion health has recently been rising in the national policy agenda as part of NHS England's (NHSE) strategic priority to reduce health inequalities. The core values of the inclusion health movement are inherent to the NHS Constitution for England, which states that while it "provides a comprehensive service, available to all... it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population".[31]

Recent years have seen a number of specific policy interventions aimed at raising the profile of inclusion health and recommending specific actions to Integrated Care Systems. NHSE's recent framework for action on inclusion health outlines specific steps NHS providers can take to improve outcomes for inclusion health populations, sharing key principles and examples of good practices where systems have effectively implemented interventions.[32] NHSE has also developed the Core20PLUS5 framework, an approach to inform the reduction of healthcare inequalities at both a systemic and local level.[33] The 'Core20' population represents the most deprived 20% of areas in England, while the 'PLUS' refers to groups experiencing additional or intersecting barriers in access to, experience and/or outcomes from NHS services, including inclusion health groups. The '5' highlights five major disease types or clinical areas where inequalities are particularly marked. These frameworks all complement the NICE Guideline on integrating health and social care for people experiencing homelessness, as described above.

Wider changes to the health and social care landscape, designed to facilitate integrated services for people in inclusion health groups, supported these developments in NHSE's health inequalities agenda. The Health and Care Act 2022[34] introduced integrated care systems (ICSs), 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, specifically focusing on reducing health inequalities. Under the Act, NHS bodies also have a legal duty to consider the effects of their decisions on the health and wellbeing of people in England (including inequalities in health and wellbeing) and the quality of services they provide (including inequalities in the benefits of these services). Integrated care boards have statutory duties to support partnership working, which would help tackle inequalities, and they are encouraged to consider how their strategic plans will address disparities in health and wellbeing outcomes.

More widely, The Homelessness Reduction Act 2017[35] introduced a Duty to Refer which specified public authorities, including emergency departments, urgent treatment centres and inpatient services, must refer service users who they think may be homeless or threatened with homelessness to a local housing authority. The Duty to Refer aims to ensure closer collaboration and partnership working between public bodies to effectively prevent homelessness by ensuring that people's housing needs are considered when they encounter public bodies.

The NHS is currently facing some of the most severe pressures in its history[1,2]:

- **Around 6.39 million people are currently waiting for treatment because of the backlog in secondary care;[1]**
- **England has a very low proportion of doctors relative to the population, resulting from years of insufficient funding, workforce planning and government accountability;[2]**
- **Compared to other nations, the UK has a very low total number of hospital beds relative to its population.[2]**

These pressures are making it more difficult for the general population to access the healthcare they need, with public satisfaction with the NHS reaching record lows in recent years.[36]

While many people feel these constraints, for those most in need, these current pressures only exacerbate the barriers they experience in accessing appropriate healthcare.

The NHS has a number of top-down directives and performance targets designed to increase capacity and improve patient flow to ease these burdens, such as reducing waiting times for elective treatments and being seen in A&E, as well as reducing acute bed occupancy.

Adherence to these national directives aimed at the general population can be perceived to make it difficult for ICSs to shift resources towards improving the health of the most disadvantaged and excluded members of their communities. And yet, there is an evident failure to integrate the needs of inclusion health populations into the responses to these mainstream pressures. Many of these initiatives, such as the increase in virtual wards to provide care and Discharge to Assess, often perceive the needs of inclusion health groups as an 'add-on' rather than incorporating them into the core elements of the strategy.

While it is clear that NHS England and some elements of wider Government policy actively seek to tackle health inequities, other deliberate decisions across wider Government policy have made it harder for the health system to improve access, experience and outcomes for inclusion health groups, or have adversely affected the social determinants of health.

Hostile environment policies are having a detrimental impact on the health of migrants.[13,14,10,37] These policies, which have developed over the last decade, aim to make it as challenging as possible for people without official immigration status to reside in the UK by restricting access to secure employment and housing, bank accounts, and other essential services, such as healthcare. In 2015, the government introduced new measures to charge overseas visitors up to 150% of the cost of treatment for some NHS services in England.[38]

These regulations, designed to ensure that NHS services do not lose income by providing care to those ineligible for free treatment, are also known as 'cost recovery'.

Parliament recently approved a 66% increase to the immigration health surcharge, which will come into effect in February 2024.[39] In practice, embedding immigration policies into the NHS has resulted in urgent and necessary care being delayed or withheld due to confusion about entitlement to care.[40] People in need of treatment can be deterred from accessing health services due to fear that they will be unable to pay their medical bills, and that their patient data will be used for immigration enforcement purposes.[40]

The hostile environment impacts multiple areas beyond the health system, which are equally important in supporting good health. People subject to the 'no recourse to public funds' condition cannot claim any benefits classed as 'public funds', including housing and income support, homelessness assistance, and social housing allocations. Those seeking asylum are unable to work while awaiting decisions and lack the means to afford basic necessities to help maintain their wellbeing and health.[14] Lack of access to these support systems has an obvious and profound impact on health equity.

While deepening inequalities have resulted from deliberate policy decisions in many ways, policy inaction is causing these inequalities in other areas. Secure and decent housing is fundamental to health and wellbeing and to preventing homelessness in the first place. However, accessing housing of any type is becoming increasingly difficult for low-income households, with the demand for housing, particularly social housing, outstripping supply.[41] It is estimated that 90,000 new social homes are required.[42,43] There is also a shortage of homes suitable for their occupants' needs and that meet varying accessibility requirements, such as ramps, stairlifts, and adapted bathrooms.[44] The lack of supply of social and suitable housing over a number of years requires significant and urgent action.

Decisions in welfare policy are perpetuating the inequality and poverty experienced by inclusion health groups by threatening economic stability. Local Housing Allowance (LHA), which determines how much housing benefit private renters can receive to support them in paying rent, has been frozen since April 2020. During this time, private rental costs have reached record levels, with just 4% of 1-3 bedroom properties being affordable for those receiving housing benefit.[45] Shortfalls between these rates and rental costs have quickly become untenable; people are forced to use other benefit incomes and welfare support to cover their rent or cut back on essentials, with many at high risk of falling into arrears and experiencing homelessness. However, the benefit cap is one of the most significant barriers to ending homelessness for some households.

As rents have risen, it increasingly impacts all households, including single people, in areas of high housing costs. The interaction between the benefit cap and Local Housing Allowance rates means that where the rates go above the benefit cap, the additional investment does not reach households, undermining additional investment into these rates.[45]

As part of the Autumn Statement 2023, the government announced that LHA rates will be uprated in April 2024, resetting the rate to cover the cheapest 30% of properties. However, these measures will also re-freeze LHA rates from 2025-26 onwards, highlighting the need for continued investment in welfare support to prevent a rise in homelessness.

1.4 How this report is structured

NHS England's vision for health service action on health inequalities is to achieve ***"exceptional quality healthcare for all, through equitable access, excellent experience, and optimal outcomes".***[32] People in inclusion health groups are at the sharp end of health inequalities, so we have used these themes: access, experience and outcomes, in the structure of this report. These three components of care apply not only to health services, but also to other relevant services, including those that are crucial for progress on the wider determinants of health, like housing.

Chapter 2 describes people's access to and experience of healthcare, highlighting both barriers to services, and the services our research found were most difficult to access – general practice, dentistry and mental health services. It also includes a particular discussion of intermediate care, the problem of discharges from hospital to the street, and the place of specialist services. This relationship between experience and access – how people's poor experience of services can become a barrier to access – is behind our thinking to discuss these issues in tandem. We touch on education and training as a means to address some of these barriers, and describe some useful tools and guides.

Chapter 3 focuses on statutory services and the wider determinants of health. **Chapter 4** is shorter and discusses the generally very poor outcomes that people in inclusion health groups experience. It draws on both hard outcome data, which is patchy due to poor data collection on inclusion health. This is discussed in more detail in **Chapter 5**, as well as perceptions and experiences from the Faculty survey. These show a worrying picture of increasingly poor outcomes and growing complexity of need, exacerbated by the cost of living and housing crises, the consequences of Government policies (on immigration or welfare, for example) and the intense financial and service pressures felt across the NHS and local government. **Chapter 6** describes our conclusions and recommendations for improvement.

1.5 A word on language

When the report says 'people' in this context, we mean people in inclusion health groups, as this is the main subject of this report. We endeavour to use inclusive language that starts with people, but we welcome feedback on improving this in the next report.

Chapter 2. Access and experience

There is significant evidence that access to and experience of services continue to be extremely poor for people in inclusion health groups[4,6,21,46,47,49,50] a significant driver of the major health inequities they experience, and that access issues are even worse for people in ethnic minority groups.[50,51]

This chapter examines the evidence explaining why access and experience are so poor, highlighting key barriers to care and describing how these barriers play out in a range of health and statutory services. It is important to note that different inclusion health groups also face specific barriers - where relevant, we highlight what the evidence shows us about these different experiences. Despite the many challenges highlighted in this chapter, we also present evidence of what can work to improve access and what is needed to drive improvements.

The evidence review, Pathway needs assessments, and Faculty survey all highlight a wide range of barriers facing inclusion health groups. Factors such as unclear care pathways, difficult referral systems, poor communication and a lack of support for transitions of care can make navigating complex healthcare systems extremely difficult.[14,50,52,53,54,55] These issues impede access by creating frustration and distrust among people who need healthcare, especially where they have to repeat histories involving experiences of trauma, leading to a lack of engagement with (or disengagement from) services.[51,53] When asked to select from a range of barriers people in inclusion health groups experience, Faculty survey respondents highlighted all of them as being common, with poor service accessibility, digital exclusion, and patients' experience of stigma and discrimination the most frequently selected.

This chapter discusses the major barriers in more detail and shows how they play out in particular health services.

"In the area you work in, which of the following barriers to mainstream service access do you think people in Inclusion Health groups experience? Please select all that apply."

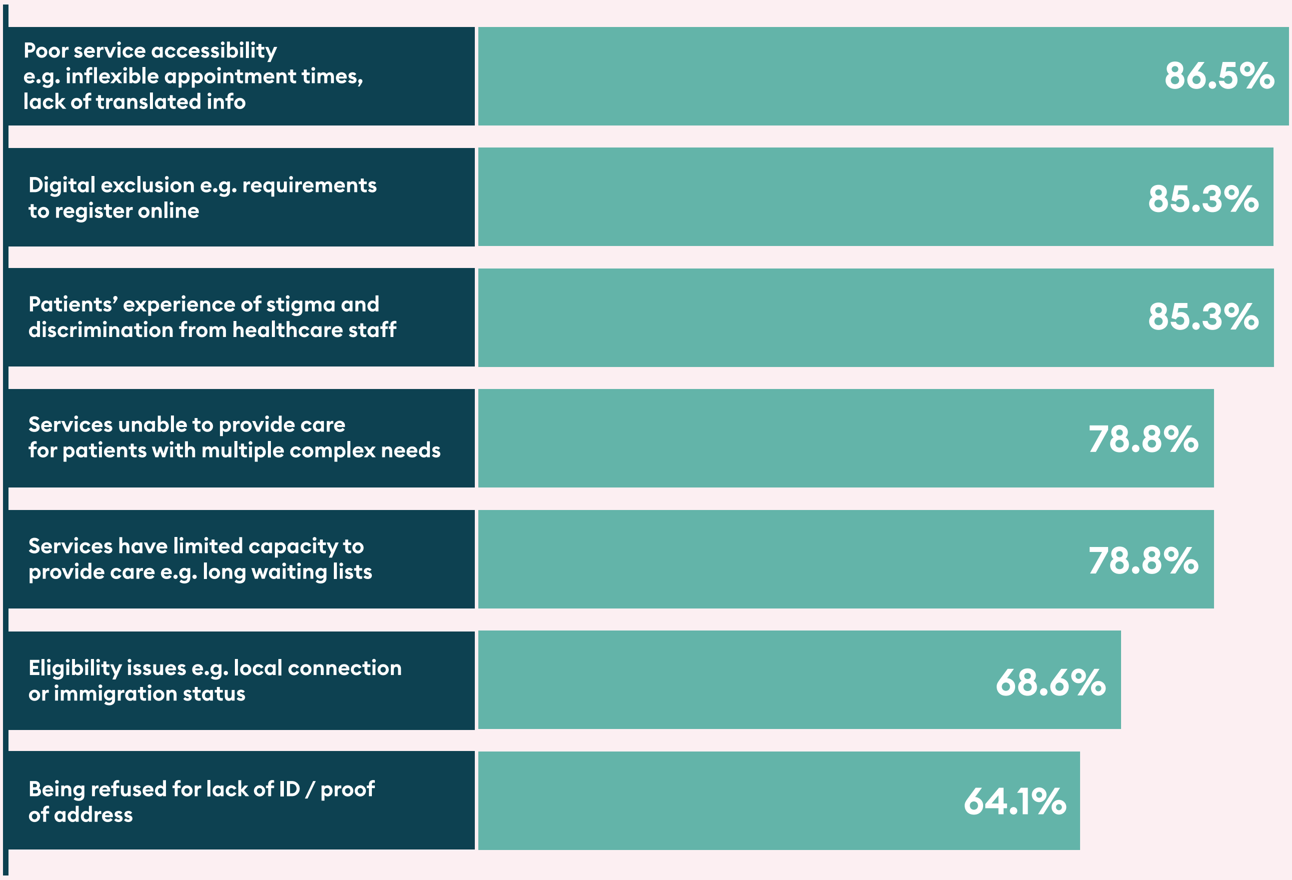

Figure 2.1: Barriers to mainstream service access for people in inclusion health groups. Source: Faculty Survey n=156

2.1 Services' inability to meet complex needs

The evidence we examined for this report highlighted services' inability to meet complex needs as a significant barrier to appropriate care. There are a number of root, systemic causes of this problem. Increased eligibility thresholds, in response to service pressures, are a key reason for reductions in access to secondary care across the NHS, according to recent research from the Health Foundation.[56]

These demand pressures in the NHS give rise to greater service inflexibility, which is at odds with the approach people with complex needs require. Our evidence review and the Pathway needs assessment highlight how this problem means that people sought care only at times of crisis and when no other options were available.[48,55,57] This is borne out by the Faculty survey respondents, who described how, in the context of reduced capacity within the health system, many services had increased their access thresholds.

One Faculty respondent said;

> **"Mainstream services are stretched, often with staff shortages and increased demands from general population as well as inclusion health clients - greater competition to access services and high thresholds needing to be met. Often services are not able to be accessed until a condition is severe enough which leaves people unsupported with multiple needs. This then means when they do access services it is harder to sustain engagement as the severity of need and symptoms has increased."**
>
> *Occupational Therapist, Specialist Mental Health Service, London*

For people in inclusion health groups who already face access barriers, this is especially problematic. The result is that patients often do not access services until they are very unwell, and their needs have become very complex.

This then becomes a vicious circle; due to capacity issues, services may be less inclined to work with complex cases, to protect their limited resources. As Faculty survey respondents said;

> **"Anyone with complex needs- homelessness, substance misuse, mental health, physical health- really struggles to access services. They are told by social services that their support needs are too high, by mental health that they need to be in recovery, and they usually wait to seek treatment for physical health until it is a severe need. Equally when these clients access hospitals- staff are dismissive, don't understand substance misuse adequately and just add to a lifetime of experience of services working against them."**
>
> *Voluntary and Community Sector Manager, South East*

> **"People living complicated lives can often find themselves at the edge of services, not ticking enough or ticking too many boxes to meet service thresholds"**
>
> *Specialist Housing Worker, South East*

> **“The deterioration of NHS services overall means that our clients are always at the bottom of the pile and left out”**
>
> *Psychologist, Specialist Service, North West*

For people in inclusion health groups with complex needs, a flexible response is required.

However, the needs assessments highlighted how, in the face of increasing pressure on the system, services have become less flexible. Faculty survey responses supported this finding, indicating rigid appointment booking processes as a key accessibility issue, with services being seen as quick to take patients off their caseload if appointments were missed.

> **“Pressures on the NHS means services are even less flexible when people don’t attend, arrive late or exhibit difficult behaviour. There just isn’t time or resources for mainstream services to cope with these issues.”**
>
> *GP, Specialist GP Practice, South East*

> **“There is very little flexibility with regards to appointments and particularly for those who finding waiting very challenging”**
>
> *Local Authority Housing Worker, London.*

This lack of flexibility is especially challenging for people in inclusion health groups who, for a range of overlapping issues – a lack of stable housing, mental health and substance misuse problems, neurodiversity and brain injury, and limited access to transport – may find it very difficult to follow rigid appointment booking processes and keep to appointment schedules.

As Faculty survey respondents described;

> **“For people with complex needs who may be chaotic, appointment availability and responses to need can be challenging.”**
>
> *Nurse, VCSE Sector, East Midlands*

> **“It is so difficult to ask someone without means, transport, resource or sometimes faculty - to return for an appointment in a week or two’s time. it is a wasted opportunity to improve health when a patient is with a clinician.”**
>
> *Local Authority Manager, North West*

> **“Receptions being inflexible with appointments. People not being in a place to make appointments themselves and needing support to have the confidence or executive functioning to do it. Neurodivergent people…find that kind of interaction very difficult.”**
>
> *Specialist Substance Misuse Service Worker, London*

Another key element of service inflexibility relates to digital service provision. The evidence scoping[6,51,54] and Faculty survey both highlighted how, following COVID and in response to the extreme pressure on the health system, many services have moved towards digital options for both booking and attending services. While digital service provision may provide flexibility for the general population, the opposite can be true for inclusion health groups. Requirements from many mainstream services to book appointments online and/or conduct consultations by phone were seen to limit service access, given that many people in inclusion health groups may have difficulties with phone and/or internet access.[6,50,54] Digital exclusion was found to be a dominant issue for people with uncertain or restricted immigration status,[18] and even more so for people living in asylum seeking accommodation.[11] As with rigid appointment processes, this represents a failure to identify and flexibly respond to the specific needs of people in inclusion health groups.

Experiences of women facing homelessness are different from men, with domestic abuse and violence, either as a precursor or result of homelessness, being a common experience.[59] However, currently, there is no standardised approach to meet women's needs.[59]

Underpinning these issues is the invisibility of inclusion health populations in key data sets. This leads to commissioners and other decision makers being unable to clearly see the needs of this population in the data, which leads to poor commissioning decisions.[59,60] For example, Pathway's needs assessments found that hospital patients were not routinely asked if they had a safe place to go after their time in hospital in any of the 23 NHS Trusts covered, and if they were asked, it was often late, not coded, not shared onward, and seemed to have little impact on what happened when the patient was discharged.

There has been progress in the system towards better and more systematic recording of patients' housing status, for example, where there are Pathway or other specialist homeless teams in hospitals (and with standard housing status fields now included in the urgent and emergency care data set) however the visibility of other inclusion health groups within standard data sets remains poor. Gypsy, Roma, and Traveller Communities,[6] male and transgender sex workers and indoor-based sex workers are frequently absent from any monitoring data,[46] creating further barriers to care due to a lack of understanding of their needs.

Because of the complex needs of people in inclusion health groups and the current inflexibility of many mainstream healthcare services, there is a clear need to effectively integrate service delivery across the health, housing and social care sectors. Integration is at the heart of the NICE Guideline for homelessness, and multiple sources of evidence reviewed for this report have indicated that more integrated modes of service delivery can have positive impacts in terms of patient engagement and outcomes[9,10,61,62] However, despite this evidence and the introduction of Integrated Care Systems as a structural facilitator, currently the meaningful integration of services around patients' needs remains far behind what is needed to improve health outcomes for inclusion health groups.

2.2 Stigma and discrimination

Stigma and discrimination occur in society towards a wide range of characteristics, including race, gender, sexuality, disability and class. The social exclusion that drives the poor health of people in inclusion health groups is largely based upon these discriminatory social attitudes, whether towards people in particular social circumstances (for example, experiencing homelessness), with certain medical conditions (such as those with mental health problems) or certain racial or ethnic backgrounds (for example, people from ethnic minorities, some migrants, and people from Gypsy, Traveller and Roma communities). People in inclusion health groups often fall into multiple stigmatised groups, deepening the social exclusion that they face.

Because stigmatising attitudes are embedded within our culture, the way they play out in the behaviour of individuals and institutions is often unconscious. While it is easy to characterise those who display stigma and discriminatory attitudes as 'bad people', it is important to focus on the fact that their attitudes are constructed and reinforced by a broader set of social assumptions. For example, the view that homelessness is a 'lifestyle choice',[17] is found among some staff working in the NHS just as it is in the general population. When considering stigma within our health system, it is important to draw this connection – with over 3 million people currently employed in health and social care,[63,64] where stigmatising attitudes exist in these contexts, they are reflective of wider social attitudes. Although stigma plays out in specific ways in health and social care services (and brings with it specific risks for patients), the attitudes on which it is based are not unique to this sector.

Many sources in the evidence review found that stigma and discrimination were a central barrier to healthcare access for inclusion health groups across many different services[14,22,49,53,60,61,] and that these negative attitudes towards inclusion health patients were often underpinned by a lack of understanding amongst staff about people's needs and backgrounds.[4,5] This finding is supported by the Pathway needs assessments, all of which found serious problems with stigma and negative bias towards people experiencing homelessness, characterised by a lack of empathy and negative judgements. Some staff who were interviewed as part of the assessments said that the attitude that homelessness was a 'lifestyle choice' was quite common among other staff, leading to unconscious bias towards these patients. Pathway needs assessment interviews with people experiencing homelessness give a sense of how stigma is experienced by people in healthcare settings. People described negative experiences such as being noticeably treated differently than other patients, being left until last to be seen and receiving communication from healthcare staff characterised by rudeness and a lack of compassion.

As participants said with lived experience said, ***"Everything is different. It's as though they're talking to an animal",*** and ***"it took me ages to get heard, to get compassion".*** One participant, who described being treated differently from others, said,

> **"I don't see the difference between a homeless person and a normal person. The treatment should be the same".**
>
> *Needs Assessment Lived Experience Participant*

Faculty survey responses supported these findings, with one respondent saying that,

> **“Although people experiencing homelessness can access services, the way they are treated once there varies widely. People can be treated in a way that is dismissive or downright hostile. There is little acceptance of the particular needs of people experiencing homelessness.”**
>
> *Allied Worker, Specialist Hospital Team, Yorkshire & The Humber*

The evidence suggests that stigma can limit health service access in different ways. On the one hand, Faculty survey respondents described how stigmatising attitudes among staff can prevent services from engaging, with patients often being blamed for their situations rather than being listened to and supported. The result is that healthcare staff do not try to understand peoples’ needs and that, ultimately, the quality of care and support provided is extremely poor.

> **“My experience is that there is no understanding of the needs of patients with addictions or who are in methadone treatment. These patients are often blamed for their situations and their ‘behaviour’ rather than shown understanding for their previous trauma and their current needs.”**
>
> *Allied Worker, Specialist Hospital Team, North East*

At the same time, the kind of experiences described above can erode people’s trust in services, which may prevent them from seeking help in the first place or make them quick to disengage from services.

Pathway needs assessments interviewees who were experiencing homelessness also described how stigma can lower self-worth, which makes it harder to engage in recovery.

> **“Stigma affects people in inclusion health groups’ confidence to approach service providers. Being more likely to be judged due to possible issues with hygiene, literacy, language barriers or stigma means people in inclusion health may not always be offered the help they need.”**
>
> *Nurse, Specialist Hospital Team, London*

While concrete evidence on how to reduce stigma towards inclusion health groups is lacking, a common theme in the research is that stigma is often characterised by a lack of understanding of people’s needs and circumstances. Education and training on the backgrounds and needs of people in inclusion health groups may help to change attitudes towards them and, consequently, their access to and experience of health services. Some evidence suggests that approaches such as trauma-informed care[51,58] and Inter-Professional Education[66] challenge stigmatising attitudes in staff and make services more acceptable to people. For this reason, Pathway needs assessments consistently recommend that staff should be trained in trauma-informed approaches to care. However, we must note that, to the extent that stigma within healthcare services is driven by wider social attitudes, a broader societal shift in attitudes is also needed.

2.3 Barriers facing migrants in vulnerable situations

Migrants in vulnerable situations include people with various restrictions on their entitlements to support, commonly called No Recourse to Public Funds (NRPF), people with uncertain immigration status, asylum seekers and people who have been granted refugee status. On top of the barriers already described, these people face various additional challenges. Language and literacy issues can make engaging with health services a challenge, particularly alongside a need to understand how the health system works in a new country.[67,11,27] For example, people are often unable to get prescriptions, and when they do, they do not know how to get the medications or how to pay for them.[14]

As one Faculty survey respondent said;

> **"Asylum seekers don't always understand what services are for, so don't know what to ask for."**
>
> *Specialist Community Mental Health Service Manager, Yorkshire & The Humber*

For people seeking asylum and facing vulnerable circumstances, the evidence shows a significant lack of access to medical care[11] for acute and chronic conditions,[12,13] especially for children and pregnant women.[14] In addition to not knowing how the healthcare system worked, people seeking asylum also came across administrative and language barriers and digital exclusion.[11,27] Additional problems that seriously impact their health include lack of access to sanitary products, proper food, visits from care providers, access to opticians and dentists.[14] For destitute asylum seekers, the repurposed barracks and hotels that board them are reported to be unsafe and do not provide enough access to healthcare for the wide range of health issues they face.[12,13,14,50]

The Refugee Council (2022) states there are insufficient means and processes for people to bring up concerns and resolve issues with the asylum support and accommodation provided.[11]

For migrants without full legal status, concerns over NHS charging policies seem to discourage them from seeking help from NHS services, and this will only be exacerbated by further changes to NHS charging policies outlined previously in this report. For undocumented migrants, there are particular fears about engaging with health services, due to the perceived risk of being reported to the Home Office.[14] This prevents people from seeking help when they need it, and fears over providing their address can prevent registration with key health services, such as GP practices.[14] For people with NRPF, there are particular problems with accessing support from palliative care teams and hospices, and in access to detox, rehab and other substance misuse services.[65,67] The Pathway needs assessments found that people with NRPF face major challenges securing support on discharge from the hospital, leading to frequent reattendances at A&E.

2.4 Improving access – what works

Although there is limited capacity and inflexibility in the system, some interventions do help, ranging from different forms of support, ideally through services that work in collaboration, environments that are psychologically and trauma-informed, in-reach, outreach and drop-in services. A literature review mapping gaps and effective interventions to improve the welfare of people experiencing homelessness found access to support, including social and health care and other non-housing support, to be common facilitators for success, as was the staff within those services' ability to coordinate and communicate well.[55] The biggest facilitators for people receiving the services were emotional engagement in the intervention and security of accommodation. And from the case workers' perspective, the main facilitators were the staff's skills and ability to engage and communicate well with recipients. These kinds of support services were often provided as in-reach services to other NHS settings and outreach services to non-healthcare settings.

In-reach support showed a decrease in people returning to rough sleeping from the Out of Hospital Care Programme.[20] A specialist homeless team working with admitted patients at a mental health hospital (a Pathway team approach), found increased engagement with psychiatry, mental health nurses, GPs (over half), and social workers after discharge from hospital.[68] Outreach and drop-in services are a key theme within the literature, with evidence suggesting they are effective at improving engagement with services,[44,69,70] reducing rough sleeping,[22] facilitating access to dental care,[71] encouraging high engagement for opportunistic testing, increasing delivery of care for hepatitis B and C,[72] and engaging people who are sex working.[44]

There is evidence that peer support can change experiences and tackle barriers for people experiencing multiple disadvantage, with specific evidence reporting positive impacts for people experiencing homelessness, such as improved social support and quality of life, reduced substance use, and better outcomes related to housing.[22] Common threads influencing change were developing trusting relationships, demonstrating respect and dignity, a person-centred approach allowing flexibility in support to respond to individual needs, offering choice, support and encouragement to make good choices, and being gender-informed.[22]

Studies suggest that trauma and psychologically informed environments can improve engagement by effectively training staff to support patients with complex needs and trauma.[58] Integrating services is also effective for people who have experienced trauma and have multiple needs, with improvements in mental health and reduced substance misuse being key outcomes.[58]

Other evidence for tackling barriers includes psychological therapy/treatment,[69] psychologically informed environments and training and staff support provided in organisations offering trauma-informed approaches.[58]

Policy and recent evidence highlight the importance of care integration and collaboration between services,[73,10] as well as collaboration with people with lived experience.[4,18,44,46,70,72,74]

Evidence suggests, and the Faculty survey found, that collaboration is happening, with many respondents valuing the opportunity to share knowledge and experience and combine resources where possible,[50,54,66,73] with NICE highlighting the importance of collaborating between health, social care and housing services.[18]

The various Pathway health needs assessments found some effective collaboration between hospitals and community providers; however, there was a need for improvement across all locations. These improvements included engagement, effective communications, and meetings to discuss and plan with primary care and community services, social services, housing, and homelessness services. From the Faculty survey, 61.3% of inclusion health specialists, and 56.5% of mainstream healthcare staff, said they had seen improvements in collaborative working with other relevant services, with examples such as collaborations between specialist services and dental organisations, and co-located service hubs to improve access being given.

For the Changing Futures programme, their baseline evaluation found a third of participants were regularly creating and developing services together with barriers to collaboration such as geographical differences, competitive commissioning, a lack of long-term funding creating more turnover and change within the services, and challenges in joining up priorities.[50] However, the Changing Futures programme strives to increase collaboration and integration; therefore, we can optimistically expect this number to increase.

Beyond Pockets of Excellence:

How ICSs can go further for people in inclusion health groups

Integrated Care Systems offer a significant opportunity for collaboration and integration between services in the interest of improving the health of people in inclusion health groups.

Many ICSs are working in this way already. Pathway, The King's Fund and Groundswell supported seven of them in 2022/23 to go further in this ambition, learning about evidence and underpinning system change to bring about improvements in services for people facing homelessness and other forms of social exclusion. The report[75] from this work suggested a framework to guide other ICSs who want to do more to address the poor access, experience and opportunities discussed here.

The seven point framework covers: Brutal truth and honesty from the outset; Shifting the balance of power; Harnessing levers for radical change; Beyond health, considering housing as a foundational step; Establishing specialist services that reflect best practice; Holding the mirror up to generalist services; Keeping truth to the fore: Evaluation and revision.

2.5 How these barriers play out in health services

In addition to identifying common barriers to health service access for inclusion health groups, the evidence also highlights several important service types that are especially challenging to access, along with barriers specific to different healthcare service types.

When asked to rate the ease of access to a range of mainstream health services, Faculty members highlighted dentistry (88.5% Difficult or Very Difficult), mental health (87.2% Difficult or Very Difficult) and primary care (71.7% Difficult or Very Difficult)) as being particularly challenging for inclusion health groups to access. However, no health service the survey asked about had more than a third of respondents rating them as being either 'Easy' or 'Very Easy to access', showing that inclusion health patients face access issues across the board.

The evidence review also highlighted general practice and dentistry as mainstream services that are particularly challenging for inclusion health groups to access.[50,71] This is especially true in areas with more deprivation, where it is challenging to recruit and retain staff, and the pressure on health services is arguably higher compared to wealthier areas due to the multiple economic and social barriers to good health.[70]

"In the area you work in, how easy do you think it is for people in Inclusion Health groups to access the following mainstream healthcare systems?"

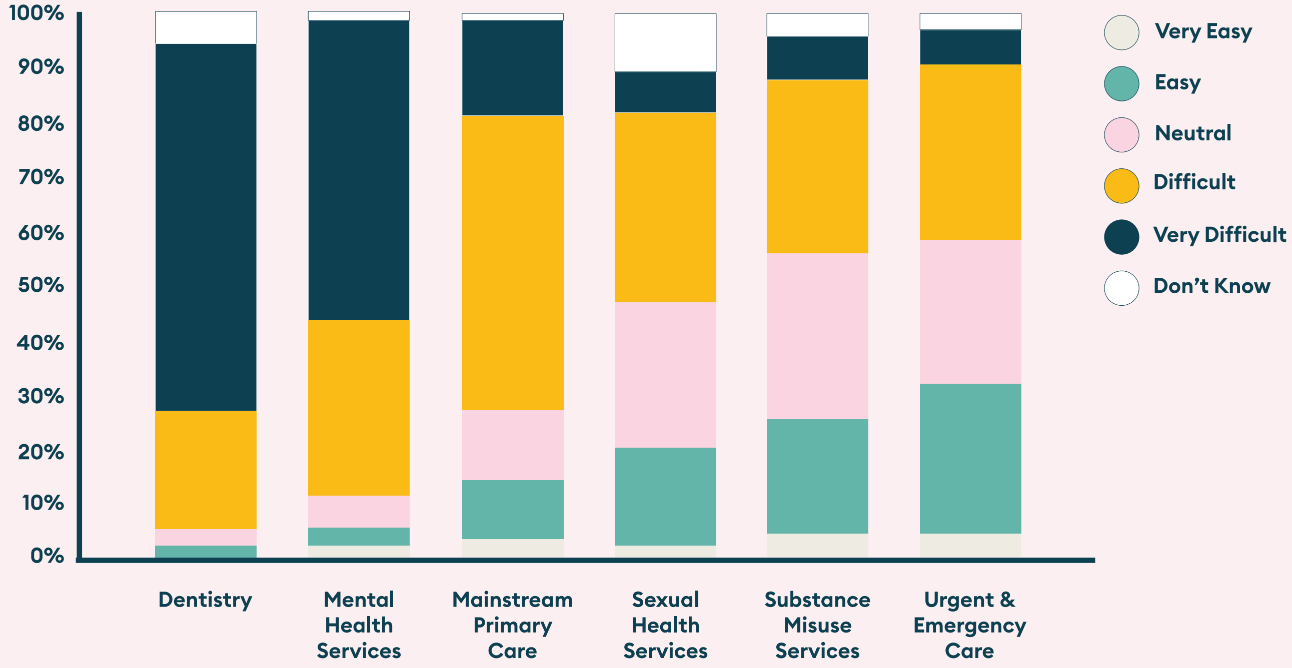

Figure 2.2: Ease of service access to mainstream healthcare services for people in inclusion health groups. Source: Faculty Survey n=156

Primary care

Primary care, which includes general practice and high street dentistry, serves a crucial function in our health system; however, its provision is not equitably spread across the country.[70]

In an exemplar of the inverse care law, despite some increased funding and staffing across England for general practice, the relative distribution of primary care services remains inequitable, and areas with more deprivation are still found to have less funding and fewer doctors.[70] From the cumulative array of needs assessments on homelessness, there is a clear need for improved access to primary care, especially General Practice, podiatry, dentistry, palliative care and other community care services, as well as non-clinical support, such as outreach to help people receive follow-up care and services. More provision of outreach services is also needed to make sure that people experiencing homelessness benefit from prevention, surveillance and disease management services.

Increasing levels of provision of these services would help to decrease relative rates of morbidity and mortality, improve care coordination and communication between services and reduce hospital admissions.

A key consequence of primary care access issues for people in inclusion health groups may be a reduction in access to preventative healthcare. Homeless Health Need Assessment (HHNA) data presented in Spotlight shows significant gaps around Hepatitis B vaccination (% of respondents with 3 doses: 12.2% in Wave 2, 5.8% in Wave 3), flu vaccination (% vaccinated in the last year: 20.8% in Wave 2, 17.6% in Wave 3), breast cancer screening (% screened in the past year: 41.1% in Wave 2, 37% in Wave 3) and cervical screening (% screened in the past three years: 57% in Wave 2, 54.1% in Wave 3), for people experiencing homelessness.[76] Survey data shows similar gaps for Liveaboard Boaters; 48% of female respondents aged 25-49 did not receive an invitation for cervical screening when they should have, and 33% of eligible people did not receive an invitation for bowel screening (Friends, Families and Travellers Survey via Spotlight).[76] Whilst NHSE data presented in Spotlight also shows a decline in breast cancer and cervical screening rates in the general population,[76] it is important to note that the impact on people in inclusion health groups will likely be greater due to wider difficulties accessing treatment services, unstable living situations and higher likelihoods of co-morbidities.

There are other barriers in preventative health. For example, in one study about cardiovascular services, people experiencing homelessness were aware of the importance of preventive measures, but they did not routinely engage with them.[61] This was due to a lack of access to facilities to maintain good hygiene, to healthy food options, to safe storage of medications, and problems of disorientation, undermining self-care potential and capacity to access services without support.

General Practice

General practice plays a fundamental role in mediating access to health and care services, especially in relation to preventative health service interventions.[77] However, people from inclusion health groups encounter multiple barriers, both in registering and then engaging with general practice.[12,50,53,78] From the very outset of trying to seek medical care in the community, people in inclusion health groups find registering difficult because many practices incorrectly require proof of identification and proof of address, which many people in these groups do not have.[50,53] Registration and maintaining registration with primary care is challenging for people who move about, which is often the experience of people within inclusion health groups.[12] In addition, many general practices ask new patients to register online, a digital exclusion for those without access to the internet or credit on their phone.

In the Faculty survey, 64% of respondents identified patients being refused for identification or proof of address as a barrier to service access, something that has been previously identified as a key barrier to mainstream primary care access.[79] A mystery shopper exercise which attempted to register Romany people with no fixed address or proof of identity clearly demonstrated these issues, with 75% of attempted registrations being refused and just 8% being accepted (Friends, Families and Travellers via Spotlight).[76] Of the refused registrations, the most common reasons were patients being unable to provide both proof of identity and address (39/75), unable to provide proof of identity (13/75), unable to use online registration facilities (11/75), and unable to provide proof of address (8/75).[76]

Once people are registered, there are multiple barriers to engaging with the service. These include discrimination, communication barriers,[78] including language barriers,[53] difficulty navigating the system, and digital exclusion, which often results from not having enough funds to own or run a mobile phone or not having the ability to use the technology.[53,77] Since the pandemic, access has become even more challenging with general practice working more remotely and online.[53]

A small number of Faculty survey respondents noted some improvements to primary care access, though these seemed to be limited to individual practices rather than across the board. Respondents noted that, even where good practice existed, it was a ***"post-code lottery"*** (Dentist, Specialist Dental Service, London) as to whether people were able to access these services. Other comments included ***"access to primary care for people experiencing homelessness is notoriously difficult"*** (Healthcare Commissioner, North East) and ***"General Practice is becoming increasingly difficult to contact, register and get appointments due to capacity issues"*** (Medical Doctor, Street Outreach Service, London).

The Pathway needs assessments found a clear need for better access to and use of primary care and for GP and other community services to engage earlier with patients. Low percentages of hospital patients registered with a GP suggest that some conditions which patients presented with at the hospital could have been managed in the community. It also indicates that potentially preventative interventions were not taking place, and because conditions are not picked up earlier on, severity when patients do seek care is higher. When a patient did have a GPs or community team involved, communication was often poor with the hospital, and when people who were homeless were admitted, there were inconsistencies in the treatment and care they received.

The first comparative study in the UK evaluating models of care in primary health and their provisions for people experiencing homelessness found that mainstream GP practices were not meeting the needs of single adults experiencing homelessness.[10] This NIHR-funded study also found that specialist services were able to provide better assistance and care, with higher satisfaction and confidence scores from their recipients.

Specialist GP services and specialist primary health care centres for people experiencing homelessness proactively anticipated and addressed barriers by offering flexible appointments, working collaboratively with other professionals, and providing continuity of care. The mainstream GP practices ran differently with large patient lists, fixed appointments, no dedicated homelessness staff, a lack of homelessness specific services, and were not linked with other existing homelessness services in the community. However, a couple of mainstream GP services did perform well for health screening and satisfaction scores, so the study suggests that if conditions are right, some mainstream GPs can meet the needs of people experiencing homelessness.

Dentistry

Access to dentistry across England is at a crisis point for all.[79] When available, it largely does not meet the needs of people in inclusion health groups[10,79] with the following contributing factors: providers lack resources, including trained staff and language translation services, confusion about who pays, and limits to how much care can be provided built into primary care contracts for dentists.[71] Also, dentists tend to be inflexible with both appointments and location of care, which is vital for inclusion health groups. In addition, phobia and anxiety about dental care are high for people in inclusion groups, to the point of them not engaging in its care.[10] By missing preventative treatment, symptoms and outcomes worsen, and without access to dentistry at all, people experience pain on a regular basis and seek help for oral health problems via already overburdened GP and A&E services. Since the pandemic, access has become worse for inclusion health groups,[77] and in addition to the incapability of the current service delivery model to meet patient needs, there is a clear need for training for dental staff to improve competency in working with inclusion health groups.[71] However, respondents from the Faculty survey also highlighted examples of drop-in services and appointment flexibility for dental health that were effective.

Faculty survey respondents noted that dental services were “non-existent” and that “access to dentistry is impossible even for those who are not in inclusion health groups” (Nurse, Street Outreach Service, London). As one respondent explained, “Dentistry is difficult for poorer people to access full stop, and it’s even worse for inclusion health groups” (Speech and Language Therapist, Specialist Community Service, London). Overall, 21% of Faculty survey respondents said that dentistry services were difficult to access, and 67% responded that they were very difficult. HHNA data further supports these findings, with just 49% of respondents in Wave 2 and 53% in Wave 3 reporting being registered with a dentist (HHNA via Spotlight).[76]

A systematic review found that integrated services (like housing services with mental health and substance use support) can be effective in improving oral health and associated health behaviours such as diet, substance use, and smoking for people experiencing severe and multiple disadvantage.[62] The review also found these interventions, specifically on substance use, to also demonstrate some evidence of cost-effectiveness, although limited.

Been a while since you smiled?

You have a right to a healthy mouth!

Keep your mouth healthy!

- Brush your teeth **twice a day**
- Use toothpaste with **fluoride**
- Brush for **2 minutes**
- Cut down on **sugary snacks and drinks**
- **See your dentist** as often as they recommend
- If you **smoke or drink alcohol** then going to the dentist is even more important.

There is an NHS Dental Service nearby that can help you!

Your local NHS dental practice(s) taking patients are:

What does treatment cost?

If you are on most benefits you can get NHS dentistry for **free**. Take proof of your benefits with you each time you go to the dentist. There may be set charges if you are not on benefits.

For more information on dental services talk to:

Call NHS 111

If you need treatment urgently.

You can find other dental practices at **www.NHS.uk**

www.groundswell.org.uk

@itsGroundswell

Produced in collaboration with Public Health England, The Healthy London Partnership and Groundswell. Groundswell is a charity that involves homeless people in creating solutions to homelessness. We specialise in supporting people with health issues.

Groundswell oral health poster:
Been a while since you smiled?[8]

Palliative care

The evidence review and Pathway needs assessments also found major gaps in provision for people experiencing homelessness and needing end of life care.[54,73] A community of practice with professionals working in or interested in homelessness and palliative care found barriers to providing palliative care related to a lack of funding for programmes creating staff capacity problems, a lack of involvement in communities, stigma in relation to substance misuse and resource constraints making it difficult to provide necessary facilities and equipment.[54]

Pathway's needs assessments found there was no end-of-life forward planning, a lack of links to hospices and palliative care and a clear need for earlier recognition of an individual's deterioration and earlier engagement with services. Putting plans into place and engaging with palliative care services are especially important for people experiencing homelessness who often do not have someone to provide care at the end of life and are often in accommodation, such as assisted living projects and hostels, not equipped to support people who are dying.

What's working in primary care

A scoping review on improving primary care access found that promising interventions were usually developed and provided in the community and for local community inclusion groups and reported advocacy, training, and involving people with lived experience as effective in improving access.[82]

To tackle barriers in primary care, some evidence suggests that simplifying the processes within the health care system for inclusion health groups would help.[53] For example, having good staff communication, providing continuity of care, increasing staff capacity, and tailoring services to better meet people's needs. The authors also highlighted other influencing factors, such as being able to see a GP face to face, as well as having remote access, and the time and ability to build trust.[53] What has shown to be effective for GP registration for inclusion health groups is outreach to help people learn and understand their rights and the services available, one-to-one support, and specialist GP services.[78] For people experiencing homelessness, having a general practice well integrated with other services and providers provided favourable outcomes.[10]

Building Equitable Primary Care toolkit[83]:

An evidence-based, interactive toolkit for practitioners and policy makers alike to help guide them in decision making to reduce health inequalities, including inclusion health groups. This toolkit is the result of a collaboration between two independent studies, EQUALISE and FAIRSTEPS, to produce a guide which explains what equitable care can look like in primary care and gives examples of how to tackle inequities in care.

The toolkit acknowledges the challenges for general practice and provides the gold standard practices can strive for based on evidence of what works.

Acute care

People facing homelessness are disproportionately heavy users of hospital services, caused in part by the barriers they face when trying to access other parts of the healthcare system.

Accident and Emergency (A&E)

People experiencing homelessness are intensive users of A&E, according to the Pathway needs assessments. This is reinforced by HHNA data showing that 48% of respondents in Wave 3 had at least one accident and emergency (A&E) attendance during the previous 12 months, and 11.3% (had at least four attendances (HHNA via Spotlight).[76] Whilst the exact figures vary, multiple sources have found that people experiencing homelessness attend A&E much more frequently than the general population. For example, prior to the scope of this review, one study found that just 0.5% of the general population attend A&E each year.[84]

HHNA data also indicates why some people in inclusion health groups attend A&E, with physical health problems/conditions (32%), self-harm/attempted suicide (18%), mental health problems/condition (14%), and accidents (10%) as the most common A&E attendance reasons amongst respondents (HHNA via Spotlight).[76] For people in prison, 2017/18 data shows laceration (9.2%), dislocation/fracture/joint injury (8.8%) and poisoning, including overdose (4.6%) as the most common reasons for attendance from this cohort (NHS Hospital Episodes Statistics via Spotlight).[76]

Faculty survey respondents noted multiple barriers to patients accessing and receiving care in these settings, including long wait times, issues with addiction withdrawal, the intense and stressful nature of A&E space, and stigmatising attitudes from A&E staff. The result is that ***"patients often self-discharge before treatment, due to waiting times and withdrawing from drugs or alcohol whilst waiting"*** (GP, Specialist GP Practice, North West). The Pathway needs assessments confirmed this; people experiencing homelessness regularly leave A&E without being seen for this range of reasons. As lived experience participants in the needs assessments said, ***"Sometimes it's just too many people there, for people who use drugs. There's a lot of mental health stuff. I'm uncomfortable in here, there's too many people. The general public are frightening"*** and ***"You can't sit there for 4 or 5 hours when you are clucking (withdrawing) from class A drugs".***

The question of why people facing homelessness use A&E so intensively is an important one. It seems to be due to a combination of factors including people's complexity of needs, lack of routine access to and engagement with primary care. As described above, the multiple barriers to primary care that people experiencing homelessness face mean that their current ability to access this form of care is severely constrained. This has two consequences. First, it makes A&E the most accessible healthcare service in their lives, driving demand there. Second, it leads to the deterioration of health conditions until people are in crisis and have no option but to go to A&E. This represents significant cumulative missed opportunities for prevention across the system and across the homeless population, in turn leading to major personal costs to individuals and high costs to the system. This points to the need for creative solutions in primary care as a possible response. High treatment thresholds and capacity issues within other services[50,65] also play a part in intensive A&E use, along with a general lack of adult social care and low engagement of safeguarding teams.[21]

Supporting people experiencing homelessness in accident and emergency settings: helpful sources for staff

Pathway, checklist and toolkit:
A toolkit, which includes a checklist, equips emergency departments to support people experiencing homelessness and rough sleeping in a person-centred, holistic way. It aids departments in recognising areas for improvement to help with admissions, length of stay, re-attendances and readmissions. It includes statutory requirements related to the Duty to Refer.[85]

Education and training:
This free course provides an overview of the challenges which can present when people experiencing homelessness attend an A&E setting, including issues of self-discharge, the safeguarding framework around self-neglect, and mental capacity.[86]

Outpatient

Hospital data analysed as part of the Pathway needs assessments consistently show that people experiencing homelessness have higher 'did not attend' (DNA) rates to outpatient appointments than other hospital patients. Data from 2019/20 shows the same trends for people in prison, who had a DNA rate of 18% compared to 6% in the general population and cancelled appointments in 14% of cases compared to 8% for the general population (NHS Hospital Episode Statistics via Spotlight).[76] For this cohort, the data show Gastroenterology (26.7% DNA), Trauma & Orthopaedics (26%) and Oral Surgery (25.8%) as the specialities with the highest DNA rates (NHS Hospital Episode Statistics via Spotlight).[76]

For pregnant women in prison, 2019/20 data shows higher proportions of missed appointments than the general population for midwifery and obstetrics appointments.[76] While the gap between the two cohorts is relatively small for midwifery (21.5% women in prison vs 16% general population), it is significantly larger for obstetrics (31.5% vs 16.8%).[76] This may be a reason why pregnant women in prison face high rates of delivery complications, such as post-partum haemorrhage (20% of births), delivery complications due to foetal stress (13% of births) and premature labour and delivery (11% vs 6.5% general population) (NHS Hospital Episode Statistics via Spotlight).[76]

Inpatient and hospital discharges

Pathway needs assessment data shows that people experiencing homelessness are more likely to have emergency inpatient admissions, as opposed to elective, than the general population. Similarly to A&E attendances, HHNA data shows physical health problems or conditions (37.3%), mental health problems/conditions (13.4%) and self-harm/attempted suicide (13.4%) as the most common reasons for admission amongst people experiencing homelessness (HHNA via Spotlight).[76] For people in prison, injury/poisoning/external cause (19%) and diseases of the digestive system (17%) were the two most common primary diagnoses on admission (NHS Hospital Episode Statistics vis Spotlight).[76]

However, people in inclusion health groups rarely have just one health problem upon hospital admission. When people experiencing homelessness are admitted to hospital, their lengths of stay are usually longer than people who are housed, due in part to the complexity of their needs, according to the Pathway needs assessments. This is reinforced by a cross-sectional audit of inpatients facing homelessness in 15 London hospitals, which highlights the relationship between the complexity of need and the importance of the availability of appropriate discharge accommodation. It found people experiencing homelessness in hospitals with high levels of complexity, including mental health problems, substance misuse and life-threatening illnesses.[8]

Fifteen of the 86 patients in the audit had five to eight coexisting conditions. The hospital teams involved with these patients reported that it was unsafe for nearly all of the patients identified to return to their previous living situation (ranging from the street to hostels), leading to delayed discharges, a phenomenon also documented in the Pathway needs assessments. However, due to the limited accommodation options available, teams admitted that many patients (24%) were most likely to be discharged to suboptimal locations. About half of the patients (51%) needed intermediate care, while 48% required other forms of long-term care. Only one patient (1%) needed accommodation alone.

This study identified a lack of appropriate step-down accommodation as a major barrier to safe discharges.[8] This was reinforced by the Pathway needs assessments, which found particular gaps in specialist services for women, people with uncertain housing eligibility, people with high mental health needs, and people with substance use issues.

Faculty survey respondents also highlighted a number of challenges to safe and effective hospital discharges. The biggest issues were shortages of appropriate accommodation, pressure from within the hospital to discharge patients to free up beds, a lack of long-term care placements and a lack of floating/wrap-around support. Highlighting these issues, a lived experience participant in the Pathway needs assessments said, ***“I was in (hospital) for 6 weeks. When the time (for discharge) came, they told me to go to housing. When I got there, they didn’t have anything for me”.***

Barriers to effective hospital discharges for people in inclusion health groups

"Outside the availability of intermediate care placements, what other barriers do you think there are to safe and effective hospital discharges for people in Inclusion Health groups? Please select all that you think apply to the area that you work in"

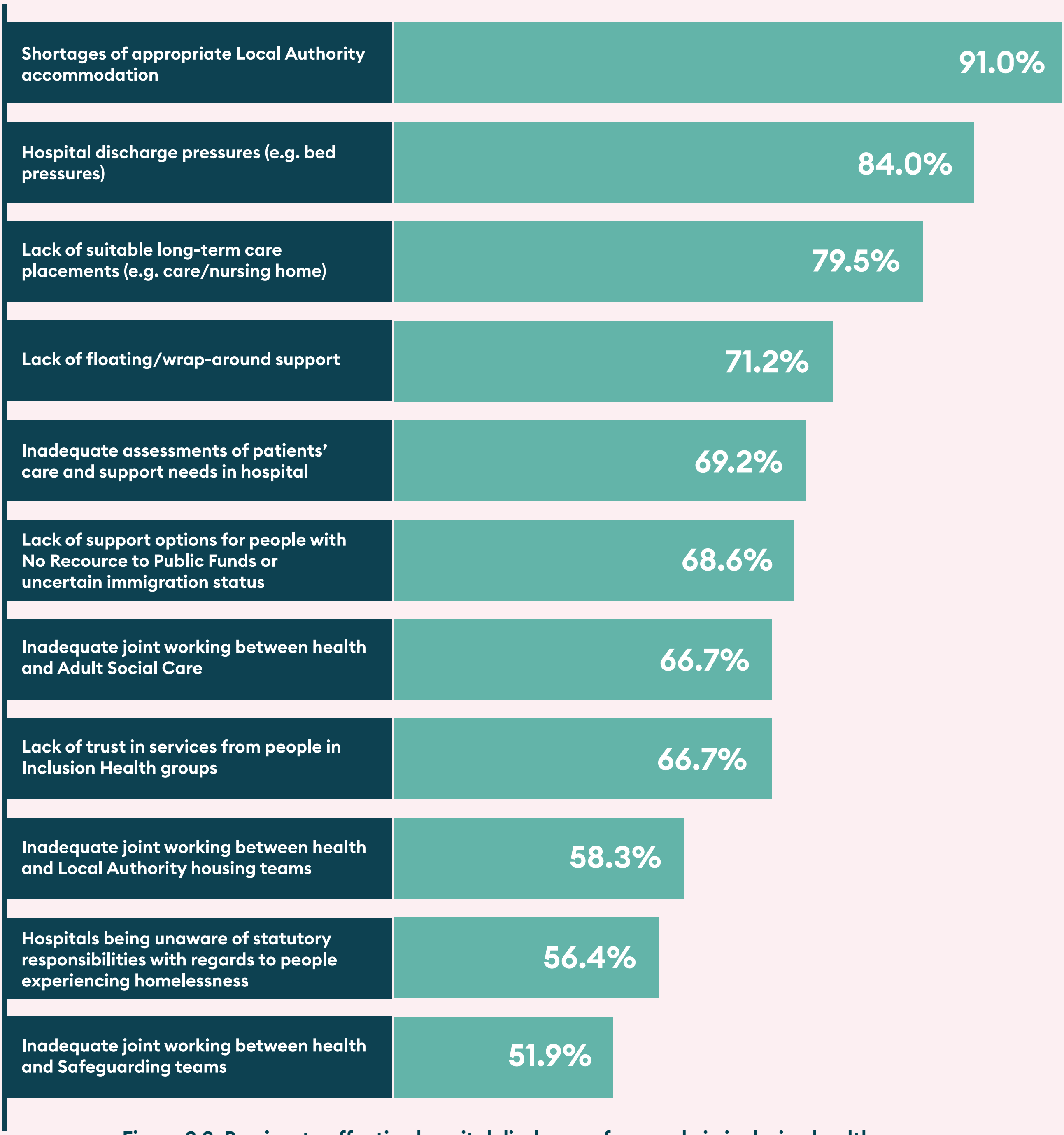

Figure 2.3: Barriers to effective hospital discharges for people in inclusion health groups
Source: Faculty Survey n=156

Hospital discharge outcomes for people in inclusion health groups

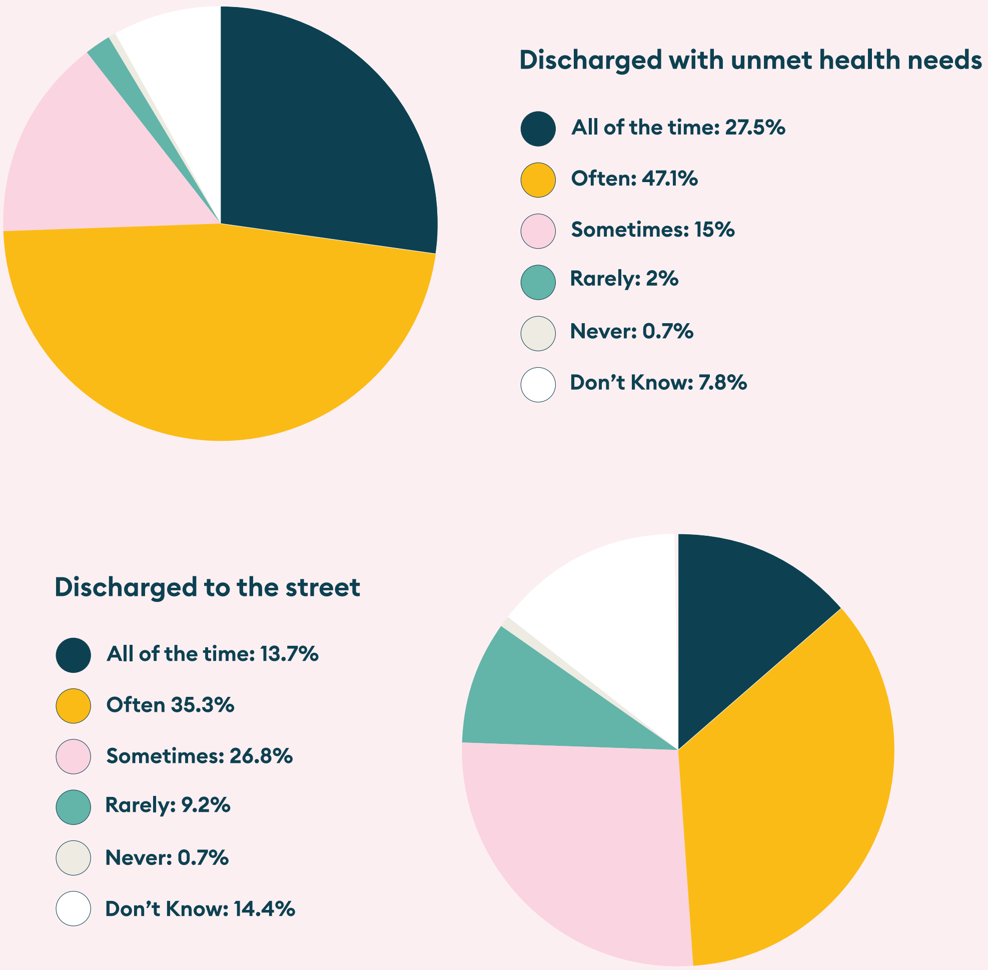

Figure 2.4: Hospital discharge outcomes for people in inclusion health groups
Source: Faculty Survey n=153

The consequence of this is that people in inclusion health groups are frequently discharged from hospitals with unmet health needs and to the street, according to Faculty members. HHNA data supports this, showing that, of respondents in Wave 3 who had been admitted to the hospital, 24% were discharged to the street, and 21% were discharged to unsuitable accommodation (HHNA via Spotlight).[76]

Uncertainty over their hospital discharge can be a significant cause of distress for people, with one lived experience participant in the pathway needs assessments saying,

> **"When you get discharged, you shouldn't have to worry about where you are going to...it made me feel lonely and depressed".**
>
> *Needs Assessment*
> *Lived Experience Participant*

The Pathway needs assessments collectively highlighted practice within hospitals as another driver of unsafe or inadequate discharges for people facing homelessness. This included inadequate discharge plans, including follow-up care, leading to people returning to the hospital. This was often due to overstretched staff combined with long referral processes, poor communication and poor coordination, and some stigma and bias. For example, GPs would be documented for follow-up when there was no GP listed for the patient, or the location for discharge would be "home" when there was no home for the patient to go to.

Other examples include a lack of arrangements for community nursing to provide wound care or discharging a patient to a hostel that was not able to provide the care needed.

Other evidence also found a lack of communication and coordination between hospitals and hostels, with hostel managers saying they are not consulted or often ignored by hospital staff, resulting in a quick return to the hospital for the patient.[21] The hostel managers thought that hospital staff did not take into account the hostel as a discharge environment, nor consider that a hostel cannot provide care.[21] Consistent recommendations from the Pathway needs assessments were to provide holistic, individualised planning, improved coordination and communication with community services and often, provide drop-in support as well as outreach services.

Other data sources support the findings that, for people experiencing homelessness or people experiencing opioid withdrawal, hospital discharges are often poorly managed.[15,19,20,87]

Due to hospitals being unable to manage the complexity of needs and a lack of appropriate accommodation to meet those needs, patients were either inappropriately discharged, delayed in hospital[18,19] or self-discharged.[15,87]

There is evidence of good practice happening with the Pathway needs assessments naming: in-reach teams, outreach services, multi-agency collaboration, multi-disciplinary meetings, including meetings about people who attend A&E frequently, A&E-based social workers, and access to legal advice.

Staff from the NHS, local authority, and third sector gave recommendations on how to improve discharges for people experiencing homelessness in deprived areas and recognised the need to improve partnership working and funding. These recommendations included education for staff about the population they serve and the law to improve confidence in questioning inappropriate discharges; improve planning by creating checklists that remind practitioners to secure support and care for the patient at discharge location through effective communication and information sharing; and recognise the importance of third sector and partnership working.[52]

The Pathway needs assessments also recommended training for hospital staff on identifying people who are homeless early on, using the statutory Duty to Refer to increase access to housing. The assessments highlighted the need to recognise that homelessness includes people in temporary accommodation and hostels, as well as people sofa surfing, in addition to sleeping rough. Where Pathway needs assessments find more than 250 homeless patient admissions per annum and no existing response, they tend to recommend the creation of a Pathway team. During 2022-23 Pathway was supporting nine Pathway hospital teams across England through our structured support offer – the Pathway Partnership Programme.

Intermediate care

Intermediate care services support people with health needs who cannot be safely managed in the community but who do not need inpatient hospital care.

This includes step-down services for those being discharged from the hospital and step-up services which aim to prevent deterioration and avoid the need for hospital admissions.
As described above, hospital discharges for people experiencing homelessness are generally poorly managed, with people commonly either being discharged to the street or back to accommodation which is not suitable for their needs. A substantial amount of evidence has highlighted how intermediate care services, in particular specialist step-down services, can have a range of positive outcomes in relation to hospital discharge. The strength of this evidence is such that specialist intermediate care provision for people experiencing homelessness has been recommended in the NICE Guideline for homelessness.[18] As well as improving health outcomes, reducing delayed discharges and improving follow-on care and support, research suggests that intermediate care is more cost-effective than standard discharge procedures and can prevent unplanned reattendances and readmissions to hospital.[19,20]

The literature suggests that there is a high level of need for such intermediate care services. A cross-sectional audit of 15 specialist homeless health teams in London hospitals found that 51% of patients on these teams' caseloads needed intermediate care following discharge due to the need for continued health support, accommodation and unresolved immigration issues.[8] An audit of homeless hostels in London identified that patients are often discharged to hostels whilst having care and support needs that are too high for these settings but which could be met in specialist intermediate step-down settings. A key challenge for hostels, which might also be met with better provision of intermediate care, was obtaining Care Act and safeguarding assessments for residents.[21]

The need for intermediate care services was also identified as a key gap in provision throughout Pathway needs assessments, with step-down services highlighted as an effective way of ensuring that the health needs of people experiencing homelessness were met following discharge. This analysis found that good step-down services should be safe spaces where other services could come and engage with patients, bringing in additional forms of support beyond medical interventions. Such integrated care is vital to address the often multiple and complex needs of people facing homelessness and is in line with evidence-based successful approaches.

Despite evidence of its effectiveness and cost-effectiveness and evidence demonstrating a high level of need for these services, the provision of specialist intermediate care remains far below what is required. Faculty survey responses highlighted significant gaps in the provision of intermediate care services for patients in Inclusion Health groups, with just 5.9% of respondents saying there was enough to meet the level of need in their local areas.

Level of intermediate care provision

"In the area you work in, are there intermediate care services that people experiencing homelessness and other inclusion health groups can access following hospital discharge?"

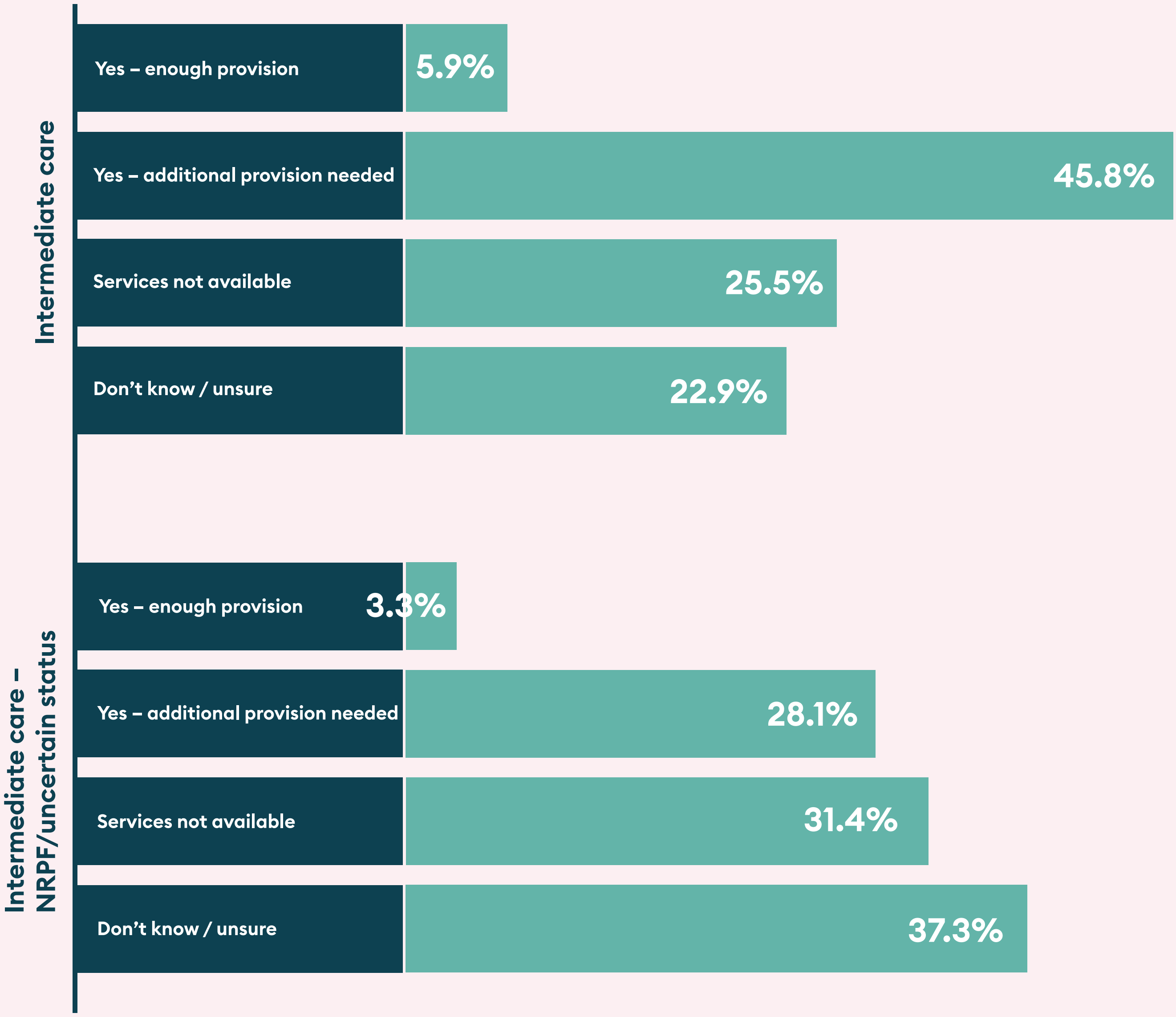

Figure 2.5: Level of intermediate care provision for people in inclusion health groups and people with No Recourse to Public Funds/uncertain immigration status
Source: Faculty Survey n=153

For patients with No Recourse to Public Funds or uncertain immigration status specifically, just 3.3% of respondents said that there was enough intermediate care provision. Pathway needs assessments also found that the provision of such services was generally lacking, which routinely resulted in avoidable hospital discharge delays, discharges to unsuitable accommodation with unmet health needs and a lack of additional care and support to secure any health gains achieved during the admissions.

Qualitative responses from the Faculty survey also showed that where specialist intermediate care does exist, it faces significant pressure in terms of demand:

> **"There are no step-down beds available and frequently people experiencing homelessness are barred from accessing rehab facilities or assessment beds as they have no address to return to. There is very limited access to social services through the hospital and this means clients are placed in inappropriate accommodation and ultimately return to hospital."**
>
> *Voluntary and Community Sector Manager, South East*

The overall gap in the provision of intermediate care is a fundamental problem that needs to be addressed urgently.[8] Previous efforts to address this gap, primarily the DHSC-funded Out of Hospital (OOH) Care Programme, were central to demonstrating the feasibility and potential benefits of such services.[19,20] Although the economic evidence began to show cost savings and the early outcomes demonstrated improved outcomes for people,[19] many of these programmes are no longer running or are at risk of closure due to the short-term nature of the funding and funding uncertainty.

Mental health & substance misuse

People in inclusion health groups are more likely to experience mental health problems than the general population, yet face multiple barriers to accessing mental health support.[32]

Mental health problems and substance misuse are deeply interlinked, with poor mental health often contributing to the development of substance misuse problems – both present significant challenges for people in different inclusion health groups. However, the evidence shows that significant access issues exist for these services and that services are often unable to effectively support patients who suffer from both conditions.

Evidence from the literature,[6,9,10] the Faculty survey, and the Pathway needs assessments show major barriers to accessing mental health services, including high service thresholds, long waiting lists, a lack of mental health outreach and very limited service capacity. For people experiencing homelessness, their mental health problems impacted their engagement with different services and care, as did their distrust of services due to poor experiences in the past.[61] Evidence and the Pathway needs assessments also found gaps in services such as work and employment support, volunteering, and other activities, aimed to help people find meaning and purpose and improve their mental health and wellbeing.[65] Just 5.7% of Faculty survey respondents felt that mainstream mental health services were 'Easy' or 'Very Easy' to access, and just 9% said there was enough specialist mental health service provision to meet the level of demand.

The evidence review identified multiple issues facing vulnerable migrants with regard to accessing mental health services.[4,11,12,13,88] In addition to language and literacy complications, asylum seekers and refugees face the challenge of being frequently moved, limiting their ability to access and receive support from services. For those living in immigration detention centres, multiple reports highlight a lack of mental health provision despite the high prevalence of mental health problems and complex trauma in these settings.

Barriers identified facing Gypsy, Roma and Traveller groups included a hesitancy amongst men to admit to mental health issues, and the fact that mental health information is usually written in a format not designed for people with low literacy levels.[6] Another study identified the same problems for Showmen, with both men and women being reluctant to admit to their mental health problems, despite a high level of prevalence.[5] With stigma associated with poor mental health and the belief that professionals would not be able to understand them and their lifestyles, most Showmen felt they had to live with their issues and just carry on.

Consistently, the literature suggests that care navigators help improve outcomes for people in inclusion groups, especially by improving people's sense of wellbeing and mental health.[22] This is also supported by the Pathway needs assessments.

Dual diagnosis

Mental health and substance misuse problems often co-occur (dual diagnosis), both within the inclusion health population and beyond. For people experiencing homelessness, HHNA data shows that 25% self-reported having a dual diagnosis, and 45% of respondents reported self-medicating with drugs or alcohol to cope with their poor mental health.[7,76] More widely, from 2017/2018 to 2022/23, the proportion of all people starting drug treatment with a mental health need rose significantly for both young people (27% to 48%) and adults (41% to 71%) (NDTMS[4] via Spotlight).[76]

Despite these well-evidenced links, mainstream mental health and substance misuse services are provided in separation. Both the Pathway needs assessments, and Faculty survey highlighted how the presence of substance misuse issues can act as a significant barrier to accessing mental health support, with services not accepting referrals for patients with substance misuse problems. As one Faculty survey respondent said,

> **"The hesitancy of these services to treat people with both poor mental health and active addiction leaves people trapped in a negative spiral".**
>
> *(Healthcare Commissioner, North East*

The Faculty survey and Pathway needs assessments highlighted how the unwillingness of mental health services to work with people who have substance misuse problems is underpinned by stigmatising attitudes around substance misuse as a 'lifestyle choice'. As a lived experience participant in the Pathway needs assessments described,

> **"Now they know about my drink and drugs I feel like they are not bothered...now they know me, they turn their nose up".**
>
> *Needs Assessment Lived Experience Participant*

Often, people were even blamed for their condition. As Faculty survey respondents said;

> **"There is often stigma and discrimination and lack of understanding amongst mental health workers about those who use substances and are experiencing homelessness."**
>
> *Psychologist, Specialist Service, Yorkshire & The Humber*

> **"Mental health services are, in my experience, a place of some of the most profound stigma and system complexity people in inclusion health groups experience."**
>
> *Researcher, National Role*

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[4] NDTMS = National Drug Treatment Monitoring System. The NDTMS collects person level, patient identifiable data from drug and alcohol treatment providers at a national level.

The result of separated mental health and substance misuse service delivery and the presence of stigmatising attitudes within these services is that people experiencing dual diagnosis struggle to access appropriate support. HHNA data hints at these barriers, with just 19% of respondents who had an alcohol problem and 24% of people who had a drug problem receiving counselling or other psychological support.[7] The Pathway needs assessments found that often, when patients with substance misuse problems were admitted to the hospital due to mental health problems, these were often overlooked and under-documented due to the stigma that exists towards people with substance misuse issues. This resulted in patients being dismissed as having behaviour issues due to substance misuse and proper psychological or neurological investigations not taking place. In addition, staff often failed to recognise when a patient was in withdrawal. This commonly resulted in patients leaving the hospital to self-medicate and then returning later or being lost to services.

Substance misuse

Compared to mental health services, Faculty respondents felt that mainstream substance misuse services were somewhat easier to access (26% rated them as easy to access) and that specialist substance misuse service provision was somewhat better (19% said there was enough local provision). However, both of these figures still indicate generally poor access, with significant gaps in access and provision. For drug treatment programmes in general, available data indicates concerning downward trends - from 2014/15 to 2020/21 - the rate of successful drug treatment programme completion declined steadily from 16% to 13%, and the proportion of Local Authorities with a lower-than-expected rate of treatment completion increased between 2018 and 2020 (NDTMS via Spotlight).[76]

Both the Faculty survey and evidence review highlighted a lack of access to stabilisation, detoxification and rehabilitation beds as key issues.[65] In addition, people experiencing homelessness have additional barriers; as one Faculty survey respondent explained, ***"Frequently people experiencing homelessness are barred from accessing rehab facilities or assessment beds as they have no address to return to".*** With regards to people with NRPF and alcohol dependencies, one survey respondent said that ***"access to rehab is almost zero".***

When someone from a hostel or supportive accommodation does access detoxification and/or rehabilitation, they are at risk of becoming street homeless if they relapse whilst within these establishments.[65] Evidence shows that some people will need multiple attempts at detoxification and rehabilitation, especially if they have a history of rough sleeping.[65] The

process or journey is not always a one-off success story; however, the current system is not designed to meet people's needs.
An evaluation of London's pathway for detoxification and stabilisation for people at risk of or experiencing rough sleeping found that, even when people were able to access detoxification or rehabilitation, the lack of suitable discharge accommodation often led to relapses.[65] A contributing factor to relapses was that the only option after completion was for the person to return to the same accommodation they lived in prior to detoxification or stabilisation, without enough or any psychological support. The access to substances in these environments was usually easy, and negative influences from others living there were strong. Some participants of the evaluation felt they were often '"setting people up to fail"' by sending them back to "wet" environments.[65] The Pathway needs assessments found the same issue. This once again shows the foundational nature of housing and how its absence is a direct barrier to recovery.

Looking specifically at opioid substance misuse, people using illicit opioids face stigma and biased treatment.[15] They have more hospital admissions than the general population within the same age group and they are more likely to self-discharge, often due to the onset of withdrawal symptoms and the lack of rapid substitute prescribing.[15] There are high risks of mortality in patients in this group.[15] For managing opioid withdrawal, poor or absent hospital policies across England and a lack of regular training for medical staff pose a risk to patients.[15] A review discovered that hospital policies in a quarter of the 134 hospitals studied did not include opioid substitution treatment (OST) prescriptions and opioid withdrawals.[15] Those with a policy in place were commonly inconsistent with national guidelines and had highly inconsistent procedures, creating barriers to timely and safe withdrawal management for inpatients. In addition, the policies often used stigmatising language and described patients as untrustworthy if using drugs. Not identifying and treating someone in withdrawal can not only cause the person to suffer, but it can also be dangerous. Without proper intervention, people are highly likely to self-discharge, self-medicate, and then return to the hospital, resulting in reattendances and admissions or, worse, creating a dangerous risk of death.

Improving service access for people with substance use problems

To better support people with substance use problems and improve access to care and services, evidence calls for integrated substance misuse support[9,61] and much of the evidence suggests peer support, as well as co-design of services with people with lived experience and co-production, can help tackle existing barriers and improve access.[22,65]

People with lived experience of substance use issues and homelessness reported that having trust in someone and being trusted in return was key to aiding recovery.[65] In addition, receiving compassion, having some choice, and receiving ongoing, long-term support that included peer support and help with personal development were helpful.[65]

For people who were rough sleeping, effective outcomes were associated with a system working together with multi-agency partnerships, preparing people prior to detoxification (such as arranging accommodation and engagement with a person-centred, biopsychosocial programme), completing residential long-stay rehabilitation and placement in stable, secure housing.[65] Noting there is not much evidence on trauma-informed care for people with substance use problems, evidence suggests the need for research on how trauma-informed care can benefit these individuals.[58]

Based on a review of substance dependency management policies across NHS Trusts, interventions (an advocacy card and helpline, online training, an advocate role, and a hospital template) were developed in collaboration with people with lived experience.[87] These interventions and an opioid dependence management policy template are being implemented and tested currently, with learning to help with further development and evaluation.[15,87]

Specialist inclusion health services

There is a growing body of evidence demonstrating the positive impact that specialist inclusion health services can have on patient engagement, health and housing outcomes.[19,20,23,68,74,90,91,92]

Specialist service provision has been recognised in NICE Homelessness guidance as key to meeting the needs of people experiencing homelessness.[18] Positive evidence exists for a wide range of specialist service types, such as specialist multi-disciplinary inclusion health teams in-reaching to other NHS services and outreaching to the streets and community, specialist step-down services[23] and embedding social workers and housing workers within homeless health teams.[92] This section explores the provision of specialist inclusion health services and discusses some of the factors that have been found to limit their effectiveness.

Faculty survey responses hinted at some improvements in specialist service provision, with 50.6% of respondents saying that it had improved over the past 3 years, and 44% noting an improvement in staffing levels and resources at their specialist service over the past year. While these responses are somewhat encouraging and may reflect a growing awareness of inclusion health, responses also showed that there are significant gaps in provision of a wide range of specialist service types.

The chart on the next page shows that, while specialist services are generally present in those areas of the country where Faculty survey respondents work, they believe there are large gaps between levels of need for these services and levels of provision. For example, while 70.3% of Faculty survey respondents said that some specialist mental health services exist in their local area, just 9% said there was enough provision. The responses indicate that street outreach services, specialist GP practices and specialist substance misuse services are amongst the more commonly provided specialist service types, although all had less than 23% of respondents say that there was enough provision. The responses also highlight significant gaps in the provision of specialist hospital-based teams (like Pathway teams), with 28% saying that the services do not exist but are needed in their local areas.

Despite their well-evidenced effectiveness, the evidence reviewed for this report suggests several factors which limit the impact of specialist services. Many specialist services operate in challenging contexts, with increasing local demand for services combined with inadequate resources and staffing levels creating unsustainable workloads undermining services' ability to achieve positive patient outcomes. In the context of rising levels of homelessness[25] and an increasing number of migrants being made homeless, 75% of Faculty survey respondents who work in specialist IH services said that increasing local demand for their service was a challenge, and 64% said that inadequate service resources were a challenge.

Staff often cover large areas or manage large caseloads, which negatively impacts care quality and can lead to high levels of burnout and stress; 61% of Faculty respondents working

Level of specialist service provision

"For the following types of specialist health service, please select what is available in the area you work in..."

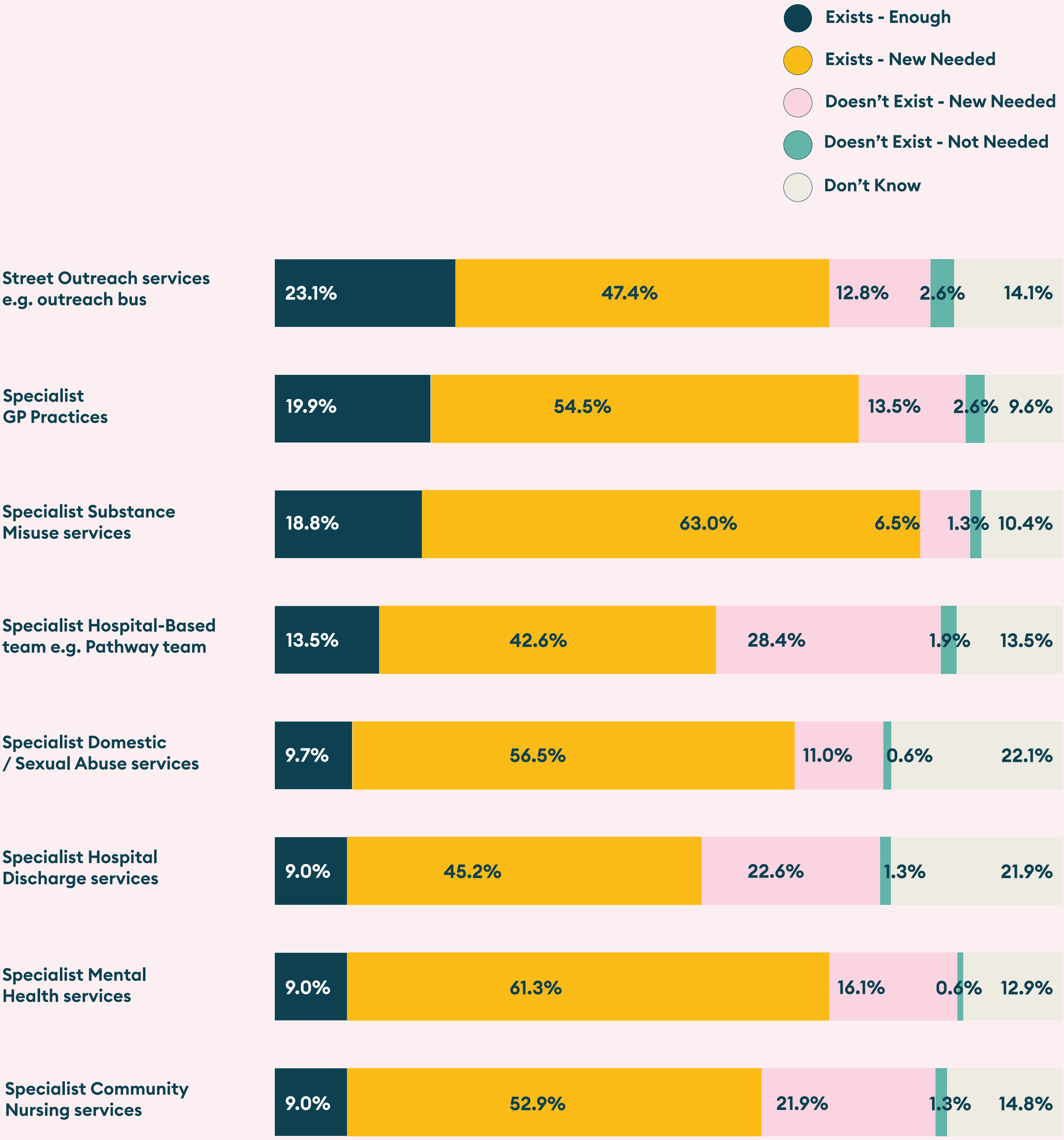

Figure 2.6: Level of specialist service provision for people in inclusion health groups
Source: Faculty Survey n=156

in specialist services said they find their work to be stressful. In this context, it is concerning that just 27% of these Faculty survey respondents said that support for staff had improved over the past year.

> **“I am the only person working in my specialist role as an Inclusion health Practitioner, for which I am allocated 7.5 hours a week to cover two large localities. This is not enough time or resource to dedicate meaningfully to Inclusion health.”**
>
> *Nurse, Specialist Community Service, East of England*

> **“I cover a huge area with very little support.”**
>
> *Nurse, Specialist Community Service,* West *Midlands*

> **“While I am able to give the right care as an individual, I find my work stressful because the team is short staffed, so the service is inadequate as a whole.”**
>
> *Nurse, Specialist Hospital Team, London*

The Faculty survey, Pathway needs assessments, and the evidence review all highlight how funding issues can limit the impact of specialist services.[6,50] Firstly, underfunding leads to inadequately resourced and staffed services, which are then limited in the care they can provide, as shown by the quotes above.

Secondly, many specialist services are funded on a short-term basis with constant uncertainty over continuation of funding – 59% of Faculty survey respondents working in specialist services described this as a challenge. Funding uncertainty has significant negative impacts on services’ ability to recruit and retain staff,[6] which limits their ability to provide effective care for patients and contributes to increasing pressure on remaining staff members. Pathway needs assessments highlight how funding uncertainty and staff turnover can also prevent relationship-building and collaborative working across local healthcare systems, both of which are key to meeting the needs of inclusion health patients. Overall, gaps in the provision of specialist services, funding and resource issues for existing services can act as key barriers to access.

Even when patients can access specialist services, the evidence suggests that the extent to which these services are able to achieve positive outcomes for patients is constrained by the challenges that people in inclusion health groups face when accessing further support from mainstream health, housing and social care services.[21,22,23] For example, specialist hospital teams may struggle to improve health outcomes without adequate housing support and effective engagement with their patients from mainstream mental health and substance misuse services. This sentiment was expressed by Faculty survey respondents who felt that, despite their hard work and some improvement, their service could only do so much without engagement and support from other mainstream services.

As respondents said;

> **“We do our best and have things to celebrate but we are simply tinkering with the shop window. There is very little in the shop itself.”**
>
> *GP, Specialist GP Practice, South West*

> **“I think health care provision generally has struggled in past few years, and those at the sharp end of that suffer more as a result. However, we have seen increased funding into specialist homelessness services and substance use services in the hope that these will expand and offer a wider service. However, this is a bit of an uphill struggle given the wider social context of a struggling health and social care system, housing system and asylum system.”**
>
> *Psychologist, Yorkshire & The Humber*

> **“For inclusion health groups, I think health outcomes are as bad now as 2020, but specialist health provision has worked bloody hard to help as much as they can.”**
>
> *Specialist Healthcare Service Manager, London*

As previously discussed, access issues with mainstream support are driven by multiple factors, including limited service capacity, stigmatising attitudes amongst staff and a lack of understanding of peoples’ needs; 73.3% of Faculty survey respondents working in specialist services said that a lack of understanding of the needs of Inclusion Health patients from other services was a key challenge, and just 26% of survey respondents working in mainstream services said they had access to enough training to effectively support inclusion health patients.

As well as preventing positive outcomes for patients, the unresponsiveness of mainstream services to the needs of inclusion health groups may further contribute to staff stress and burnout within specialist services. While pressures on staff are undoubtedly common across the NHS, specialist inclusion health staff face an “uphill struggle” and have to engage in “professional shouting from the rooftops” to secure much-needed support for their patients. Although specialist inclusion health services routinely play a central role in meeting the needs of people in inclusion health groups, the evidence is clear that their success is dependent on effective engagement in patient care from a range of other mainstream health and statutory services. The responsibility for improving the health of people in inclusion health groups cannot fall solely on these services and requires a system-wide response.


NHS
DOCUMENT WALLET
FOOLSCAP
#hello my name is...

Chapter 3. Statutory services and wider determinants of health

While the poor access to health services experienced by inclusion health groups is a central driver of the poor health they experience, it is also driven by a range of wider social determinants.[24]

Alongside the crisis within the health system, the UK is experiencing a housing crisis, rising cost of living, energy cost crisis, and consequent rising levels of destitution and poverty.[25] Many Faculty survey respondents highlighted these wider social determinants as being fundamental to the poor experiences and outcomes for inclusion health groups;

> **"Wider determinants (cost of living crisis, housing pressures) international migration, financially challenged statutory sector and political context are driving increased numbers in inclusion health groups and a very challenging planning and delivery context"**
>
> *Public Health Consultant, London*

> **"The negative trends are a direct consequence of low quality and quantity of housing in the region combined with less and less funding for local authorities to address the wider determinants of health"**
>
> *Dentist, Inclusion Health Research, National Role*

> **"The economic climate has compounded the existing complex needs and exacerbated them. Plus, in the last few months, the political climate has become increasingly polarised and divisive and is leading to inclusion health cohorts feeling less integrated at a societal level, which may lead to an increase in distrust of health and social care institutions."**
>
> *Voluntary and Community Sector Manager, South East*

Against this challenging backdrop, local authorities currently face a crisis in funding that has deep and far-reaching ramifications. Estimates point to a gap of up to £4 billion in local authority funding,[93] making it increasingly difficult for them to fulfil their minimum statutory duties. Statutory services such as housing, adult safeguarding and social care are unable to respond effectively to the needs of people in inclusion health groups, who often struggle to access and receive essential support from these services.[8,21]

The Faculty survey supported these findings, with respondents saying;

> **“Without exception, accessing safeguarding and care support is a game of high stakes chess with statutory services, at best, providing limited help with apologies that more is not possible, and, at worst, discriminating against inclusion health groups through invidious means.”**
>
> *Specialist Speech and Language Therapy Service Manager, London*

> **“In my experience over the years, response from Local Authorities, Safeguarding Teams and Adult Social Care have often been delayed or inadequate. Services are quick to say that a person has declined input or are not engaging if they do not respond immediately or as expected on initial assessment, which is often completed over the phone.”**
>
> *Nurse, Specialist Service, London*

When asked whether statutory services meet people in inclusion health groups’ needs, Faculty survey respondents felt very negatively about housing (80.8% Disagree), social care (79.5% Disagree) and safeguarding services (63.4% Disagree).

“Please indicate the extent to which you agree or disagree that the following statutory services are able to meet the needs of people in inclusion health groups in a timely and effective manner, in the area that you work in.”

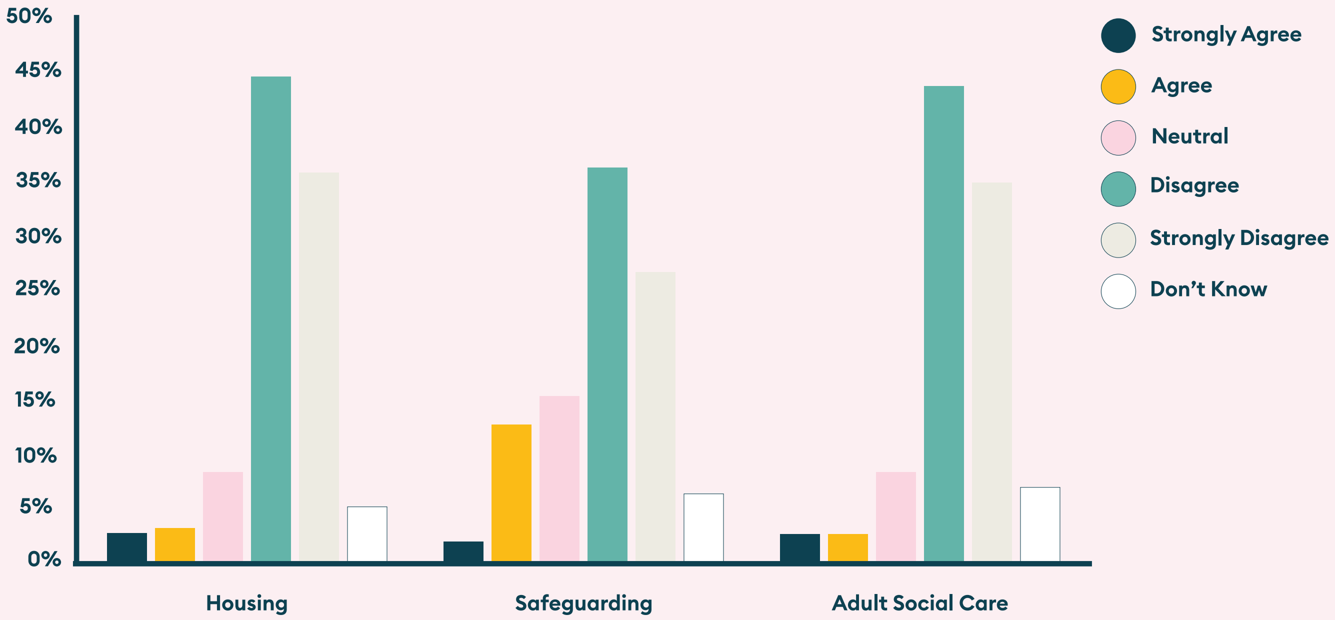

Figure 3.1: Responses to the needs of people in inclusion health groups (housing, safeguarding & social care services)
Source: Faculty Survey n=156

3.1 Housing and accommodation

Housing availability and quality is one of the most important social determinants of health,[24] and often extreme housing precarity is a common experience across inclusion health groups. This precarity is a central driver of the terrible health outcomes experienced by inclusion health groups - a lack of or poor-quality housing actively contributes to worse health, while health recovery following treatment is extremely difficult without somewhere safe and stable to recover.[24] Effective housing and accommodation responses are therefore vital to improving health outcomes for inclusion health groups.

However, the UK currently faces a deep housing crisis. Rising rents, LHA freezes, changes to housing benefits, and the benefit cap have all drastically reduced the affordability of renting, which is compounded by the increasing cost of living.[45] There is also a basic lack of sufficient social-rented and affordable housing.[45] The result is that more and more people experience housing precarity and, ultimately, homelessness. Crisis' monitoring of 'core homelessness' numbers shows an increase over time, reaching 242,000 in 2022,[25] while government statistics show that, between July and September 2023, 109,000 households were living in temporary accommodation, a 10% increase on the same time last year.[94] The government's most recent rough sleeping snapshot, which estimates how many people are rough sleeping on a given night, showed 3,898 people sleeping rough across England, an increase of 27% on the previous year.[95]

Local authorities are under extreme pressure to provide housing support to ever-increasing numbers of people with declining levels of housing stock and financial resources. They are having to spend increasing amounts of money on providing emergency and temporary accommodation by renting out hotels and B&Bs to house people, and many private landlords are capitalising on this demand by renting property to local authorities at high prices. As a result, spending on temporary accommodation has soared, with some councils spending between a fifth to a half of their core housing budgets on emergency or temporary accommodation.[96]

These pressures are further exacerbated by statutory demands placed on councils. While the 2017 Duty to Refer was a positive step in encouraging more effective housing responses, research has found that councils often struggle to meet their statutory duties to people experiencing homelessness who are being discharged from hospital.[43] The research found that, due to a lack of resources and poor integration between health and housing services, local authority responses to Duty to Refers from hospitals were often delayed or resulted in inappropriate housing placements.[43] Councils have also faced increased demands on housing due to the Ukrainian and Afghan placement schemes, along with wider asylum dispersal pressures. Housing options teams are bearing the brunt of these challenges, and research has shown that these teams are facing staff shortages driven by inadequate council resources and high levels of stress and burnout amongst the teams.[25]

In this challenging context, Faculty survey respondents highlighted how securing housing support for inclusion health groups is extremely difficult, with delayed responses, a lack of long-term housing options, the rejection of referrals because of priority need and intentionality judgements and a general lack of engagement all identified as key challenges.

As one respondent said;

> **“The housing teams are under extreme pressure with lack of provision, they are not easily accessible, and they often do not engage with our clients as they are difficult to reach”**
>
> *Nurse, Specialist Inclusion Health Service, Yorkshire & The Humber*

A further result of the current crisis is that the quality of available accommodation is often extremely poor and inappropriate for the complex needs typically seen amongst inclusion health groups. Importantly, Crisis’ research into ‘core homelessness’ shows the numbers of people living in unsuitable temporary accommodation having the largest proportional increase of all forms of homelessness.[25] Living in unsuitable accommodation prevents people from improving their health.

> **“Where people are housed, we often see inappropriate housing, e.g. placed in housing in which somebody is very vulnerable. Provision for women facing severe and multiple disadvantage and those with physical disabilities is especially limited.”**
>
> *Psychologist, Voluntary and Community Sector Service, East Midlands*

> **“People experiencing homelessness get offered inadequate temporary accommodation of poor standard and go through cycles of eviction/ rough sleeping/further inappropriate housing with no secure housing offer.”**
>
> *GP, Specialist GP Practice, South West*

On top of preventing recovery, there is evidence suggesting that living in temporary accommodation can actively contribute to poor mental and physical health. Survey research from Shelter found that 66% of people living in temporary accommodation reported it as having a negative impact on their mental or physical health, and 71% said their stress or anxiety had worsened because of their living situation.[97] People with lived experience shared from Groundswell that they do not have autonomy or control when it comes to temporary accommodation and they can lose confidence to engage and advocate for themselves.[98] One person said, **“I feel like I am sitting here, and everyone is just sucking all of the life out of me. And I have nothing left; I cannot fight anything anymore”.**

Living in temporary accommodation can also limit access to essential health services, such as primary care and mental health, because people may be placed in areas far away from the services they were previously using before moving into Temporary Accommodation.[98] As well as the limited and often inappropriate provision of temporary accommodation placements, the evidence review, [8,15,19,20,88,99] Pathway needs assessments, and Faculty survey all highlighted a lack of specialist and supported accommodation as a major gap in provision. For example, despite consistent evidence of its positive impact on a wide range of key outcomes, the provision of Housing First style interventions remains far below the level of need[25] and there are also gaps in the provision of other supported accommodation such as long-term care placements.[8,21] There is also a lack of specialist single-sex accommodation for women who, due to common experiences of domestic and sexual violence and abuse, often do not feel safe in places such as mixed hostels.[100]

This lack of safe accommodation heightens the risks that women face from violence and abuse and can cause them to abandon their accommodation placements for even riskier situations such as sleeping rough or sofa surfing.

In addition to the above challenges, many migrants face further barriers to accessing adequate housing support. For migrants with No Recourse to Public Funds, no statutory housing support is available, drastically reducing their options for securing housing. While some support may be available through third sector or Care Act referral pathways, these options are extremely limited and difficult to access. Research has shown that, for asylum seekers living in asylum hotels and immigration detention centres, accommodation has multiple negative impacts, including worsening physical and mental health, increasing feelings of isolation and loneliness and limited access to health services due to frequent moves.[4,12,13,14]

3.2 Adult social care and discharge to assess

While effective support in relation to the basic provision of housing is crucial for inclusion health groups, people also need to be supported in their accommodation once they have it. Due to the high levels of illness, disability and frailty within inclusion health groups,[8,21] many people have care and support needs that require input from Adult Social Care. Similar to housing, however, the deteriorating socio-economic climate and reduced local authority resources have led to significant pressure on Adult Social Care, which is currently in the midst of an ongoing workforce crisis.[101]

In this context, the evidence identified multiple challenges to securing social care support for people in inclusion health groups, including delayed response times, poor communication, inconsistent assessment outcomes and varying levels of engagement between different local authorities.[20,21,23,99] Faculty survey responses identified similar challenges and highlighted how social care teams often have a poor understanding of the complex needs of people in inclusion health groups, leading to inadequate assessment outcomes;

> **"In general, there is a very poor response from Adult Social Care teams across the board to concerns raised for this cohort. There is a lack of understanding of the issues and complexity faced by them and stigma around behaviours and presentation."**
>
> *VCSE Service Manager, London*

> **"Adult Social Care are massively overstretched. I can think of some really good examples of social care work, but also some very poor ones."**
>
> *Psychologist, VCSE Service, East Midlands*

Particular challenges were identified by the evidence review[23] and Faculty survey around Care Act assessments for people in hospital or step-down accommodation. For people in hospital, care act assessments often focus on peoples' apparent capabilities while on an acute hospital ward, failing to consider their likely living situation post-discharge. The result is that people will be assessed as having no care needs as they are able to function on the ward, leading to no or inadequate support after their discharge from hospital. As Faculty survey respondents said;

> **"I often hear that they are independent on the ward so they have no care needs, they do not take into account the conditions the person will be living in when they leave the hospital"**
>
> *Nurse, Mainstream Healthcare Service, Yorkshire & The Humber*

> **"I can't get appropriate Care Act Assessments for people experiencing homelessness in hospital which is discriminatory and affects their health outcomes"**
>
> *Nurse, Specialist Service, North West*

For hospitals using Discharge to Assess pathways, delays in assessment while people are in step-down accommodation contribute to people staying longer than they need in these settings, preventing move-ons and reducing the availability of already limited step-down placements for more people experiencing homelessness.[23] Delays in social care assessments, while people are in hospital, can also contribute to hospital discharge delays.

3.3 Adult safeguarding

Safeguarding aims to protect the health and wellbeing of at-risk adults by making sure they have the care and support they need and are safe from abuse and neglect. As people in inclusion health groups can often be in vulnerable circumstances, they are considered high-risk groups.[32] Safeguarding Adult Reviews (SARs) are ways to reflect on incidents for multi-agency and individual learning to see how the neglect, abuse, and/or death being reviewed could have been avoided. The most common of all SARs, including cases from inclusion health groups, is self-neglect, which makes up 45% of all SAR cases.[17] SARs found that failures are often due to practitioners’ lack of understanding or even recognition of self-neglect as a safeguarding risk, usually because an assumption has been made that a person is making ‘lifestyle choices’.[17]

Often, practitioners do not complete full assessments on risk and capacity, as well as care and support needs and do not make use of the full extent of the law.[17] Given the rates of self-neglect among some people facing homelessness, this lack of understanding is a particular barrier to care for this population.

Of the 86 patients experiencing homelessness in a hospital audit conducted across 15 hospitals in London, staff reported concerns about safeguarding in about 30% of these patients, with self-neglect being the main concern for over half.[8] Homeless hostel managers also reported having very vulnerable individuals living in hostels but struggling to get engagement from safeguarding teams.[21] The main reason managers put in a safeguarding referral was self-neglect; however, members of the local safeguarding team will often assume the person has capacity and leave, instead of triangulating information from other sources.[21,99] These managers reported they often have to make multiple referrals but still receive biased responses highlighting the residents’ substance use or self-neglect as reasons why they will not intervene.

There is a broad inconsistency of understanding and responsibility in relation to safeguarding and homelessness. Professionals often do not see people experiencing homelessness as appropriate for safeguarding referrals and instead think the person is making 'lifestyle choices' or that their main need is housing and so not the responsibility of safeguarding.[89]

Research also found that staff need training on how to recognise, protect, and support victims of modern slavery who are also experiencing homelessness.[52] Social care teams often do not understand the multi-layered complexity of needs, but even when that is not an issue, the general awareness of the lack of service provision and gaps in support for people experiencing homelessness is also a practical barrier, as staff feel there is nothing they can do.[89] And a study looking at homelessness and self-neglect worryingly found that social workers were not sure if homelessness and or self-neglect should be considered a safeguarding risk.[16] From communities of practice involving professionals including social workers and safeguarding leads, police and probation officers, a study found that “for people who are homeless, safeguarding has sometimes felt like no-one’s business because no one agency is seen as responsible.”[102]

Many Faculty survey respondents expressed challenges securing support from local safeguarding teams who only take referrals seriously with significant advocacy or with support or interventions from senior management in regional safeguarding structures. In particular, a failure to take self-neglect referrals seriously was highlighted as a key gap, leading to preventable deaths.

> **“Safeguarding referrals are a token gesture without any real outcomes.”**
>
> *GP, Specialist GP Practice, London*

> **“Safeguarding becomes a bit abstract if there is nowhere to house people.”**
>
> *GP, Specialist Hospital Team, South West*

> **“Safeguarding concerns are only dealt with in a timely manner if there is professional shouting from the rooftops in my experience.”**
>
> *Mental Health Practitioner, Specialist Substance Misuse Service, York & The Humber*

Multi-agency working, with experienced and trained multi-disciplinary staff, is considered effective and good practice for working with people who self-neglect and are experiencing homelessness.[16,102] Safeguarding Adults Reviews are also effective ways of spreading learning; however, social workers would benefit from more system level clarity about their safeguarding responsibilities in relation to homelessness, safeguarding and self-neglect.[16]

Guides and tools to promote safeguarding

Multiple Exclusion Homelessness Practitioner Safeguarding Toolkit: In collaboration with safeguarding and legal experts, people with lived experience, practitioners, and researchers, this toolkit has practical techniques to support practitioners with safeguarding.[103]

Modern Slavery and Human Trafficking

Trafficking Guidance for homelessness services: To increase awareness and educate about human trafficking and modern-day slavery, Homeless Link provides guidance for homeless services to help raise awareness and educate as a form of prevention.[52]

The Passage Modern Slavery Toolkit

A toolkit to help client-facing staff within Local Authorities and organisations develop multi-agency working and services to better support individuals experiencing and survivors of modern slavery.[104]

Chapter 4. Health outcomes

In the context of extremely poor access to health and statutory services, the national housing crisis and a deteriorating socio-economic climate, health outcomes for inclusion health groups continue to be extremely poor. People from inclusion health groups continue to experience high rates of preventable and treatable conditions and mortality rates many times higher than the general population, along with particular issues with mental health, substance dependence, and untreated physical health problems.[6,32]

Concerningly, 57% of Faculty survey respondents felt that health outcomes had worsened among people in inclusion health groups over the past three years, while three quarters thought that the complexity of needs had increased. Respondents highlighted an increase in co- and multimorbidity, increasing levels of complexity at younger ages, and increases in the levels of mental health and substance misuse problems amongst these groups.

> **“Hostel staff report that the people within their higher support/ complex needs hostels are coming in at a progressively younger age and with increasing complexity. This is a trend over more than 3 years - more likely over around 5-7 years”**
>
> *Medical Doctor, Inclusion Health Research, National Role*

> **“We are now seeing more clients with more complex health needs, including life-limiting conditions, and have to fight to garner support and remain an advocate as they cannot speak for themselves.”**
>
> *Nurse, Specialist Community Nursing Service, London*

“Over the past three years, I think that health outcomes for people in inclusion health groups have…”

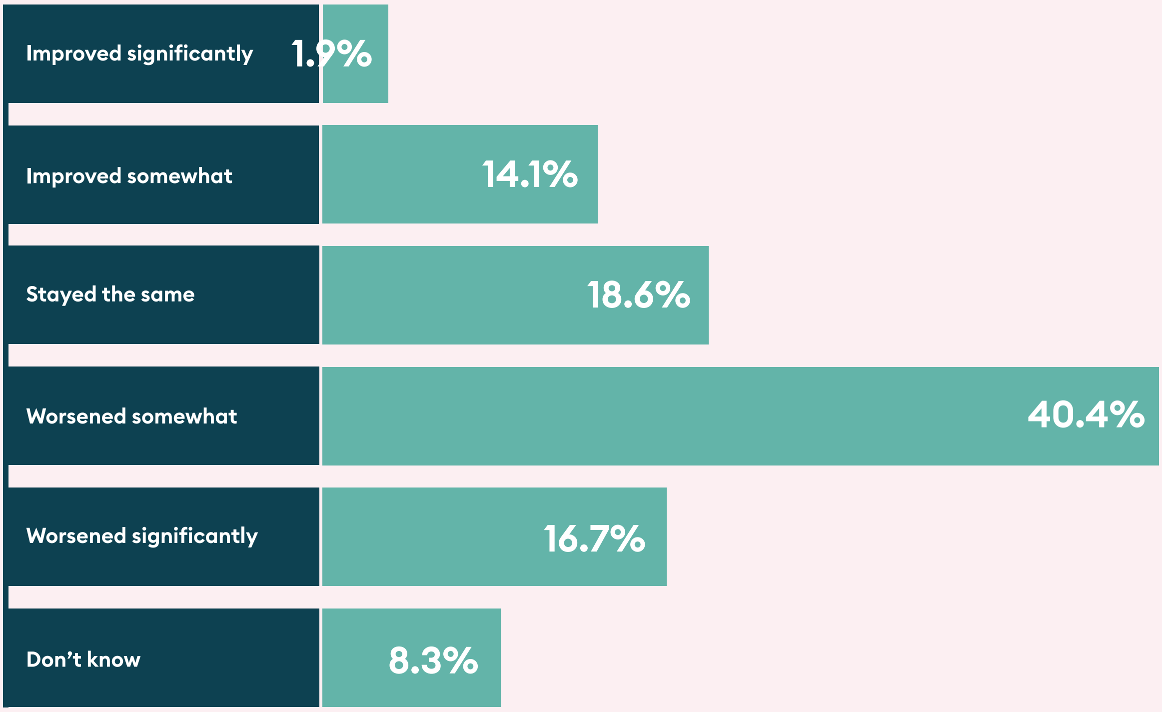

Figure 4.1: Perceived health outcomes for people in inclusion health groups
Source: Faculty Survey n=156

“Over the past 3 years, I think that the complexity of health, care and support needs amongst people in Inclusion Health groups has…”

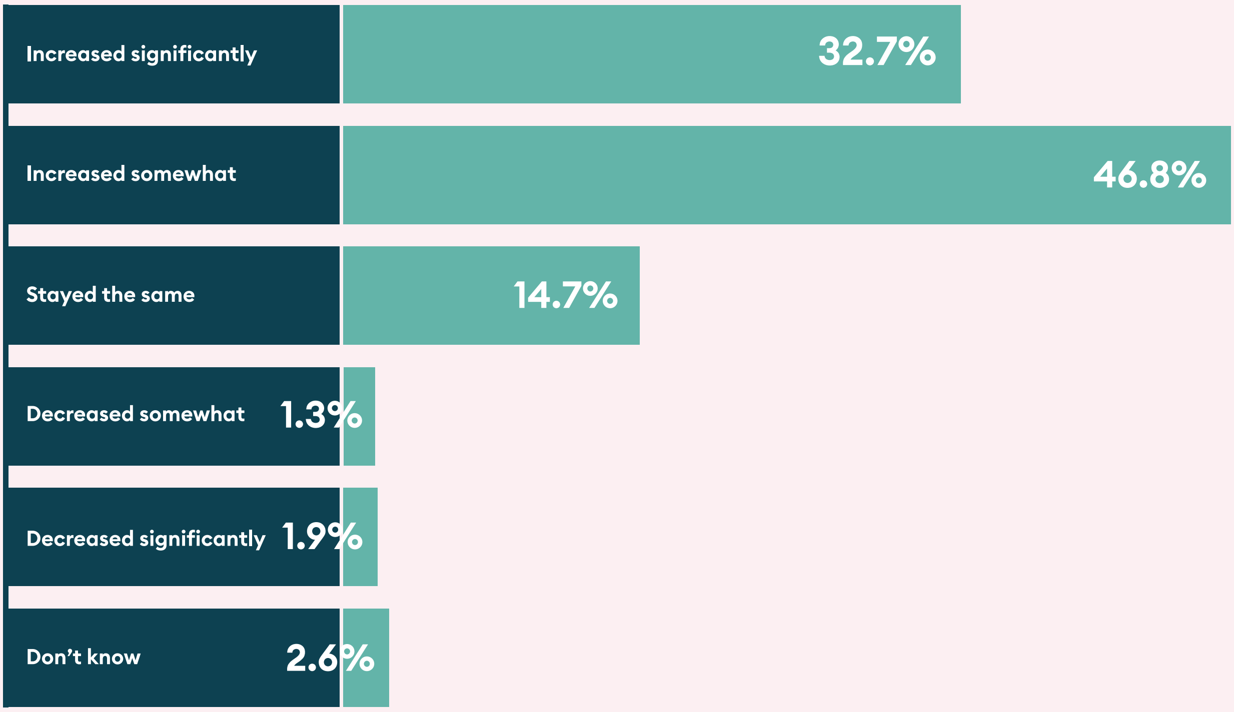

Figure 4.2: Perceived complexity of health, care and support needs amongst people in inclusion health groups
Source: Faculty Survey n=156

4.1 Mortality

With death as the most extreme poor outcome, available mortality data reflects this very challenging picture. Numbers of reported deaths among people experiencing homelessness are estimated to have risen from 482 in 2013 to 741 in 2021 in England and Wales,[77] though this may well be an under-estimate.

The Museum of Homelessness, using a different methodology, estimated 779 deaths in 2021 and 951 in 2022 in England and Wales.[105] While these figures cannot show us whether the increases are driven by higher mortality rates, changes in recording practices or increasing numbers of people experiencing homelessness, they must be a significant cause for concern, nonetheless.

ONS (via Spotlight) data highlights mental health issues and addictions as notable causes of death among people experiencing homelessness, with drug poisoning, suicide and alcohol-related deaths accounting for over half of all estimated deaths. There are also a significant number of deaths from preventable and treatable physical conditions.[76]

The ONS is considering ceasing the publication of its statistics on the deaths of people experiencing homelessness, and its consultation on this issue has recently closed. While these statistics are experimental, they are critically important to building the overall picture of the health of people facing homelessness. In light of the already significant gaps in such health data, the ONS should work towards raising the quality of the homelessness deaths data to the level of National Statistics rather than cease their publication.

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[5] The GP Patient Survey assesses patients' experience of healthcare services provided by GP practices, including experience of access, making appointments, the quality of care received from healthcare professionals, patient health, and experience of NHS services when their GP practice was closed. The survey also includes a number of questions assessing patients' experience of NHS dental services.

4.2 Multimorbidity

Evidence shows that people in inclusion health groups often experience complex combinations of physical health, mental health and substance misuse. For example, a hospital audit of people experiencing homelessness found many patients with multimorbidity, with 17% having more than five physical health conditions and over one third with a combination of mental health, substance misuse and physical health issues (described as tri-morbidity).[8] Other studies of people experiencing homelessness found that people often live with multiple long-term conditions and experience levels of frailty normally associated with the elderly.[8,21,99]

HHNA data supports these findings around multi-morbidity; of those with a physical health condition (78% of all respondents), 48% had between 2 and 4 physical health diagnoses, and a further 29% had between 5 and 10 physical health diagnoses.[7] Of the physical health conditions identified among respondents, joint aches/bone and muscle problems (37%), dental/teeth problems (36%), asthma (24%), eye/vision problems (22%) and stomach problems, including ulcers (20%) were the most commonly reported.[7] 63% of HHNA respondents reported a long-term illness, disability or infirmity, compared to just 22% of the general population.[7] Amongst a wider cohort of people in drug treatment, available data suggests an increasing complexity of need, with the proportion of people with one or more disabilities rising from 18% in 2016/17 to 30% in 2022/23 (NDTMS via Spotlight).[76] It is unclear from this data, however, whether this is driven by increasing levels of need, or better recording and reporting of disabilities within NDTMS datasets.

A comparison of people with known psychiatric needs who were and were not experiencing homelessness found higher prevalence and severity of mental health, substance misuse and physical health amongst the homeless cohort,[46] and a study of people experiencing homelessness who had overdosed identified that 70% were frail, with an average of 2.2 mental health problems and 5.4 physical health problems per participant.[9]

For the Gypsy, Roma and Traveller communities, NHS Race and Health Observatory (2023) published a report highlighting the increasing prevalence of poor health outcomes.[6] Even compared to other ethnic minority groups, access and health outcomes are far worse for these communities, with significant numbers of people with chronic conditions, disabilities, and mental health problems. GP Survey[5] data presented in Spotlight partially supports these findings, with 20.5% of White Gypsy/Irish Travellers having at least two long-term conditions, one of which was musculoskeletal, compared the England average of around 13% (GP Survey via Spotlight).[76] However, for White Roma, this figure was just 6%.[76] Asylum seekers in vulnerable circumstances also have low health status compared to the general population and high physical health, mental health and safeguarding risks.[12,13,27]

Multiple hospitals covered by the Pathway needs assessments reported that the development of multiple and complex conditions could have been prevented through effective community care and earlier interventions. Instead, the lack of provision results in conditions becoming more severe and ultimately requiring acute hospital care. They also showed that a lack of adequate follow-up care post-discharge prevents recovery and causes further health deterioration, resulting in further hospital admissions.

4.3 Mental health

Recent evidence continues to show that mental health outcomes are extremely poor for different inclusion health groups.[6,27,46,47] For people experiencing homelessness without children who were owed a prevention or relief duty in 2022/23, 32.1% had a mental health support need (DLUHC[6] via Spotlight).[76] Among other cohorts of people experiencing homelessness, extremely high rates of mental health problems have been shown; 82% of respondents to the HHNA had a mental health diagnosis, and 44% had three or more diagnoses – comparatively, in 2020, just 10.2% of the general population reported a mental health condition (HHNA and GP Survey via Spotlight).[7] While the experience of homelessness itself has a detrimental impact on mental health, it is interesting to note that HHNA data shows that 72% of respondents reported developing a mental health problem prior to becoming homeless.[76] This suggests poor mental health can play a key role in pushing people into housing precarity and homelessness.

Similarly, an evaluation of the first year of the Changing Futures programmes found that 83% of participants had experienced mental ill health, and almost 70% had experienced mental ill health combined with drug/alcohol problems.[50] HHNA data also highlights mental health as a key reason for hospital attendance and admission for this group; 32% of respondents' most recent A&E attendances were due to suicide, self-harm or mental health problems, and 28% of respondents' most recent Inpatient admissions were for the same reasons (HHNA via Spotlight).[76]

Mental health similarly presents a significant problem for asylum seekers, refugees and other migrants who often suffer from social isolation, loneliness and feelings of imprisonment, in addition to widespread experiences of trauma.[13,14,27] These factors have a huge negative impact on the mental health and wellbeing of this group. A review of detainees at an Immigration Removal Centre identified high levels of mental health issues and that almost all had a potential history of being tortured.[27] For asylum seekers in hotel accommodation, decreases in wellbeing and increases in mental health issues have been documented.[57] Both of these sources highlight how the conditions people are accommodated in actively contribute to declining mental health outcomes.

> **"The increasingly hostile environment for asylum seekers, for example, has led to poorer mental health. Whilst healthcare is finally realising this is an area which needs greater attention and is putting roles and strategies in place to improve this area, the general climate and policy is detrimental."**
>
> ***Midwife, Specialist Inclusion Health Service, South East***

A report on clinical assessments of asylum seekers identified for relocation to Rwanda found that the prospect of removal was having significant detrimental impacts on their mental health, resilience and wellbeing, especially for those who had experienced trauma.[36] Out of the 37 people in the report, 26 had strong signs of histories of torture and 17 of being trafficked.

Fifteen out of 37 people were living with post-traumatic stress disorder. For some individuals, the risk of self-harm and suicide increased, with attempts at suicide already being reported. For people in prison, self-harm (often indicative of poor mental health) presents a serious concern; from 2013 to 2021, the rate of self-harm incidents in prisons has risen for both males (214 per 1000 to 561 per 1000) and females (1546 per 1000 to 3697 per 1000) (HMPPS[7] via Spotlight).[76]

4.4 Substance misuse

As with mental health, the evidence shows poor health outcomes associated with substance misuse for inclusion health groups. To note, the evidence primarily relates to people experiencing homelessness, and although there is more readily available, recent data for drug misuse versus alcohol misuse, the Pathway needs assessments had evidence from many hospitals showing major negative outcomes for alcohol dependency. For this group, multiple evidence sources show both drug and alcohol misuse to be common. From the HHNA, 54% of respondents reported using illegal drugs in the 12 months prior to responding (compared to 8% in the general population), and 29% reported having an alcohol problem.[7] In 2022/23, 18.6% of homeless households without children who were owed a duty were recorded as having a drug or alcohol problem or both (DLUHC via Spotlight).[76] In 2021/22, NDTMS data shows that 16.1% of people starting drug treatment had a housing problem at the beginning of their treatment (NDTMS via Spotlight), and amongst people who inject drugs, the proportion who reported being homeless in the past year rose steadily from 32% in 2012 to 41% in 2022 (UKHSA UAM[8] Survey via Spotlight).[76]

4.5 Improve health outcomes by listening to people with lived experience

Considering there are many gaps in the evidence on how to improve outcomes for inclusion health groups, the evidence reviewed for this report strongly endorses listening to those with lived experience to help current patients better navigate through service barriers and challenges[15,22,61] and preferably to go further by coproducing services.[8,44] With sex workers, there is evidence suggesting that codesigning and codelivering services are effective.[44] When engaging people with lived experience, it is important to strive for diversity to understand different perspectives and experiences by including people who are already engaged with services and people who are not.[50]

A rapid literature review found benefits from including people with lived experience within research projects. With joint research the outcomes provided higher levels of insight and learning, facilitating opportunities for reciprocal learning and relatability for research participants.[106]

[6] Department of Levelling Up, Housing & Communities, Homelessness Case Level Information Collection (DLUHC H-CLIC) - Statutory homelessness data on an individual case level for all homelessness applications to Local Authorities

[7] HMPPS safety in custody statistics – statutory datasets covering deaths, self-harm and assaults in prison custody in England and Wales.

[8] UKHSA UAM: UK Health Security Agency's Unlinked Anonymous Monitoring Survey. Survey of people who inject drugs, focussing on the prevalence of social risk factors and communicable disease.

Chapter 5. Gaps in data and evidence

Accurate data can help to reduce inequities.[78] As inclusion health has grown as a movement, the quality and availability of evidence relating to these populations have improved.

However, there are still many important gaps in our understanding. While this section separates these gaps into ‘Data’ and ‘Research’, it is important to note the interdependence between the two – improved public data on inclusion health groups would widen the scope of research possibilities as well as the quality of research and research has a key role to play in identifying the best approaches to improving public data on inclusion health groups.

5.1 Gaps in data

Although OHID's Spotlight tool is a step in the right direction in terms of improving the availability of public data on inclusion health groups, it also highlights the gaps that exist in this area. Firstly, the data that is presented within Spotlight is subject to several key limitations, such as;

- Across the tool, indicators cannot be filtered by region or demographics such as gender. This limits the usefulness of the data, particularly for ICSs looking to use the tool for local inclusion health strategic planning.
- 23 of the 114 indicators are taken from Homeless Link's Homeless Health Need Assessment (HHNA) surveys. Whilst this data is important, it is subject to the methodological limitations of survey data in lieu of more comprehensive health service derived data. In particular, the most recent results of the HHNA (Wave 3, 2018-2021) are based on a much smaller sample than previous waves, and results may be skewed because they were collected during COVID-19.
- 45 of the 114 indicators are taken from National Drug Treatment Monitoring System (NDTMS) datasets or the UK Health Security Agency's surveys of people who inject drugs. While substance misuse is certainly a key issue within inclusion health, there is no capacity to drill down into this data on specific inclusion health groups, such as people experiencing homelessness or vulnerable migrants.
- Mortality data taken from the Office for National Statistics is based on experimental statistics, which may underestimate the number of deaths among people experiencing homelessness.

Secondly, the data which is not available in Spotlight highlights the 'invisibility' of many inclusion health groups within public health data.

- There is a noticeable lack of NHS health service data within the tool relating to key inclusion health groups. For example, while Hospital Episode Statistics (HES) data are available for prison populations (searches can be run on prison postcodes), the same is not true for people experiencing homelessness due to inadequate recording of housing status. These gaps contribute to the invisibility of inclusion health populations in local needs assessments and, therefore, local commissioning, further perpetuating the gaps in access to services described in Chapter 2.
- There are no indicators relating to healthcare access and outcomes for vulnerable migrants or sex workers. Identifying these groups within data presents an additional challenge because of the obvious concerns within these groups about identification and trust. For example, while understanding the health needs of undocumented migrants through coding in NHS data would be useful, there is a real risk that this identification could lead to further stigmatisation or be used to alert the Home Office and lead to negative outcomes for these individuals. Similarly, sex workers may not wish to be identified as such due to the risk of further stigmatisation from health services.

In order to improve the visibility of inclusion health groups within public data, there are some clear paths to improvement. While the recording of housing status is possible within community care, secondary care and mental health care settings, it is a) not mandatory and b) not consistent across different datasets. By ensuring that housing status is recorded and consistent across care settings, people experiencing homelessness could be much more easily identified within health service data. This would allow a more comprehensive understanding of health needs, service access and treatment outcomes for this population. Similarly, consistently mandated use of 'Gypsy/Irish Traveller' and 'Roma' ethnicity codes across different health settings would enable these groups to be identified within health service data.

To help narrow gaps in available data, the London School of Economics (2024) developed Integrated Management Dashboards as part of their evaluation of the Out of Hospital Care Models programme.[74,107] These interactive digital dashboards were launched at the end of 2023 with the hope that they would help to improve the quality of data by assisting programmes with a standard approach to recording key outcomes. They are designed to be used as tools at both local and national levels to improve care and service commissioning for people experiencing homelessness.

5.2 Gaps in research

Trauma-informed care, psychologically informed environments and mental health interventions

Given the prevalence of trauma amongst people in inclusion health groups, there is a clear need for trauma-informed care (TIC) and psychologically informed environments (PIE). However, despite the growing popularity of both TIC and PIEs, there is a lack of robust evidence regarding their effective implementation and impact.[57] A rapid review of the evidence on trauma-informed approaches as part of the government's Changing Futures programme suggested looking at the different ways 'trauma-informed' is defined and implemented, including facilitators and barriers and impact outcomes.[58] Similarly, the Center for Homelessness Impact (CHI) highlight a large degree of "variability and ambiguity on the definition and implementation" of PIEs and TIC.[108] Whilst qualitative evidence suggests that both PIEs and TIC can improve service acceptability, there is a need to demonstrate the impact of different models of implementation on outcomes.

The CHI also highlight the need for further evidence regarding other effective mental health interventions for people experiencing homelessness. In addition to the gaps noted above, there is limited evidence regarding the impact of psychosocial interventions and preventative interventions on mental health outcomes and a lack of UK-based evidence for other effective interventions, such as Assertive Community Treatment and Family Critical Time Interventions.[108]

Understanding and evidencing the health needs of inclusion health groups

There is a need to improve our understanding of the health needs of different distinct groups who fall under the inclusion health umbrella. The evidence review, Faculty survey responses and gaps in Spotlight all highlight sex workers,[44] asylum seekers and other migrants as groups where our understanding of health needs is particularly lacking. Another group not well represented in the literature is Showmen, who are often subsumed in the Gypsy, Roma, and Irish Travellers groups,[5] making it difficult to know their health needs and gaps in access.[44]

There is also a need to further explore the multiple vulnerabilities and intersections that occur within different inclusion health groups. For example, "hidden" groups such as women, young people and ethnic minorities within the broader group of people experiencing homelessness,[60] and for sex workers, indoor-based sex workers, transgender people and male sex workers.[44]

Our evidence review highlighted key areas where new evidence is needed to improve understandings of chronic disease prevalence[44,69,61] and rehabilitation from traumatic brain injury.[109] Faculty survey respondents similarly highlighted brain injury and neurodiversity (ADHD, Autism, Learning Disabilities and Personality Disorders) as key research areas, both in terms of evidencing and understanding the level of need and in identifying effective interventions and approaches.

This research area clearly highlights the important relationship between research and public data – while improved public data would benefit our ability to identify the needs of inclusion health groups, Faculty survey respondents highlighted the need for new research investigating the best approaches to improving the visibility of inclusion health populations within NHS data, in order to effectively quantify and describe needs, service access and health outcomes.

Tackling stigma and discrimination

The evidence reviewed for this report clearly highlights stigma and discrimination as a key barrier to improving the health of people in inclusion health groups and gives us an understanding of how stigma plays out in healthcare settings and is experienced by people. However, further evidence is needed, both in terms of mapping and understanding stigma in healthcare contexts and in terms of reducing stigma. While some evidence suggests that approaches such as TIC/PIEs and Inter-Professional Education (IPE)[66] can challenge stigmatising attitudes, Faculty survey respondents highlighted gaps both in our understanding of how inclusion health groups are framed and perceived by healthcare staff and of the interventions and policies which can improve attitudes. CHI's Evidence and Gap Map also highlights the need for research on the effectiveness of advocacy and public information campaigns with regard to public attitudes and engagement. Given the centrality of stigma to the social exclusion that people in inclusion health groups face and their worse access to and experience of healthcare services, this is a key evidence gap moving forward.

The role of healthcare in homelessness prevention

Much of the evidence described in this report describes the catastrophic impact of homelessness on health, not only directly on health outcomes but also on people's ability to access and engage with services. The evidence also showed that poor service access leads to higher levels of complex needs and an overreliance on acute and emergency services among people experiencing homelessness. It is, therefore, in the interests of health services to understand more about the role they can play in the prevention of homelessness across all vulnerable groups and at-risk populations and at different levels of prevention.

Although the Homelessness Reduction Act's Duty to Refer places a duty on acute and mental health hospital services to refer people at risk of homelessness as a form of tertiary prevention, recent Pathway-Crisis research has demonstrated the limitations of this statutory mechanism.[44] Further research is needed to show how health services could play an effective role in immediate homelessness prevention through statutory routes.

There is also a need to understand more about the role that health services, such as primary care and mental health services, can play in upstream prevention through the early identification of risk factors for homelessness, such as mental health problems, various forms of neurodiversity, childhood trauma, abuse and neglect. Supporting this, more evidence is needed on the causal chains that lead people into homelessness in order to identify the best opportunities and approaches for health services to engage in upstream prevention.

Cost-effectiveness of services and interventions

Alongside showing the effectiveness of different interventions and services on outcomes for people in inclusion health groups, there is also a clear need for evidence demonstrating the cost-effectiveness and cost-benefits of such interventions. In particular, Faculty survey respondents noted gaps in evidence around the cost-effectiveness of floating support/ community services, supported housing models, specialist primary care and palliative care.

As well as evaluating the cost-effectiveness of specific services and interventions, there is also a need to demonstrate the wider social costs of failing to provide effective interventions to inclusion health groups. In addition to healthcare resources, effective interventions and services may reduce costs across a range of other services, including housing and the criminal justice system. The LSE/Kings led evaluation of the Out of Hospital programme has made some progress in this area, linking data from health, housing, social care and criminal justice settings to show the significant cost-benefits of intermediate care provision to both the healthcare system and wider society.[19,20] Although providing effective care and support for people in inclusion health groups should not be motivated solely by economic arguments, the financial constraints within healthcare and wider statutory services demand this kind of evidence in the foreseeable future.

Chapter 6. Conclusions and recommendations

The NHS Constitution (2023) promises “to provide convenient, easy access to services” and has established expectations for staff to provide “fair and equitable services for all” with the aim to “reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care”.

However, as this report has shown, people in inclusion health groups struggle to access health and social care and have poor experiences when they do, resulting in dismal health outcomes. This is especially the case for migrants in vulnerable circumstances who are not having some of their basic human rights met.

Extreme capacity problems are matched with a rigid system that often does not recognise, let alone meet, the needs of all the people it serves. In addition, there are major barriers to accessing care for people in inclusion health groups, especially in general practice, mental health, dental care and intermediate care upon discharge from the hospital. Together, these produce systemic neglect, resulting in the widening gap between their outcomes and those of the general population. A central barrier that came up time and time again in the evidence was stigma and discrimination, which mirrors our society’s beliefs about people in inclusion health groups. They stem from negative attitudes, unconscious biases, and a widespread lack of understanding of peoples’ needs and the causes of those needs, all of which have devastating implications.

This report has shown that good health goes beyond health services themselves. The evidence for the social determinants of health is well-established, and our analysis shows that the health and life expectancy of people in inclusion health groups is fatally undermined here, too. The housing crisis that grips our nation hits this vulnerable group particularly hard, denying them both a safe and stable home in which to live and recover and causing significant practical barriers to accessing the vital services they need.

However, there is hope. We know that specialist inclusion health services make a difference. In addition to driving better outcomes through person-centred, trauma-informed care, these services are building relationships, strengthening collaborations, and leading the way in care integration and in the inclusion of people with lived experience. More of these services are needed. But they cannot do it alone. Caring for people in inclusion health groups is everybody’s business, and this report has shown the vital role that mainstream services must play, especially in prevention and early intervention, ending the cycle where people’s needs have deepened to crisis point before they receive help. We know what good practice looks like. We have evidence-based guidance to help with implementation. Specifically, with NICE 214, the Duty to Refer under the Homeless Reduction Act, NHS England's Inclusion Health Framework, CQC guidance, and the Out-Of-Hospital Care Models Programme for people experiencing homelessness. In very many ways, we know how to move forward and significantly improve the lives of some of the most vulnerable and excluded groups in our society. And we know that there are many Integrated Care Systems who are acting on this evidence, as Pathway's collaborative programme with the King's Fund and Groundswell showed last year. We call on all ICSs to follow their lead, but we recognise that this means swimming against the tide. It requires working within the imperatives of a system that is designed for the mainstream population, and that does not always appear to support and reward action for helping the most vulnerable people in our society. Nor does it provide them with the structural foundations of housing and welfare that would provide the underpinnings of good health.

The very poor experiences and outcomes described in this report, therefore, require fundamental systemic reform, driven by clear and joined up leadership at national level. This must span funding, accountability, data, and workforce development within the health service, in tandem with further drive towards integrated services with housing and social care, and action to address the housing crisis. This will require deep consideration with relevant partners, but for now, we highlight some urgent priorities for action.

Together, Crisis and Pathway are calling for:

1. **The current and next Westminster Government, working with NHSE and ICSs, to increase the availability of specialist primary care, acute hospital, and community services to better meet the needs of inclusion health populations. Most urgently, this should include a National Safe Discharge programme to end the unsafe practice of discharging patients from the hospital to the street.**

2. **NHS England to set out clear expectations in its next Operational Planning and Contracting guidance to address the extremely poor experiences and outcomes of inclusion health groups.**

3. **Integrated Care Systems to assess themselves against the NICE Homelessness Guideline (NG214) and the NHSE Inclusion Health Framework and take action on their findings in their planning and funding of services.**

4. **The CQC to specifically assess for action on inclusion health groups in its ICS inspection regime.**

5. **All NHS hospital trusts and GP practices to assess how far their frontline services deliver trauma-informed care and put improvement plans in place.**

6. **Over the long term, the Westminster Government to put in place a plan capable of increasing the supply of social rent homes to meet current and future need – 90,000 new social rented homes in England per year for the next 15 years, coupled with significant investment in Housing First at scale nationally and supported housing, to prevent people with complex support and health needs from cycling in and out of homelessness and rough sleeping.**

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Appendix A. Evidence & methods

Evidence examined for this report

1. Brief scoping review of the literature

To identify current and emerging evidence and gaps, the authors of this report conducted a scoping review of key papers related to inclusion health. A call for known, recent evidence was made within the Pathway organisation, steering group, and Pathway Fellows (people individually engaged in inclusion health research or interventions who come together via Pathway). As literature was examined, their reference lists were also reviewed and relevant publications were included. Papers were excluded from the review if they were non-English, primarily focussed on housing or not related to inclusion health topics.

127 publications were identified and narrowed down to the 85 published between 2022-2023. Other key literature with an older date was used to help provide an introduction and background. The following themes emerged: health outcomes, intermediate care, barriers/challenges (to access, experience and outcomes) evidence to tackle barriers/tested solutions, opportunities, and gaps in evidence.

2. OHID Spotlight

The analytical tool from the Office for Health Improvement and Disparities, Spotlight (2023) is a data platform that gathers and shares key public health statistics of Inclusion health groups. The platform was developed as a response to the limited availability of public data regarding the healthcare and outcomes of people in inclusion health groups, due to the ‘invisibility’ of these populations within many public datasets.

The platform draws on a range of data sources (listed in ***Appendix B***) to present 114 distinct indicators across four themes: health outcomes, preventative healthcare, healthcare access and use, and wider determinants of health.

For this report, we reviewed and thematically organised each of the 114 indicators, following the primary themes of access and experience; health outcomes; evidence to tackle barriers, challenges and opportunities; and gaps in evidence. Where the data was available, key trends over time were also identified.

3. Analysis of Pathways health needs assessments

Pathway provides bespoke needs assessments for NHS Trusts to help them understand how hospital systems provide care for, manage, and discharge people experiencing homelessness. The needs assessments employ a mixed-methods approach, using qualitative interview data and quantitative hospital record data, to assess current practice, identify local needs and aid in developing local services. The authors of this report analysed previous needs assessments to explore the common themes. Each addressed the core data of attendances and admissions, the views of staff from the hospital and often from services outside the hospital, and where possible, the views of patients experiencing homelessness who use the healthcare system.

In total, 16 needs assessments conducted between 2011 to 2022, which include 23 Trusts as well as other units such as a Centre for Mental Health, were combined for qualitative analysis. The full thematic findings from across all 16 needs assessments can be found in ***Appendix C***.

4. Faculty survey

A new mixed method, cross-sectional online survey was designed to capture the perspectives and views of the Faculty for Homeless and Inclusion health (The Faulty). The Faculty is an international network of healthcare practitioners, commissioners, researchers, Third Sector staff, Local Authority workers and civil servants either working in/or with an interest in homeless and inclusion health. This report analyses responses from people based in England.

The survey collected quantitative and qualitative data on a range of topics relevant to the inclusion health agenda, including health complexity and outcomes, service access, intermediate care and research priorities. Recruitment to the survey took place via email where all Faculty for Homeless and Inclusion Health members were invited to participate. To increase returns, invitations of recruitment to join the free and open Faculty was sent out through partner organisations.

Quantitative variables were analysed using descriptive statistics, and qualitative data was analysed using thematic analysis. See ***Appendix D*** for detailed results and survey questions.

Appendix B. Spotlight

The data sources from Spotlight that are presented in this report are;

Statutory and public datasets

National Drug Treatment Monitoring System (NDTMS) data
National Drug Treatment Monitoring System. The NDTMS collects person level, patient identifiable data from drug and alcohol treatment providers at a national level.

Office for National Statistics (ONS) data
Within Spotlight, ONS data is used to present data relating to estimated mortality numbers and causes for people experiencing homelessness, based on deaths where homelessness was recorded. As these figures are dependent on the accurate recording and reporting of homelessness, they may underestimate the true level of mortality for people experiencing homelessness.

His Majesty's Prison and Probation Service Statistics (HMPSS) data
Statutory datasets collected by HMP Services.

Hospital Episode Statistics (HES) data
The HES database contains administrative data from English hospitals operating within the NHS. Within Spotlight, HES is primarily used to present data for prison populations, as this group is easily identifiable by searching for patient records with recorded addresses of prisons. A key limitation of HES with regards to Inclusion health patients is that groups such as people experiencing homelessness and/or migrants in vulnerable circumstances are not identifiable due to a lack of recording of these characteristics.

Department of Levelling Up, Housing and Communities (DLUHC) H-CLIC datasets
Statutory homelessness datasets relating to homelessness applications to Local Authorities.

Survey data

Homeless Link - Homeless Health Needs Audit (HHNA) survey

The Homeless Health Needs Audit (HHNA) is a survey and methodology developed by Homeless Link in 2009 and used by local authorities to gather local data about the physical and mental health needs of people experiencing homelessness and how they access services. The survey is completed in waves – for this report data from Wave 2 (2015-2017) and Wave 3 (2018-2021) is presented. It is important to note that Wave 3 data was collected during COVID and contains a significantly smaller number of responses than Wave 2.

UK Health Security Agency – Unlinked Anonymous Monitoring (UAM) survey

The UAM survey collects data around the prevalence of HIV, Hepatitis B and Hepatitis C, alongside other risk factors, amongst people who inject drugs. The survey results may be limited by response bias; those in contact with services and engaging with treatment may be more likely to respond to the survey.

GP Patient Survey

An independent patient experience survey run by Ipsos on behalf on the NHS. This source is primarily used within Spotlight for general population comparisons where relevant.

Friends, Families and Travellers Survey

Friends, Families and Travellers carried out a survey of 356 people from the Liveaboard Boater community. Boaters were asked about their experiences of healthcare services, and the challenges they face when accessing care. This was the largest UK project to record the self-reported health status and healthcare experiences of Liveaboard Boaters.

Appendix C. Analysis of Pathway health needs assessments

Pathway's health needs assessments are generally conducted with quantitative and qualitative data to help regions understand how hospital systems provide care, manage, and discharge people experiencing homelessness. The following is an analysis of 16 health needs assessments (23 Trusts) conducted between 2011 to 2022.

Mental health and substance use issues

People experiencing homelessness had high A&E utilisation and, when admitted to the hospital, they usually had longer lengths of stay compared to people who were housed. Mental health issues were often reasons for admissions. There was evidence from hospital data showing that substance use issues, specifically alcohol dependency, had a major negative impact on patient outcomes. Hospital data also showed higher incidences of mental health issues and overall drug and alcohol issues for people experiencing homelessness. These were often not investigated and sometimes dismissed due to perceived 'behaviour issues' and bias towards patients with substance use problems. This resulted in staff not identifying when patients were in withdrawal and sometimes staff even blaming patients for their condition. Patients felt they were treated differently due to their substance use issues. Other times, patients would leave the hospital without treatment, most likely to self-medicate, only to return to hospital later. Other times, patients were detoxed while in hospital, only to return to a previous living situation where substances were readily available, then back to hospital again, creating a cycle of A&E attendances and admissions. For mental health beds, there was less pressure to discharge people; however, this created delayed discharges and "bed blocking".

Gaps and inconsistencies of community care

Access to GP, including registration, clinical input and access to community care and services

The needs assessments found a clear need for better access to and use of primary care for GPs and other community services to engage earlier with patients. Low percentages of patients were registered with a GP, suggesting that some conditions patients were presenting with at the hospital could have been cared for in the community. However, it also suggests that preventative healthcare was not being delivered, and because these conditions were not dealt with earlier on, they can often be severe when patients attend hospital. When a patient did have a GP or community team involved, the communication was poor with the hospital and when people who were homeless were admitted, there were inconsistencies in the treatment and care they received.

In addition, often services were not flexible enough to match the complexity of people experiencing homelessness, especially for people who were sleeping rough, resulting in patients seeking care when there were no other option and at a point of crisis. The services that do exist often lack the flexibility needed to care for people experiencing homelessness.

The needs assessments evidenced the need for more clinical, such as podiatry and dentistry, and non-clinical support, such as outreach, for people experiencing homelessness, because without having a GP, most patients did not have follow-up treatment/care when discharged from the hospital. Community outreach in place was recommended to help individuals follow-up with referrals (such as for housing), attend appointments (such as support to minimise risk with drug and alcohol use) and to register/see a GP. For clinical outreach, the need was around prevention and reducing emergency admissions to hospital, but it was also about supporting primary care clinicians and improving coordination of care. Strong, ongoing communication between primary and secondary care was identified as key.

Mental health, drug and alcohol, and palliative care

The needs assessments also found there were large gaps in community services for mental health, drug and alcohol use and palliative care. In addition, for localities that shared a hospital, some had more services than others, causing confusion as to which services were available where. For rehabilitation from substance misuse, there were access issues for people with no address, leaving inadequate interventions available for this population. This was especially the case for people experiencing drug dependency.

Often there was no forward planning for end of life care and no links to palliative care and hospices in place for people experiencing homelessness. The needs assessments identified the need for earlier identification and engagement, as well as ongoing support and engagement. This was to provide psycho-social as well as medical interventions before the need for hospital admissions, and to better support staff at accommodations such as hostels and assisted living who are not equipped to deal with these extensive health, mental health, and substance use issues. There were also gaps in provisions to help people experiencing homelessness find purpose and meaning through activities, work, and volunteering.

Inappropriate discharge locations

A major gap in the system was unsuitable accommodation and provision in place following hospital admissions for this population. This led hospitals to either hold patients who were medically fit for discharge longer, “blocking beds” for people who needed acute care, or discharging to unsuitable accommodation or no accommodation at all, meaning that patients were discharged to the street.

There was a recognition for the need to improve appropriate step-down (and step-up) options, including for people being coming out of prison to help with transition and aid in recovery. Although some patients may not have needed continued acute medical treatment, many still needed intermediate care. Intermediate care could have provided additional support and care to increase mobility and/or heal and recovery. In addition, there were scarce amounts of other types of accommodation such as supported accommodation for higher mental health support, or specialist provisions for women, leading hospital staff with little option on where to discharge patients. This was especially true for people with substance use issues and/or mental health issues, leaving accommodations to select the least complicated cases because the demand was so high, leaving some people in the most vulnerable position without proper accommodation and support. In addition, there were significant housing issues found for people with uncertain eligibility around housing.

One needs assessment found the need for medical respite to help with low level medical needs, people with uncertain eligibility and No Recourse to Public Funds, people with long term addictions and people with a history of chaotic living and rough sleeping. Another needs assessment found the need for safe spaces for people to go and be. This safe place could potentially also offer medical interventions as well as be a place where services come and engage patients.

Patients often had inadequate plans in place upon discharge, usually due to overstretched hospital teams and the sometimes-lengthy process for referrals including completion of paperwork. Discharge planning was often started late and since staff did not often enquire about a safe place to go on discharge, staff would find out later during admissions that a patient needed housing. The process of a housing referral/Duty to Refer to accommodate someone takes time and therefore this caused delays to hospital discharges.

After a hospital discharge, people experiencing homelessness often do not receive any follow-up care and patients often did not attend follow-up appointments. A large reason for this is that the plans were not individualised to patients' specific needs and circumstances. For example, some assessments found that a discharge location would be marked “home”, when they had no known address. Another example was where the hospital listed the GP to follow-up after discharge; however, the patient did not have a GP recorded. Some other reasons were chaotic living, patients not being clear on or not remembering the details of their follow-up plans, and the inability to pay for transportation to get to appointments. One particular challenge was follow-up for patients with unclear local connection, causing uncertainty over what was available to them.

Although there were some examples of good partnership working, overall communication fell short and there was a lack of coordination in community services and follow-up. This ranged from no arrangements for wound care from community nursing, to inappropriate referrals to community services. Often, hospital staff did not know what community services could provide, resulting in referrals being completed after hours when there were no services available, and patients discharged to hostels without communication about their needs, meaning patients ended up in accommodation that could not provide the required care. This was especially important for Trusts to improve as it showed patients in vulnerable circumstances at risk were in need of better coordination and handover.

Consistently, a recommendation was to implement a more consistent approach to discharge planning for people experiencing homelessness that started early and was more holistic to meet the individual patients’ needs. Better communication and coordination were also needed with primary care, such as better discharge summaries that included if the patient self-discharged and as for one needs assessment, discharge summaries to mention if methadone was prescribed along with the dosing. Better communication and joined-up working were also needed with housing, social care, and other community services.

Without adequate plans for discharge and follow-up care, patients had suboptimal outcomes and often were back at A&E or readmitted. The needs assessments often recommended outreach services as well as drop-in support.

Effective partnering

Although there were some reports of effective partnering between hospitals and community providers, most needs assessments found this was lacking or needed improvement. Often, this was seen when a patient was admitted, the hospital staff had challenges in obtaining information and then discharged the patient. In addition, community teams reported that hospital staff needed knowledge about local services.

What became clear for some was that hospitals would benefit from more engagement and collaboration with homeless services, primary care, housing, social work, and community health services. This was more than improving communication; it was also about coming together to discuss high-risk patients to develop proactive plans to improve pathways of care and services.

Identifying patients and data collection

A consistent problem found was that hospital staff were not identifying all patients who were experiencing homelessness, and when they do, usually, it is not in a timely manner. When patients were identified, the information was not coded and shared. There needed to be more consistency on if and how staff enquired with patients about having a safe place to go upon discharge.

There also needed to be more consistency in how this information was then communicated to other staff within the hospital. There needed to be more consistency in documenting onward destinations. One hospital had an issue with documentation listing “normal place of residence” for patients known to be homeless, leaving it challenging to understand if these patients were returning to inappropriate accommodations such as to the streets.

None of the needs assessments completed had a Trust consistently coding this information. The lack of coding meant there was a lack of data to help understand the true numbers of people experiencing homelessness and their needs. In addition, it made the review of data and outcomes extremely difficult. Not having the data documented also impacted effective planning and commissioning. For example, one locality discovered they needed this data to understand the number of admitted patients from other boroughs.

Leaving A&E without being seen

Across needs assessments, there was a percentage of patients experiencing homelessness that would come into A&E but would leave before completing treatment. Sometimes, this was due to negative experiences with staff or fear of negative treatment, and/or due to long waits resulting in people leaving for drugs/alcohol. The needs assessments identified a need for education and training to change staffs' negative attitudes, lack of empathy and unconscious bias.

Consistently across the needs assessments, there were issues around the lack of empathy from staff, demonstrations of negative attitudes, and unconscious bias towards people experiencing homelessness. The needs assessments highlighted the necessity for training and tackling stigma and bias. Additional education needs on the following were also identified:

- Support staff to identify people experiencing homelessness early. Part of this was to understand the definition of homelessness so that staff recognise people in temporary accommodation and hostels, as well as those sofa surfing, are all considered homeless, in addition to people rough sleeping.

- Recognition that homelessness is not a lifestyle choice and someone experiencing it is vulnerable, experiencing severe and multiple disadvantages.

- Understanding of multiple issues people experiencing homelessness face, their complex needs, often including a history of trauma, issues around drug and alcohol, mental health and the prejudice patients face from health and social care staff. This should also include the management of substance use issues, the Care Act and mental capacity assessments.

- Trauma-informed communication skills that demonstrate empathy to patients and help staff have the confidence to engage and ask the right questions to someone about homelessness and correctly document and share the information onward as needed. These skills would also include de-escalating situations and dealing with patients demonstrating negative behaviours.

- The Duty to Refer is a statutory duty, and staff must notify local authorities if a patient is homeless or at risk of becoming homeless. Staff also need to know what to expect around housing, including statutory duties and limitations.

- Resources need to be available with signposting so staff know how to refer patients appropriately.

Peer advocacy or care navigators

Some needs assessments identified the need for care navigators and/or peer advocates. These roles could engage with patients, develop relationships, support them in attending appointments and help them navigate complex systems.

NRPF and no clear local connection

In some areas, a large percentage of people had either no clear local connection or No Recourse to Public Funds (NRPF). Some of these individuals had not exercised their rights, most likely because they did not know how to and/or have the means to do so. Others were considered illegal immigrants. There were major challenges and limitations to help support these patients, often resulting in frequent A&E attendances.

Shared good practice

Good practice was happening in some locations, with a usual plea for more. These examples were outreach services, multi-agency working and meetings, such as meetings to discuss people who attend A&E frequently and effective partnerships with community programmes. Also, roles were placed to provide additional support for people experiencing homelessness, such as a hospital-funded social worker in A&E and someone to provide legal advice. Other roles were joint working between primary and secondary care.

Inconsistent funding

Needs assessments acknowledge that the biggest challenge for caring for people experiencing homelessness was inconsistent funding. Pilots or teams were often put into place with minimal funding and were not recommissioned. With many closures of hostels, shelters and other homeless provisions, budget cuts were having a major impact on people experiencing homelessness and the hospital team trying to discharge them into the community. Difficulty securing long-term funding also left teams constantly learning new pathways and services, compromising relationship building and multi-agency working. When it comes to medical respite, there is often a tussle over who should fund it; however, many suggest the need for joint funding.

Appendix D. Faculty survey

A total of 156 completed responses from respondents based in England were analysed for this report. Respondents came from a range of roles and backgrounds across healthcare, the third sector, local authorities and government, with some respondents reporting multiple roles. Of all respondents, 42.3% were healthcare practitioners working in specialist inclusion health services, 16% mainstream healthcare staff, 8.3% specialist inclusion healthcare service managers and 8.3% voluntary service managers. A range of other roles were recorded, including people working in research and data (7.7%), voluntary service staff providing direct care (7.1%), local authority managers (2.6%) and housing workers (2.6%) and healthcare commissioners (1.3%). These percentages are based on the total number of individual respondents – as some respondents reported multiple roles, the percentages in the table below sum to over 100%.

Table AD.1: Please indicate your current role

	Total	%
Healthcare practitioner providing direct care - specialist homeless/IH service	66	42.3%
Healthcare practitioner providing direct care - Mainstream healthcare service	25	16.0%
Healthcare manager - Specialist Inclusion Health/homeless health service	13	8.3%
Voluntary and Community Sector manager	13	8.3%
Research/Data/Evaluation	12	7.7%
Voluntary and Community Sector worker providing direct care/support	11	7.1%
Voluntary and Community Sector - other	6	3.8%
NHS employed allied worker (eg housing, social worker) - Specialist Inclusion Health/homeless health service	4	2.6%
Local Authority Housing Worker	4	2.6%
Local Authority Manager	4	2.6%
Healthcare manager - Mainstream healthcare service	3	1.9%
NHS employed allied worker (eg housing, social worker) - Mainstream healthcare service	3	1.9%
Government Policy/Civil Service role	3	1.9%
Voluntary and Community Sector - Policy/Lobbyist	2	1.3%
Local Authority Social Worker	2	1.3%
Healthcare Commissioner	2	1.3%
Other	19	12.2%

Three quarters (118, 76%) had a professional healthcare qualification, even if it was not being used. Of the qualifications reported, nurse (38.3%) and medical doctor (31.3%) were the most common, with a range of other backgrounds being reported, including occupational therapists (6.3%), mental health practitioners (3.1%) and dentists (2.3%). As a small number of respondents reported multiple qualifications, a total of 128 qualifications were reported and the percentages in the table below correspond to this figure.

Table AD.2: Please indicate your professional background

	Total	%
Nurse	49	38.3%
Medical Doctor	40	31.3%
Occupational Therapist	8	6.3%
Mental Health Practitioner	4	3.1%
Psychologist	4	3.1%
Dentist	3	2.3%
Social Worker	3	2.3%
Psychiatrist	2	1.6%
Counsellor/Psychotherapist	2	1.6%
Speech and Language Therapist	2	1.6%
Health Care Assistant	2	1.6%
Physiotherapist	1	0.8%
Care Navigator	1	0.8%
Other (please specify)	7	5.5%
Total qualifications reported	**128**	

Of the 156 respondents, 128 (82.1%) considered themself to be working in inclusion health.

Table AD.3: Please indicate for how long you have been working in inclusion health

	Total	%
Less than 1 year	17	13.3%
1-5 years	52	40.6%
6-10 years	19	14.8%
11-15 years	17	13.3%
15+ years	23	18.0%

Respondents were most commonly located in London (25.6%), South East (18.6%), South West (14.1%) and Yorkshire & The Humber (10%). 70% worked in Urban areas, 24% in both Rural and Urban areas and 4% in Rural areas only.

Table AD.4: Please indicate your region of work

Region of work	Total	%
England London	40	25.6%
England South East	29	18.6%
England South West	22	14.1%
England Yorkshire & Humber	16	10.3%
England National Role	14	9.0%
England North West	14	9.0%
England East Midlands	6	3.8%
England North East	5	3.2%
England West Midlands	5	3.2%
England East of England	5	3.2%

The survey results presented in this report should be caveated with the relatively small sample size, alongside typical limitations on survey data. However, the depth of qualitative data collected has allowed us to gain a strong understanding of the views of survey respondents. Between-group comparisons of quantitative data were not completed (e.g. between regions) given the small number of respondents for each.

Survey questions

Section 1 – Inclusion health overview

1. Over the past 3 years, I think that health outcomes for people in Inclusion Health groups have...

Table AD.5

	Total	%
Improved significantly	3	1.9%
Improved somewhat	22	14.1%
Stayed the same	29	18.6%
Worsened somewhat	63	40.4%
Worsened significantly	26	16.7%
Don’t Know	13	8.3%

2. Over the past 3 years, I think that the quality of mainstream healthcare provision for people in Inclusion Health groups has...

Table AD.6

	Total	%
Improved significantly	2	1.3%
Improved somewhat	30	19.2%
Stayed the same	35	22.4%
Worsened somewhat	54	34.6%
Worsened significantly	25	16.0%
Don’t Know	10	6.4%

3. Over the past 3 years, I think that specialist healthcare provision for people in Inclusion Health groups has...

Table AD.7

	Total	%
Improved significantly	17	10.9%
Improved somewhat	62	39.7%
Stayed the same	19	12.2%
Worsened somewhat	28	17.9%
Worsened significantly	13	8.3%
Don’t Know	17	10.9%

4. Over the past 3 years, I think that the complexity of health, care and support needs amongst people in Inclusion Health groups has..

Table AD.8

	Total	%
Increased significantly	51	32.7%
Increased somewhat	73	46.8%
Stayed the same	23	14.7%
Decreased somewhat	2	1.3%
Decreased significantly	3	1.9%
Don’t Know	4	2.6%

5. Please briefly describe what lies behind any trends noted above, or highlight trends affecting specific Inclusion Health groups in particular, if you feel able to comment – Free text

6. Please indicate the extent to which you agree or disagree with the following statements, in relation to the area that you work in;

- "People in IH groups with housing needs get these needs met in a timely and effective manner by Local Authority housing teams"
- "People in IH groups with safeguarding needs get these needs met in a timely and effective manner by Safeguarding services"
- "People in IH groups with care needs get these needs met in a timely and effective manner by Adult Social Care"

Table AD.9

"People in IH groups with housing needs get these needs met in a timely and effective manner by Local Authority housing teams"		
Strongly Agree	4	2.6%
Agree	5	3.2%
Neutral	13	8.3%
Disagree	70	44.9%
Strongly Disagree	56	35.9%
Don't Know	8	5.1%

"People in IH groups with safeguarding needs get these needs met in a timely and effective manner by Safeguarding services"		
Strongly Agree	3	1.9%
Agree	20	12.8%
Neutral	24	15.4%
Disagree	57	36.5%
Strongly Disagree	42	26.9%
Don't Know	10	6.4%

"People in IH groups with care needs get these needs met in a timely and effective manner by Adult Social Care"		
Strongly Agree	4	2.6%
Agree	4	2.6%
Neutral	13	8.3%
Disagree	69	44.2%
Strongly Disagree	55	35.3%
Don't Know	11	7.1%

7. Please elaborate on any of your responses to the previous question, if you wish to do so – Free text

8. In the area you work in, how easy do you think it is for people in Inclusion Health groups to access the following mainstream healthcare services?

Table AD.10

	Very Easy	Easy	Neutral	Difficult	Very Difficult	Don't Know
Mainstream Primary Care	3.8%	10.9%	12.8%	53.8%	17.9%	0.6%
Urgent & Emergency Care	4.5%	27.3%	26.6%	31.8%	6.5%	3.2%
Mental Health Services	1.9%	3.8%	5.8%	32.1%	55.1%	1.3%
Substance Misuse Services	4.5%	21.2%	30.1%	32.1%	7.7%	4.5%
Dentistry	0.0%	2.6%	3.2%	21.2%	67.3%	5.8%
Sexual Health Services	3.2%	17.4%	26.5%	34.8%	7.7%	10.3%

9. Please elaborate on your above responses if you wish to do so. For example, if you think there are any service types that are particularly hard for a specific Inclusion Health group to access, please briefly describe the service and the group – Free text

10. In the area you work in, which of the following barriers to mainstream service access do you think people in Inclusion Health groups experience? Please select all that apply

Table AD.11

	Total	%
Poor service accessibility (e.g. inflexible appointment times, lack of translated information)	135	86.5%
Digital exclusion (e.g. requirements to register online)	133	85.3%
Patients' experience of stigma and discrimination from healthcare staff	133	85.3%
Services unable to provide care for patients with multiple and complex needs	123	78.8%
Services have limited capacity to provide care (e.g. long waiting lists)	123	78.8%
Eligibility issues (e.g. local connection or immigration status)	107	68.6%
Being refused for lack of ID/proof of address	100	64.1%

11. Please elaborate on your above responses, if you wish to do so. For example, if you think there are any specific barriers faced by particular Inclusion Health groups, please briefly describe the barrier and the group – Free text

12. For the following types of specialist health service, please select what is available in the area that you work in

Table AD.12

	Exists, enough provision	Exists, additional provision needed	Doesn't exist, new provision needed	New provision not needed	Don't Know
Specialist GP Practices	19.9%	54.5%	13.5%	2.6%	9.6%
Specialist Community Nursing services	9.0%	52.9%	21.9%	1.3%	14.8%
Specialist Community Health Visiting services	2.6%	32.3%	22.6%	2.6%	40.0%
Specialist Mental Health services	9.0%	61.3%	16.1%	0.6%	12.9%
Specialist Substance Misuse services	18.8%	63.0%	6.5%	1.3%	10.4%
Specialist Domestic/Sexual Abuse services	9.7%	56.5%	11.0%	0.6%	22.1%
Specialist Hospital-Based teams	13.5%	42.6%	28.4%	1.9%	13.5%
Specialist Hospital Discharge services	9.0%	45.2%	22.6%	1.3%	21.9%
Street Outreach services (eg outreach bus)	23.1%	47.4%	12.8%	2.6%	14.1%
Health Peer Advocacy services	7.1%	37.0%	26.0%	1.3%	28.6%

Section 2 – Hospital discharge

1. In the area you work in, how often do you think that people in Inclusion Health groups are discharged from hospital with unmet health needs?

Table AD.13

	Total	%
All the time	42	27.5%
Often	72	47.1%
Sometimes	23	15.0%
Rarely	3	2.0%
Never	1	0.7%
Don't Know	12	7.8%

2. In the area you work in, how often do you think that people experiencing homelessness are discharged from hospital to the street?

Table AD.14

	Total	%
All the time	21	13.7%
Often	54	35.3%
Sometimes	41	26.8%
Rarely	14	9.2%
Never	1	0.7%
Don't Know	22	14.4%

3. In the area you work in, are there intermediate care services that people experiencing homelessness and other Inclusion Health groups can access following hospital discharge?

Table AD.15

	Total	%
Yes	9	5.9%
Yes - additional provision needed	70	45.8%
Not available	39	25.5%
DK/Unsure	35	22.9%

4. In the area you work in, are there intermediate care services that people with No Recourse to Public Funds or uncertain immigration status can access following hospital discharge?

Table AD.16

	Total	%
Yes	5	3.3%
Yes - additional provision needed	43	28.1%
Not available	48	31.4%
DK/Unsure	57	37.3%

5. Outside of the availability of intermediate care placements, what other barriers do you think there are to safe and effective hospital discharges for people in Inclusion Health groups? Please select all that you think apply to the area that you work in

Table AD.17

	Total	%
Shortages of appropriate Local Authority accommodation	142	91.0%
Hospital discharge pressures (eg bed pressures)	131	84.0%
Lack of suitable long-term care placements (eg care/nursing homes)	124	79.5%
Lack of floating/wrap-around support	111	71.2%
Inadequate assessments of patients’ care and support needs in hospital	108	69.2%
Lack of support options for people with No Recourse to Public Funds or uncertain immigration status	107	68.6%
Lack of trust in services from people in Inclusion Health groups	104	66.7%
Inadequate joint working between health and Adult Social Care	104	66.7%
Inadequate joint working between health and Local Authority housing teams	91	58.3%
Hospitals being unaware of statutory responsibilities with regards to people experiencing homelessness	88	56.4%
Inadequate joint working between health and Safeguarding teams	81	51.9%

6. Please leave any additional comments regarding hospital discharge and intermediate care provision for people in Inclusion Health groups, if you wish to do so – free text

Section 3A: Specialist inclusion health services

1. Please indicate which type of specialist service you work in. If you work across multiple services, please select one that you would like to provide information about.

- Specialist GP practice
- Specialist community nursing service
- Specialist hospital-based team (Pathway team)
- Specialist community Health Visiting service
- Specialist mental health service
- Specialist addictions service
- Specialist hospital discharge service
- Specialist step down (intermediate care) service
- Street outreach bus or other street outreach service
- Homeless health peer advocacy service
- Other (please specify)

2. For the following statements, please indicate the extent to which you agree or disagree

- I am able to provide the care that is needed for my patients
- My service is able to work effectively with other services across health, housing, social care and safeguarding
- My service is able to effectively safeguard patients
- My service is able to provide care in a trauma-informed manner
- My service is able to communicate effectively with patients about their health needs/care
- My service is consistently co- produced with lived experience input
- I find my work stressful

3. Please elaborate on your responses to the previous question, if you wish to do so – Free text

4. Do you face any of the following challenges in providing effective care for your patients from Inclusion Health groups? Please select all that apply

Table AD.18

	Total	%
Increasing local demand for your service	56	74.7%
Lack of understanding amongst other staff/services about the needs of patients in Inclusion Health groups	55	73.3%
Inadequate service resources (eg staff, office space)	48	64.0%
Lack of understanding about your service from other staff/services	47	62.7%
Uncertainty over continuation funding	44	58.7%
Stigma and discrimination from other staff/services towards service users	38	50.7%
Poor/lack of data sharing with other relevant services	29	38.7%
Inadequate professional support and supervision for staff members	21	28.0%
Other (please specify)	4	5.3%

5. Please elaborate on your responses to the previous question, if you wish to do so – Free text

6. Over the past year, have there been any improvements to your service that have benefitted staff and/or service users? Please select all that apply from the list below

- Improved data sharing with other local services
- Improved staff levels/service resources
- Improved support and supervision for staff
- Improved collaborative working with other relevant services
- Improved use of Lived Experience input
- Improved safeguarding policies at your service
- Improved service accessibility (eg flexible appointment times)
- Other (please specify)

7. Are you able to access training that helps you to work safely and effectively with patients in Inclusion Health groups?

- Yes - enough
- Yes - some but not enough
- No
- Don't Know/Unsure

8. Do you experience any of the following barriers when accessing relevant training? Please select all that apply

- Training is not available
- I am uncertain where/how to access training
- I am not given time off by my managers to complete training
- I am unable to find time for training due to my workload
- Other (please specify)

9. Are there any specific training topics that you think would improve your ability to provide effective care for people in Inclusion Health groups, that you have been unable to access? If so, please briefly describe up to three

10. With regards to improving healthcare and outcomes for people in Inclusion Health groups, do you think that are any important training gaps for mainstream healthcare staff? If so, please briefly describe up to three

Section 3B: Mainstream healthcare staff

1. Which type of mainstream healthcare setting do you work in? You may select more than one if relevant

- General Practice/Primary Care
- Hospitals – Urgent & Emergency Care
- Hospitals – Other Services
- Outpatient Services/Clinics
- Community Healthcare Services
- Other

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

- I have the knowledge and skills I need to provide effective care for people in Inclusion Health groups
- My service is able to work effectively with other relevant organisations across health, housing,
- social care and the third sector to the meet the needs of Inclusion Health patients
- My service is able to effectively safeguard patients from Inclusion Health groups
- My service provides care in a trauma-informed manner
- My service is able to communicate effectively with patients from Inclusion Health groups about their health needs/care

3. Please elaborate on your responses to the previous question, if you wish to do so – Free text

4. Do you face any of the following challenges in providing effective care for people in Inclusion Health groups? Please select all that apply

- Inadequate service resources (eg staff, office space)
- Inadequate professional support and supervision for staff members
- Stigma and discrimination from other staff/services towards patients in Inclusion Health groups
- Lack of understanding amongst other staff/services about the needs of patients in Inclusion Health groups
- Increasing local demand on your service from patients in Inclusion Health groups
- Lack of information about other services/community organisations that can provide support for patients in
- Inclusion Health groups
- My service is not designed to provide care for patients with complex needs
- Poor/lack of data sharing with other relevant services
- Other (please specify)

5. Please elaborate on your responses to the previous question, if you wish to do so – Free text

6. Over the past year, have there been any improvements to your service that have improved your ability to provide effective and safe healthcare for people in Inclusion Health groups? Please select all that apply from the list below

- Improved data sharing with other local services
- Improved staff levels/service resources
- Improved support and supervision for staff members
- Improved collaborative working with other relevant services
- Improved safeguarding policies at your service
- Improved service accessibility (eg flexible appointment times)
- Other (please specify

7. Are you able to access training that helps you to work safely and effectively with patients in Inclusion Health groups?

- Yes - enough
- Yes - some but not enough
- No
- Don’t Know/Unsure

8. Do you experience any of the following barriers when accessing relevant training? Please select all that apply

- Training is not available
- I am uncertain where/how to access training
- I am not given time off by my managers to complete training
- I am unable to find time for training due to my workload
- Other (please specify)

9. Are there any specific training topics that you think would improve your ability to provide effective care for people in Inclusion Health groups, that you have been unable to access? If so, please briefly describe up to three

Section 3C: Healthcare service commissioning

1. Does your ICS have a named strategic lead for Inclusion Health

- Yes
- No
- Don't Know/Unsure

2. Please indicate the extent to which you agree of disagree with the following statements;

- My ICS has a strategic plan for meeting the needs of our local Inclusion Health population
- My ICS involves people with lived experience in the design and delivery of healthcare services
- My ICS is taking steps to improve the visibility of Inclusion Health populations in routine datasets (eg improving coding of housing status)
- My ICS works effectively with Local Authority partners to ensure that health and housing are well integrated to meet the needs of people in Inclusion Health groups
- The concept of Inclusion Health is well understood within my ICS's leadership

3. Does your ICS use any of the following levers and funding streams to meet the needs of local Inclusion Health populations? Please select all that apply

- CORE20PLUS5
- Health Inequalities Funding
- Primary Care DES Contract
- Mainstream Funding Streams
- Safeguarding Policies and legislation
- NICE Guidance NG214: Integrated health and Social Care for people experiencing homelessness
- Rough Sleeping Initiative
- Changing Futures Programme
- Other (please specify)

4. With regards to commissioning healthcare services that meet the needs of your local Inclusion Health population, do you face any of the following challenges? Please select all that apply

- Difficulty recruiting appropriately skilled staff
- Difficulty securing long-term funding
- Lack of data to evidence the need for services
- Lack of data to evidence the efficacy of services
- Inclusion Health is not a local strategic priority
- Poor understanding within ICS leadership of the needs of people in Inclusion Health groups
- Other (please specify)

5. Please elaborate on your responses to the previous question, if you wish to do so – Free text

6. With regards to commissioning Intermediate Care services that meet the needs of your local Inclusion Health population, do you face any specific challenges? If so, please briefly describe in the box provided

7. With regards to improving healthcare and outcomes for your local Inclusion Health population, what current opportunities for improvement are there within your ICS? Please briefly describe up to three

Section 3D: Policy, data & research

1. In your opinion, which research areas or topics do you think should be the priority for new/more research, with regards to improving healthcare and outcomes for people in Inclusion Health groups? Please briefly outline up to three

2. In your opinion, which policy developments do you think would be impactful in terms of improving healthcare and outcomes for people in Inclusion Health groups? Please briefly outline up to three

3. Are you aware of any local and/or national current initiatives to improve the collection and use of data for people in Inclusion Health groups? If so, please briefly describe and/or share web links in the box provided

Section 3E: Other inclusion health staff

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

- I have the skills and knowledge needed to provide support for people in Inclusion Health groups, within my role
- I have the skills and knowledge needed to provide support to other organisations that are working with people in Inclusion Health groups, within my role
- My organisation is able to work effectively with other relevant organisations across health, housing, social care and the third sector, to meet the needs of people in Inclusion Health groups

2. Are you able to access training that helps you to work safely and effectively with patients in Inclusion Health groups?

- Yes - enough
- Yes - some but not enough
- No
- Don't Know/Unsure

3. Do you experience any of the following barriers when accessing relevant training? Please select all that apply

- Training is not available
- I am uncertain where/how to access training
- I am not given time off by my managers to complete training
- I am unable to find time for training due to my workload
- Other (please specify)

4. Are there any specific training topics that you think would improve your ability to provide support for people in Inclusion Health groups and/or organisations working with people in Inclusion Health groups, that you have been unable to access? If so, please briefly describe up to three

Pathway’s Partnership Programme

Pathway’s Partnership Programme is a national support programme designed to help systems commission specialist homeless hospital teams, based on Pathway’s ten years of accumulated experience and research creating and supporting a network of teams.

The initial step is usually for the NHS locally to commission a specialist Pathway homeless and inclusion health needs assessment. If the needs assessment finds that a local system would benefit from a Pathway team then we work with local partners to scope, specify, design and commission a service. Through our Partnership Programme we help localities recruit and train staff and once teams go-live they have access to Pathway’s on-going support offer: quality standards and performance monitoring, regular training updates and best practice, quality benchmarking with other teams, and quality improvement support. Localities that join the programme then contribute to its design and future development and supply activity data that helps to inform Pathway’s national advocacy and policy work.

Pathway teams improve outcomes for homeless patients and are quality and cost effective, particularly where they are part of a system-wide approach to homelessness.

What are Pathway Teams and what do they do?

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. Teams typically comprise some combination of GPs, Nurses, Housing Workers, Social Workers, Occupational Therapists and Care Navigators. The overall goals of a Pathway team are to maximise the benefits of a hospital admission and ultimately improve health outcomes for people experiencing homelessness and multiple exclusion.

Teams achieve this through a wide range of activities including:

Building relationships of trust with patients and meeting immediate practical needs – for fresh clothes, shoes, making contact with friends and family;

Conducting holistic, patient-centred assessments;

Clinically-supported housing advocacy and discharge planning;

Convening and attending multi-disciplinary meetings involving key hospital and community services;

Ensuring patients are registered with a GP they can access on hospital discharge; making appropriate referrals to Safeguarding, Social Care and other key services such as substance misuse;

Where such services exist, managing the referral of patients to specialist intermediate care services on discharge and continuing care co-ordination in that setting;

Establishing patients' legal entitlements to benefits, and housing support and to regularising their immigration status;

Training and educating local colleagues to promote culture change.

Pathway teams are NHS employed staff who work with their patients to bridge the boundaries between health, housing and social care.

More information:

For more information about the Pathway Partnership Programme and Pathway's needs assessment process:

Visit: **www.pathway.org.uk**
Email: **paul.hamlin@pathway.org.uk**

Pathway
Homeless & Inclusion Health

Crisis
Together
we will end
homelessness