“The Opposite of a Siege Mentality”: Collaborative Action on Inclusion Health

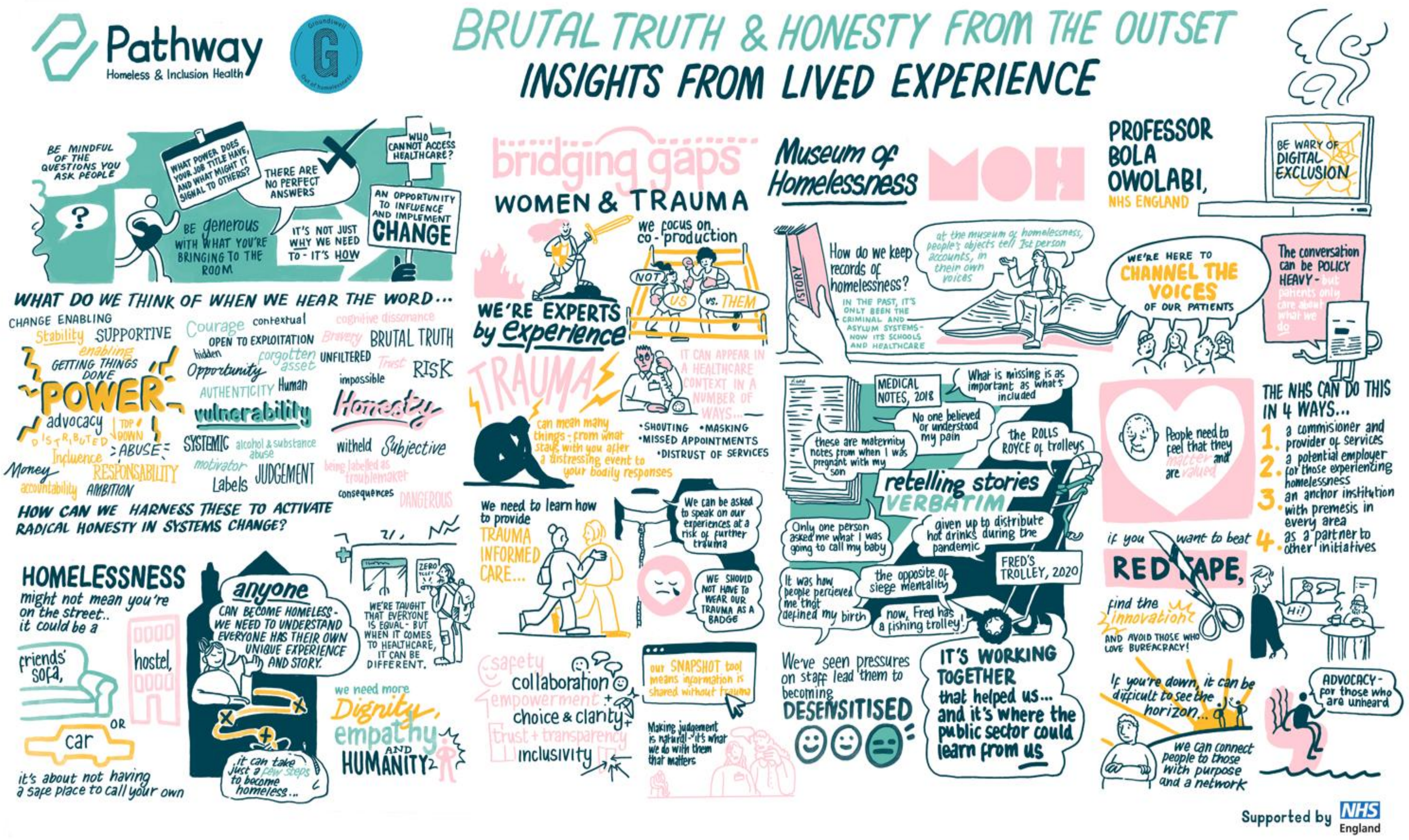
Gill Taylor

June 2025

Pathway
Homeless & Inclusion Health

"Participating in the programme is one of the best things we've done. We're really proud that we can share our ideas and our work with people from across the country"

- Bridging Gaps Volunteer


Pathway
Homeless & Inclusion Health
BRUTAL TRUTH & HONESTY FROM THE OUTSET
INSIGHTS FROM LIVED EXPERIENCE
BE MINDFUL OF THE QUESTIONS YOU ASK PEOPLE
?
WHAT POWER DOES YOUR JOB TITLE HAVE, AND WHAT MIGHT IT SIGNAL TO OTHERS?
THERE ARE NO PERFECT ANSWERS
WHO CANNOT ACCESS HEALTHCARE?
BE generous WITH WHAT YOU'RE BRINGING TO THE ROOM
IT'S NOT JUST WHY WE NEED TO - IT'S HOW
AN OPPORTUNITY TO INFLUENCE AND IMPLEMENT CHANGE
WHAT DO WE THINK OF WHEN WE HEAR THE WORD...
CHANGE ENABLING
Stability
SUPPORTIVE
enabling
GETTING THINGS DONE
POWER
advocacy
TOP DOWN
DISTRIBUTED
ABUSE
Influence
Money
RESPONSABILITY
accountability
AMBITION
Courage
contextual
OPEN TO EXPLOITATION
hidden
forgotten asset
Opportunity
AUTHENTICITY
Human
vulnerability
SYSTEMIC
alcohol & substance abuse
motivator
Labels
JUDGEMENT
cognitive dissonance
Bravery
BRUTAL TRUTH
UNFILTERED
Trust
RISK
impossible
Honesty
witheld
Subjective
being labelled as troublemaker
consequences
DANGEROUS
HOW CAN WE HARNESS THESE TO ACTIVATE RADICAL HONESTY IN SYSTEMS CHANGE?
HOMELESSNESS might not mean you're on the street.. it could be a
friends' sofa,
hostel,
OR
car
it's about not having a safe place to call your own
anyone CAN BECOME HOMELESS - WE NEED TO UNDERSTAND EVERYONE HAS THEIR OWN UNIQUE EXPERIENCE AND STORY.
it can take just a few steps to become homeless...
ZERO
WE'RE TAUGHT THAT EVERYONE IS EQUAL - BUT WHEN IT COMES TO HEALTHCARE, IT CAN BE DIFFERENT.
we need more Dignity, empathy AND HUMANITY
bridging gaps
WOMEN & TRAUMA
WE'RE EXPERTS by experience
we focus on co-production
NOT US vs. THEM
TRAUMA
can mean many things - from what stays with you after a distressing event to your bodily responses
IT CAN APPEAR IN A HEALTHCARE CONTEXT IN A NUMBER OF WAYS...
•SHOUTING •MASKING
•MISSED APPOINTMENTS
•DISTRUST OF SERVICES
We need to learn how to provide TRAUMA INFORMED CARE...
We can be asked to speak on our experiences at a risk of further trauma
WE SHOULD NOT HAVE TO WEAR OUR TRAUMA AS A BADGE
safety
collaboration
empowerment
choice & clarity
trust + transparency
inclusivity
our SNAPSHOT tool means information is shared without trauma
Making judgement is natural - it's what we do with them that matters
Museum of Homelessness
MOH
STORY
How do we keep records of homelessness?
IN THE PAST, IT'S ONLY BEEN THE CRIMINAL AND ASYLUM SYSTEMS - NOW ITS SCHOOLS AND HEALTHCARE
at the museum of homelessness, people's objects tell 1st person accounts, in their own voices
MEDICAL NOTES, 2018
What is missing is as important as what's included
No one believed or understood my pain
these are maternity notes from when I was pregnant with my son
the ROLLS ROYCE of trolleys
retelling stories VERBATIM
Only one person asked me what I was going to call my baby
given up to distribute hot drinks during the pandemic
FRED'S TROLLEY, 2020
It was how people percieved me that defined my birth
the opposite of siege mentality
now, Fred has a fishing trolley!
We've seen pressures on staff lead them to becoming DESENSITISED
IT'S WORKING TOGETHER that helped us... and it's where the public sector could learn from us
PROFESSOR BOLA OWOLABI, NHS ENGLAND
BE WARY OF DIGITAL EXCLUSION
WE'RE HERE TO CHANNEL THE VOICES OF OUR PATIENTS
The conversation can be POLICY HEAVY - but patients only care about what we do
People need to feel that they matter and are valued
THE NHS CAN DO THIS IN 4 WAYS...
1. a commisioner and provider of services
2. a potential employer for those experiencing homelessness
3. an anchor institution with premesis in every area
4. as a partner to other initiatives
if you want to beat RED TAPE, find the innovation AND AVOID THOSE WHO LOVE BUREACRACY!
Hi!
If you're down, it can be difficult to see the horizon...
we can connect people to those with purpose and a network
ADVOCACY - for those who are unheard
Supported by NHS England

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Forewords

Alex Bax, Pathway CEO

In finalising this report for publication, the content of my foreword has changed several times. Grappling with how to introduce a document calling for more, at a time when local systems are grappling with how to manage with significantly less, is a daunting task narratively and ethically. With this in mind it feels appropriate that the report's primary call is for central government leadership, investment and inter-departmental collaboration around inclusion health, to support the continued efforts of local systems and services.

When Pathway began its work in 2008, the healthcare landscape for people experiencing homelessness and social exclusion was fragmented and unsupported by policy. What did exist was held together by the tenacity and passion of a small number of highly committed individuals and teams. Although the years between then and now could hardly be characterised by an abundance of public investment, nonetheless there have been notable steps forward in both policy and practice, and this was clearly evident in the leadership programme the learning in this report derives from. We publish this report at a pivotal moment for the NHS and the need for bold, inclusive, and evidence-driven action to reduce health inequalities remains as urgent as ever.

Inclusion health groups are a priority 'PLUS' group in NHS England's Core20PLUS5 approach, which provides a framework for reducing healthcare inequalities at both national and system level. In October 2023, the NHS England national framework for NHS action on inclusion health gave the field its first discrete national policy footing and gave ICSs with a set of guiding principles. The framework calls for practical action, by establishing strategic leadership within the ICS, improving data and evidence gathering, commissioning services that respond to need and developing robust evidence about what works locally. It was Pathway's pleasure and privilege to be involved in the development of the framework, which was a significant milestone in the field, giving inclusion health much needed emphasis among the many competing pressures facing public services.

Today our health system stands at a crossroads. Once again, the NHS is in bureaucratic flux, with the future shape of system leadership to be defined by the Government's imminent 10-Year Plan. While the structures and responsibilities described in this report—especially Integrated Care Boards and Systems (ICBs and ICSs)—are now set to evolve, merge or even be replaced in the coming years, I think that the learning captured here is relevant whatever the detailed organisational form. The core principles of collaborative working, data-driven action, and meaningful inclusion health planning are relevant to any future configuration of health and care and remain the bedrock of the inclusion health field.

What is clear amidst this uncertainty is that Integrated Care Boards (ICBs) are assuming a fundamentally different role—one rooted in population health, digital intelligence, and a renewed focus on strategic commissioning, rather than system convening. This positions ICBs as essential actors in the inclusion health agenda, where creative integrated commissioning holds the key to socially determined health needs, but it also raises questions about who brings, and holds, the local system together in the months and years to come. Much of this report is a conversation with and between local systems, and although roles, responsibilities and structures will be different going forward, their relevance in improving outcomes, not only for inclusion health groups but for everyone, holds true.

Equally, the need for integrated services remains a constant within and beyond inclusion health. The evidence is unequivocal: integration works—especially for excluded populations, where fragmented care often means unmet need and avoidable harm. Whether integration is led by ICBs, ICSs, local authorities, neighbourhood teams, or new entities we are yet to define, the call to action is the same: integration must be strategic, person-centred, trauma-informed, and shaped by those with lived experience.

Neighbourhoods will likely form the bedrock of this next era of NHS reform. It is in these localities that many of the most dynamic and relational models of integrated care are already emerging; the inclusion health field has been the vanguard of the types of integrated multi-disciplinary and co-located services that the promise of locality models is built on. This report speaks to them, too—urging neighbourhood leaders and their commissioners to embed inclusion health principles into service design, data collection, workforce development, and community partnerships.

As systems evolve, our shared challenge is to ensure that inclusion health is not sidelined as a ‘niche’ concern or ‘nice to have’, but rather embedded as a driver of wider health equity and an exemplar of what can be achieved with incisive leadership, a motivated workforce and the permission to work creatively. Tackling extreme health inequalities must remain a visible, measurable and resourced priority —not just for the benefit of those most at risk, but because a health system that works for the most excluded is better for everyone.

The title of this report draws from our allies at the Museum of Homelessness, who shared one of the Museum's object stories, 'Fred's Trolley', as part of the programme's first session. The story of the trolley shines a light on the collaboration, solidarity and resourcefulness of the grassroots sector in response to homelessness during the pandemic and acts as a powerful reminder of what can be achieved, in even the darkest times, when we insist on a shared future.

This report draws from a wealth of learning, generously shared by practitioners, lived experience experts, and system leaders as part of our ICS Inclusion Health Leadership Programme. We thank them all, as well as NHS England for their support for this programme. We offer the report not as a roadmap tied to a specific moment or structure, but as a guide to what is possible—whatever comes next.

Professor Bola Owolabi CBE MRCGP FRSPH

Inclusion health groups face some of the most acute healthcare inequalities in our society, living on average 20 years less than the general population. Social exclusion and multiple interacting risk factors such as stigma, discrimination, poverty and complex trauma drive poor health outcomes.

That is why NHS England has inclusion health groups at the heart of our priority populations in the Core20PLUS5 approach to reducing healthcare inequalities, and why we produced a national inclusion health framework in 2023.

Our inclusion health framework was intended to help every Integrated Care System (ICS) to shape and take their next steps in improving access to, experience, and outcomes of health services for people in inclusion health groups, recognising that systems will be at different stages in this journey.

Drawing on local insights from a cohort of ICSs from around the country, and from professional and lived experience experts both nationally and internationally, this report encapsulates how policy has been put into practice since the landmark publication of the framework, just less than two years ago.

I am pleased to read about what can be activated when you co-design a programme with people from inclusion health populations at the heart of it. The report is a testament to the persistent resilience of marginalised people and those who work in the inclusion health landscape.

With clear recommendations for national action and local delivery, the report outlines a bottom-up, system-wide blueprint for how we continue to mobilise this important agenda at scale.

This report is right to call for collaborative action. No single organisation, profession or sector can reduce health inequalities for inclusion health groups in isolation. NHS leaders must act as agents of change at all levels of the system, alongside their system partners. The multiple interacting causes of social exclusion and ill health in inclusion health groups require cross-sector, interagency working within ICSs, and through strategic coproduction with people with lived experience.

We are entering a significant period of change across the health system. By taking a strategic, partnership approach to inclusion health, ICSs can reduce system pressures, better utilise resources and work with communities to develop approaches that save lives while contributing to the Government's commitment to halve the gap in healthy life expectancy.

We must stop admiring the problem and leaving it in the 'too difficult' pile. If we can get it right for the most marginalised, we can get it right for all of society. The cost of failing to act is too high, for individual patients and our health systems.

Introduction

Inclusion health is not a new construct, but nor is it one that enjoys widespread understanding across health and social care. Although the evidence of common needs between excluded groups[1] is now widely accepted, with the experiences of patients facing homelessness receiving a particular spotlight, it remains the case overall that inclusion health 'literacy' and integration into mainstream health and care strategies is inconsistent. The growing platform of health inequalities, whilst welcome and much-needed, risks overshadowing the discrete strategic and operational considerations of populations living at the extreme margins of inequity and exclusion, known as 'inclusion health groups'.

This report builds on the momentum generated by the *NHS England Framework for NHS action on Inclusion Health*, published in autumn 2023. It seeks to advance the conversation on how Integrated Care Systems (ICSs) can turn the promise of inclusion health into reality at scale. It follows our *Beyond Pockets of Excellence* report and distils insights from the second collaborative ICS Learning Programme, curated by Pathway with support from Groundswell and NHS England.

Aimed at NHS system leaders, both locally and nationally, the report examines developments in policy and practice since the release of the NHSE framework in 2023. It offers high-level recommendations to ICSs and to national bodies and government departments, with the aim of building on existing learning to strengthen both strategic and operational approaches to inclusion health. By showcasing promising examples from local systems, the report also highlights how leadership, expertise, and tenacity are driving a shift from isolated excellence to systemic change – despite the significant challenges facing public services.

Programme participants celebrated that the Framework has helped secure 'a foot in the door' for inclusion health; the challenge now is to establish it as a system-wide priority rather than a specialist concern. The evolving role of ICSs, alongside workforce restructuring and resource constraints, significantly influenced the learning programme's design and delivery. Our focus was on leveraging 'the art of the possible' in the NHS's new operating model.
The programme unfolded against the backdrop of a general election, with widespread hope for meaningful policy change that at the time of writing remains in the balance.

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[1] Luchenski, Serena et al. "What works in inclusion health: overview of effective interventions for marginalised and excluded populations". https://www.researchgate.net/publication/325142265_What_works_in_inclusion_health_overview_of_effective_interventions_for_marginalised_and_excluded_populations

As this report is published, the NHS 10-Year Plan nears publication—a key moment for action. Shifting the dial on inclusion health requires sustained investment in transformational systemic change; an ambitious and well-resourced 10-Year Plan for the NHS will lay the foundations for such change.

This report shares key learnings, critical questions and system insights, suggesting pathways for positive action. Grounded in the real experiences of inclusion health populations and practitioners at all levels, it provides a window into the opportunities and complexities of designing systems and services that truly meet the needs of those forced to live at the margins. It has been our pleasure to learn from all of those who participated in the design and delivery of the programme, either as participants, expert speakers, facilitators or as part of our Advisory and Steering Groups. It is our privilege to reflect some of their expert insights in this report.

The Programme

Background

Led by Pathway, the national homeless and inclusion health charity, the programme was a collaboration with Groundswell, whose focus is the voice and power of individuals and communities experiencing homelessness, and NHS England. Our partnership was supported by a multi-disciplinary Steering Group of expert clinicians and senior leaders, whose governance ensured the programme made the best of available resources, the latest evidence and relevant law and policy drivers.

The commitment to working collaboratively extended into the design of the programme, where an Advisory Group of expert clinicians, sector allies and lived experience experts shaped the prioritisation of programme content and the selection of expert speakers. Importantly, the Advisory Group pressed for the inclusion of speakers with bold ideas and pioneering ways of working, as well as those engaged in the less visible work of strengthening infrastructure. The Advisory Group also emphasised the importance of a programme that included voluntary and community sector insights, that explored principles as well as practices and that considered the intersection of race, gender and disability for inclusion health populations.

Our 2023 cohort took inspiration from what Professor Sir Michael Marmot[2] described as ‘building back fairer’, to explore the ambition of moving beyond pockets of excellent practice for particular inclusion health populations, and towards health equity for all.

In 2024, our concerns about delivering inclusion health outcomes at scale remain just as live and our second cohort grappled with that challenge in their applications to join the programme. A year on from the first, they asked “*how can ICSs effectively navigate the opportunities and barriers at play, to deliver the ambitions of the NHSE framework*?” As such, we made efforts to consider inclusion health at scale, emphasising efforts to scale up and broaden out individual programmes and place-specific interventions.

With that in mind, we developed a programme that wove together the five key principles for practical action outlined in the NHSE framework, alongside the seven

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[2] Marmot, Prof. Sir Michael. “Build Back Fairer: The COVID-19 Marmot Review”. https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review?gclid=EAIaIQobChMIqLbV8omf_wIVT-vtCh0YGALaEAAYASAAEgIJNfD_BwE

pillars for integrated inclusion healthcare outlined in the Beyond Pockets of Excellence report.

Whilst the challenges for systems are important, it is the stark human consequences of exclusion that foregrounded the programme. Experiences of homelessness, addiction, sex work and detention are increasingly synonymous with notions of isolation, risk and stigma but we know from our work that these insights are only one part of what lived experience offers the inclusion health field. In co-designing the programme with people from inclusion health populations, we sought to amplify the creativity, imagination and dynamism that marginalised people and communities have in abundance in the face of significant challenges.

Our lived experience facilitators decided to start the programme with a whole day of contributions from lived experience. This undoubtedly made for one of the most impactful learning experiences we have ever been part of, a view that our participants shared wholeheartedly.

Who was involved?

Programme design sought the active engagement of participants; learning from our first cohort confirmed that an optimum cohort size would include 7 ICSs. Each ICS would name a lead participant, who would have the opportunity to invite up to 3 guests from their system to join them at each session of the programme.

We were keen to bring together systems at different stages of inclusion health maturity, with different priority populations, from different areas of the country and with lead participants in roles of varying breadths, from both local authorities and

NHS organisations. Learning from our first cohort highlighted the importance of participants having the support of senior leaders to take forward their learning into tangible action, so we introduced the requirement to name a senior sponsor as a prerequisite element of the Expression of Interest process.

As well as sharing the opportunity to express interest in joining the programme on our website and social media channels, we sent a letter of invitation to every ICS in the country. We were overwhelmed by the response; 50% of all ICSs submitted an expression of interest, evidencing the appetite for collaborative learning for leaders working in this area.

A panel of Pathway and Groundswell colleagues selected the following seven ICSs to join the programme:

- Birmingham and Solihull
- Black Country
- Cambridgeshire and Peterborough
- Cheshire and Merseyside
- Kent and Medway
- Surrey
- West Yorkshire

Coaching

Once selected, the lead participant and named senior sponsor from each ICS were invited to attend a coaching session with the programme lead and facilitator. The aim of the pre-start coaching session was to surface specific learning goals for each lead participant and to identify what positive change in their local inclusion health infrastructure would look like. Participants also completed a brief survey at this stage which was designed to assist in evaluating the programme's impact.

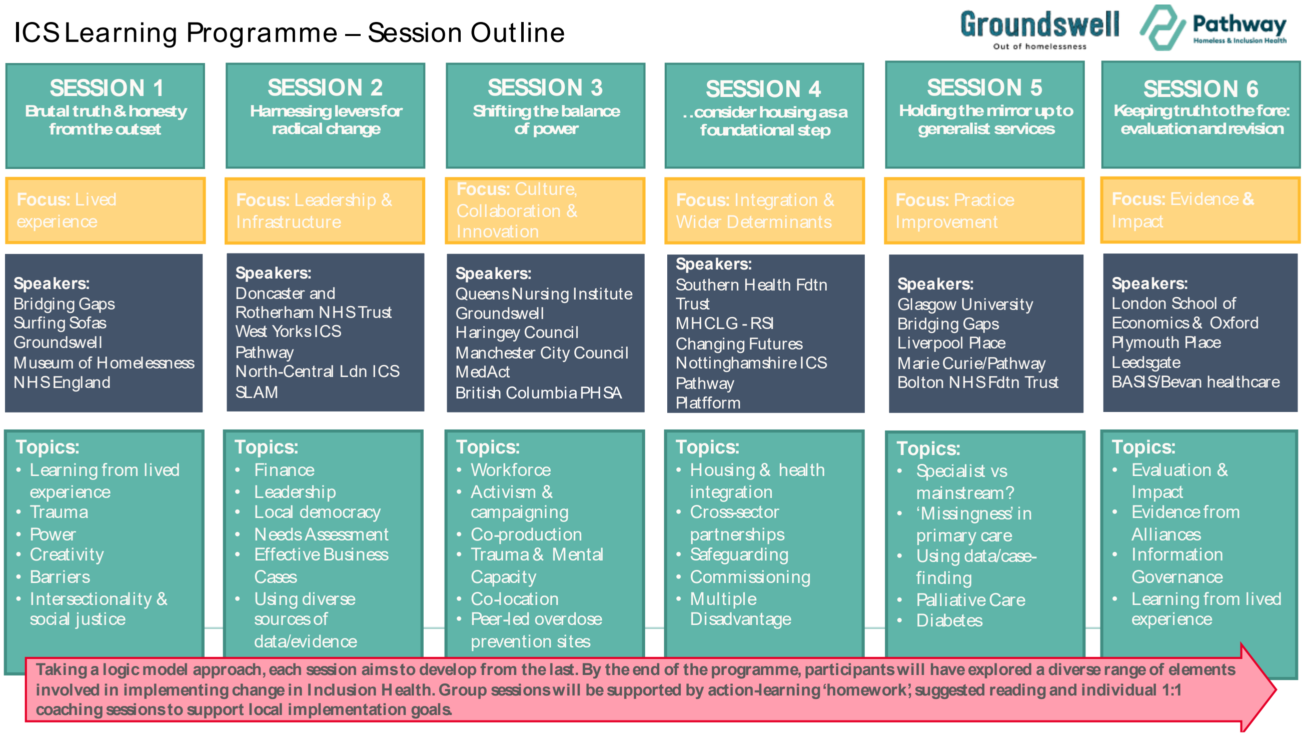
Informal coaching took place throughout the programme and drew on peer support; participants met with the programme facilitator to troubleshoot live issues and opportunities in their systems and Pathway were invited to contribute to events and conversations happening locally to share expertise and insights from our Faculty and networks.

Lead participants and senior sponsors were invited to attend a final coaching session to conclude the programme. The aim of this session was to create an opportunity to reflect on the learning and explore how it would be integrated into local strategy and planning. A welcome outcome of these coaching sessions was the evidence that learning was already being implemented locally; systems had already begun to enhance local governance and strategic prioritisation of inclusion health and several were planning inclusion health summits and conferences.

Programme Delivery

The programme started in late March 2024. Seven full-day sessions took place over the following four months, with the first and the last held in person in London and Birmingham respectively.

The six sessions that made up the main body of the programme were each designed around a broad theme, incorporating the five NHSE principles for action set out in the framework and the seven pillars for inclusion health we set out in Beyond Pockets of Excellence. Each session brought together presentations from guest speakers, group discussions and interactive activities to explore ideas and share local examples. Inspired by action-learning set approaches, each session ended with a task to be completed ahead of the next session; these ranged from listening to a poetry album, to meeting with frontline inclusion health practitioners to meeting in small groups with other participants to discuss a specific area of practice.



ICS Learning Programme – Session Outline

SESSION 1 Brutal truth & honesty from the outset	**SESSION 2** Harnessing levers for radical change	**SESSION 3** Shifting the balance of power	**SESSION 4** ..consider housing as a foundational step	**SESSION 5** Holding the mirror up to generalist services	**SESSION 6** Keeping truth to the fore: evaluation and revision
Focus: Lived experience	**Focus:** Leadership & Infrastructure	**Focus:** Culture, Collaboration & Innovation	**Focus:** Integration & Wider Determinants	**Focus:** Practice Improvement	**Focus:** Evidence & Impact
Speakers: Bridging Gaps Surfing Sofas Groundswell Museum of Homelessness NHS England	**Speakers:** Doncaster and Rotherham NHS Trust West Yorks ICS Pathway North-Central Ldn ICS SLAM	**Speakers:** Queens Nursing Institute Groundswell Haringey Council Manchester City Council MedAct British Columbia PHSA	**Speakers:** Southern Health Fdtn Trust MHCLG - RSI Changing Futures Nottinghamshire ICS Pathway Platfform	**Speakers:** Glasgow University Bridging Gaps Liverpool Place Marie Curie/Pathway Bolton NHS Fdtn Trust	**Speakers:** London School of Economics & Oxford Plymouth Place Leedsgate BASIS/Bevan healthcare
Topics: • Learning from lived experience • Trauma • Power • Creativity • Barriers • Intersectionality & social justice	**Topics:** • Finance • Leadership • Local democracy • Needs Assessment • Effective Business Cases • Using diverse sources of data/evidence	**Topics:** • Workforce • Activism & campaigning • Co-production • Trauma & Mental Capacity • Co-location • Peer-led overdose prevention sites	**Topics:** • Housing & health integration • Cross-sector partnerships • Safeguarding • Commissioning • Multiple Disadvantage	**Topics:** • Specialist vs mainstream? • 'Missingness' in primary care • Using data/case-finding • Palliative Care • Diabetes	**Topics:** • Evaluation & Impact • Evidence from Alliances • Information Governance • Learning from lived experience

Taking a logic model approach, each session aims to develop from the last. By the end of the programme, participants will have explored a diverse range of elements involved in implementing change in Inclusion Health. Group sessions will be supported by action-learning 'homework', suggested reading and individual 1:1 coaching sessions to support local implementation goals.

In the programme's seventh and final session, participants from our first and second cohorts came together for a day of reflective discussion. This session provided phase two participants an opportunity to hear about how learning from the programme had been taken forward by our first cohort, how it had supported them to achieve local ambitions and what remains challenging. This session included in-depth discussions about key developments in policy and practice that could enable systems to realise the promise of inclusion health at scale.

The recommendations that conclude this report derive from discussions throughout the programme that were solidified in the final session in Birmingham. They have since been discussed and strengthened in discussions with the System Leaders subgroup of the Faculty for Homeless and Inclusion Health and the Pathway Fellows network.

What happened afterwards?

Lead participants felt strongly that the opportunity to meet and work with each other was a huge benefit of the programme. A welcome but unexpected outcome of the programme was that they decided to continue to meet periodically as a peer group, to share updates and seek advice on the development of their inclusion health work.

In addition, a number of participants designed and delivered local inclusion health events following the programme, shared their work as part of the System Leaders subgroup of the Faculty for Homeless and Inclusion Health and as part of the annual Inclusion Health Symposium hosted by Pathway in 2024 and 2025. Pathway were pleased to host and to contribute to these opportunities to share learning

"Never give up. Learn from values-driven experts – their tough minds and tender hearts make the difference. Listening to Ellie Atkins talk about brain injury and ending rough sleeping, or the Object Stories from the Museum of Homelessness are hugely important when combined with what we know about the evidence-base. It's all incredibly powerful and not an either/or."

- Clare Mahoney, Inclusion Health Lead (Liverpool Place), Cheshire and Merseyside ICS

"The Programme provided a useful platform to connect with inclusion health leads from other areas across the country and exchange our experience of driving action on inclusion health within our systems. The shared learning has strengthened our determination to place the voice of experts by experience in the centre of decision- making and has equipped us with ideas and mechanisms to do so. This includes the review of our governance and the establishment of the Birmingham and Solihull Inclusion Health Partnership and the development of system wide action plan for the city."

- Monika Rozanski, Service Lead (Inclusion Health), Public Health, Birmingham City Council

- Nicola Pugh, ICS Inequalities Programme Manager, NHS Birmingham and Solihull

Inclusion Health at Scale – Promising Practice

This section of the report reflects on key areas of policy and practice explored during the programme. It shares insights from programme speakers and the discussions and activities that flowed from their contributions, as well as examples of promising practice from participating systems.

Each subsection is intentionally brief and introduces the key priorities for systems and some of their reflections on the challenges and opportunities in each area.

Some of the ideas, tips and lessons learned explored by our speakers and participants are included in each subsection as 'System Insights'. The aim of including these brief 'nuggets' is to share some key learning points and reflections from people with experience of practical delivery, to enrich the thinking of those who may be beginning to navigate the challenges and opportunities of each area or who are looking to enhance work that may have already started.

The positive practice examples included aim to illustrate how systems and services are grappling with inclusion health at scale, with examples from voluntary sector organisations and pioneering international initiatives highlighting what is possible when cross-sector partnerships and lived experience leadership are given the value, space and priority they deserve.

Lived Experience Participation and Co-Production

Inclusion health practitioners and services have long understood that reducing healthcare inequalities and exclusions must be foregrounded by a commitment to the participation of people with lived and living experience. The NHS framework specifically identifies strategic co-production[3] as an approach to establishing sustainable and empowered lived experience involvement in health service design and decision-making. Whether defined as participation, co-design or strategic co-production, what's important is that people are empowered and supported to participate in making decisions that will affect them.

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[3] NHS England (n.d.) Strategic Co-production. Available at: https://www.england.nhs.uk/get-involved/resources/strategic-coproduction/

We were honoured to work with a wide variety of lived experience experts throughout the design and delivery of the learning programme. People with lived experience, including those now working in professional roles within the sector, were part of the Advisory Group that shaped the programme's content, and a separate lived experience group came together to stage a 'takeover' of Session 1.

System Insights:

- Lived experience involvement is a strong driver for action and not just a 'nice to have' - people from all parts of the system respond strongly to lived experience voices.
- Co-production is a journey and not a destination; it takes time and a commitment to continuous improvement to build trusting, accessible and engaging approaches to power-sharing in service design.
- People with lived experience want to share their expertise and knowledge to bring about real change, not just their personal stories. People should not have to 'wear their trauma as a badge' in order to be listened to.
- Although co-production is understood as good practice, programme participants and speakers reflected that securing the time and resources needed to do it well can be challenging and requires creativity and flexibility.
- The participation of people with lived experience can and should take many different forms; different projects and activities will benefit from different types of involvement.
- If your co-production activity isn't challenging, confronting and uncomfortable at times then it's probably not going as well as you think! Good co-production doesn't shy away from the difficult truths.
- Remunerating lived experience input is not just a 'nice to have', people should be compensated fairly and appropriately for their time, involvement and expenses.
- Employing people with lived experience in inclusion health roles is crucial and not only as 'peers'; ICSs should review their recruitment practices to improve accessibility and reduce barriers for inclusion health groups.

Vancouver – Overdose Prevention Sites

We were privileged to be joined online by Jonathan Orr, a Crisis Intervention Specialist from British Columbia, who led the establishment of Canada's first overdose prevention site and a pioneering workforce development initiative for Canada's inclusion health sector. Overdose prevention services in Vancouver have supported thousands of safe injections and prevented hundreds of overdoses, something highly relevant to the UK where drug-related deaths are increasing and a leading cause of death for inclusion health populations.

Jonathan spoke about the detailed and ongoing co-production in the development of overdose prevention services. He spoke about the crucial role of psychologically-informed and visibly peer-led physical environments that reduce physical barriers between staff and users, minimise administration and encourage peer support. Importantly, Jonathan shared how people still in active addiction had challenged statutory agencies to engage with the perceived and actual risks of peer support, challenging stigma and recognising the collective knowledge that people with lived experience have of the issues they face. He reminded participants how lived experience communities have always shaped healthcare practice, even where this is not acknowledged in policy.

He spoke about investing in the development and support available for inclusion health staff, especially those with lived experience. He described a first of its kind project to co-develop a training curriculum for people with lived experience to work effectively in peer roles within the inclusion health sector. The 16-module online curriculum, supported by a range of additional learning tools, is designed to ensure that "every door is the right door" for people from inclusion health populations, recognising that trust, engagement and outcomes are significantly improved by the unique relational capacity of those with lived and living experience.

He encouraged participants to take time to ensure people with lived experience can participate meaningfully and not tokenistically in co-production and service delivery, recognising this will likely require paced and detailed work with funders, policymakers and commissioners to secure their support for positive risk-taking in service design and delivery. He also encouraged participants not to be disheartened by barriers along the way; not everyone will see the value of co-production at first. Inviting senior leaders and funders to meet people with lived experience, to visit services and to spend time exploring their confidence around risk was valuable in securing and sustaining their investment.

Bridging Gaps and Bristol

Bridging Gaps is a group of women who have experienced complex trauma, including addiction, homelessness, mental health problems, sexual exploitation, domestic and sexual violence, and poverty. Working with the NIHR and the Centre for Academic Primary Care at the University of Bristol they have been working collaboratively to improve access to primary care for people with experiences of trauma.

Working alongside GPs including Dr Lucy Potter, researcher Dr Michelle Farr and staff from Bristol charity One25, Bridging Gaps have embedded trauma-informed principles into the way GP practices support women in the city. This work made innovative use of Enhanced Access funding available to all primary care networks, with a focus on reducing health inequalities.

Through their work together they developed a training course and facilitated this at five different GP practices across Bristol. They worked in more depth with three practices to enhance access for people with complex needs, including developing a specialist clinic in one practice - Wellspring in east Bristol. The new clinic offered longer appointment times, proactive ‘reaching out’ to women facing especially complex barriers and two named GP leads who patients were able to get to know. More than 100 women have now accessed this service, many who had not seen a GP in years.

A key aspect of their work was the development of a ‘Personal Snapshot’ tool to enable women to take control of the information shared and discussed with clinicians and practitioners. Importantly the tool helps reduce the number of times women would need to ‘tell their stories’ to professionals, in recognition of the re-traumatising effects this can have and the barriers it may create to effective diagnosis and treatment of stigmatised health needs, around mental and sexual health for example.

Bridging Gaps emphasised that creating the right environment for co-production was a crucial foundation of their success. Regular meetings, collaboration with relevant support agencies to manage safeguarding or other issues that arise through the process and the consistency of professionals involved were all important ways the group were enabled to remain engaged and build trusting relationships with each other and professionals.

They also emphasised the importance of ensuring that when things don’t go to plan that professionals ensure those involved don’t see this as failure but as a learning opportunity that strengthens the project. For many severely excluded people the experience of perceived failure may be especially challenging to self-esteem which can increase the risk of disengagement from co-production activities.

Strategic Leadership

Insights from the first learning programme cohort highlighted the crucial role that visible, accountable and values-driven leadership plays in inclusion health.

In the second round of the programme, and with the NHSE principles for action in mind, our second session focussed on different forms of leadership. We heard from ICS senior leaders, local politicians and sector experts, who shared their insights as leaders and about the role of leadership in shifting the dial on inclusion health. Our participants reflected on what they heard by sharing examples from local systems about how they had secured senior level buy-in for inclusion health priorities and what that had opened up.

Participants from systems where senior leaders made visible commitments around inclusion health felt more confident to innovate, to advocate and to build cross-sector partnerships around key issues. They shared how the behaviour of people in senior leadership positions set the tone, pace and direction of travel. Importantly for inclusion health, senior leaders are able to establish a strategic footing for inclusion health amongst a sea of other pressing and sometime conflicting priorities, giving permission for the wider workforce to champion the needs and experiences of inclusion health populations and to test new and innovative ways of working.

System Insights:

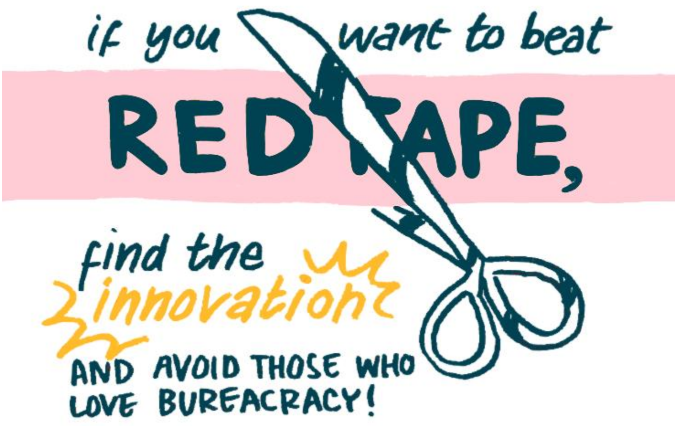
- Inclusion health needs visible, accountable local leadership in order to establish a seat at the table in strategic decision-making.
- Inclusion health leaders and senior champions are not only working in NHS organisations; the local authority, VCS and local politicians all have a role to play.
- Local politicians have an important role to play in championing the health needs and experiences of vulnerable local residents.
- ICS senior leaders should advocate for good governance around inclusion health to ensure it is a priority for the whole system.
- Leadership on inclusion health isn't only about hierarchy and seniority, but the support of Directors and other senior staff sends a clear message.
- Everyone can be a leader, but they need the permission, support and confidence of senior staff to make change happen.
- Inclusion health leadership can and should come from unusual places in systems; Finance Directors can play a key role if they are furnished with good evidence and strong business cases.

West Yorkshire

We had already invited Rob Webster, CEO of West Yorkshire ICB to share his insights as an expert speaker before West Yorkshire were selected to join the programme as participants. Rob spoke in Session 2 about the personal experiences that cemented his commitment to tacking inequalities, and some of the ways he brings that to life in his work. He felt it was important for focus on inequality and exclusion to be a mainstay of leadership and not a ‘nice to have’.

One thing he shared that participants returned to several times during the programme was that “everyone needs somewhere to live, someone to love and something to do”. This short statement points to how inclusion health leadership requires leaders to look for what connects patient populations and not what makes them different, which brings to mind Sir Michael Marmot’s call for ‘proportionate universalism’[4] when approaching exclusion and inequality.

Rob believes that leadership can happen from every seat in the organisation, indicating that inclusion health leadership is about giving permission to those best-placed to make decisions and drive forward change, regardless of hierarchy and job role.



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[4] Public Health England (2014) Local action on health inequalities: Tackling health inequalities through action on the social determinants of health: lessons from experience. Available at: https://assets.publishing.service.gov.uk/media/5a7dcac5ed915d2acb6ee2a6/Briefing10_Lessons_from_experience_health_inequalities.pdf

Oxfordshire

We were joined by Dr Cllr Hosnieh Djafari-Marbini an independent elected member in Oxford and also the city's first Migrant Champion. As a consultant anaesthetist, a politician and a first generation Irani migrant, Hosnieh shared really powerful insights that drew on a mix of personal testimony and professional experience.

Hosnieh shared how her own migration story had inspired her to take action in her community. She told of the legacy of political action in her family and reminded participants of the political nature of inclusion health. She spoke about how her work as a local politician had brought her into contact with recently settled families who were facing huge barriers to accessing healthcare and reminded participants that elected members and local democracy have a potentially significant role to play in championing inclusion health.

She spoke about how important it is that elected members are brought into conversations about inclusion health and health inequalities. She spoke about the Migrant Champions Network, which she co-founded, and encouraged participants to get in touch with their local Migrant Champion to discuss healthcare.

She brought an important focus on the importance of local leaders taking practical action. Importantly she reminded participants of the importance of connecting with informal community leaders and building trust with “deeds not words alone”.

Understanding Needs

All strategy, decision-making and commissioning relies on good quality needs data and analysis. Whilst there is a lot of research about inclusion health populations, most prevalently about those experiencing homelessness, the availability of good quality local data about personal characteristics, health co-morbidities, interactions with services and overall health outcomes is patchy.

In response, our programme placed heavy emphasis on getting the most out of available data, evidence and analysis by drawing on examples from diverse sources and inviting speakers with interesting, and at times unusual, experiences and perspectives. Together with expert speakers we explored what makes a good needs assessment, how to make inclusion health business cases, how to use data to secure iterative investment in services and how to integrate data and insights from lived experience and staff feedback alongside quantitative analyses.

Joint Strategic Needs Assessments (JSNAs)are a strong foundation for integrated practice; by surfacing data that makes the connection between health and its wider determinants - e.g. employment, housing conditions and social care needs - inclusion health comes alive for those outside the NHS. JSNAs are felt to offer an important window into the holistic needs and experiences of communities and highlight opportunities to bridge gaps between people and services.

Now that ICSs are beginning to settle and embed, many are looking to better understand the needs of people within their new geographical footprints.

System Insights:

- System-level needs assessments are crucial to understanding inclusion health needs, and importantly the disparities and differences between places.
- Inclusion health needs assessment should make use of widely available 'grey data' from sources outside the NHS.
- Best practice in inclusion health needs assessments centres lived experience, both in contributing data and in co-producing the needs assessment process and 'product'.
- The absence of available data is not a reason not to say anything! What does the absence of data indicate about what needs to change?
- Don't be lazy... just because there is likely a lot more data about people experiencing homelessness than other populations, don't let this skew the whole JSNA towards those experiences. Make time and space to include the most excluded in your analysis, even if this is in very small-scale or snapshot samples.
- Inclusion health JSNAs should always be a collaborative venture between the NHS, local authority, Voluntary and Community Sector (VCS) and lived experience contributors.

North Central London

We were joined by Priyal Shah, Inclusion Health Programme Lead in North Central London (NCL), at session two of the programme. Priyal shared learning from the development of the NCL Inclusion Health Needs Assessment which was one of the first of its kind when it was completed in 2022 and was borne from the recognition of the human and financial cost of unplanned care arising from unaddressed access and outcome barriers.

NCL conducted their needs assessment in two stages. The first stage of the project saw twenty statutory and voluntary sector partners from the five places within NCL come together to conduct a Rapid Evidence Review. The review considered over 100 local and national datasets concerning the demographics, health needs and service access of inclusion health populations and informed the development of the second stage of the needs assessment. The second stage of the needs assessment involved in-depth interviews with people from inclusion health groups, frontline staff and local stakeholders to bring real experiences to life in the quantitative data collated and analysed in the first stage.

Learning from NCL makes a strong case for inclusion health needs assessments prioritising the intersections of race, gender and other characteristics alongside inclusion health experiences. Their work also highlighted the importance of identifying and remedying data gaps for some inclusion health populations, especially for Gypsy, Roma and Traveller communities and how this is an iterative process which should not act as a barrier to getting started.

Surrey

As a Changing Futures area, Surrey have invested heavily in co-production with people with lived experience of multiple disadvantage. An example of this commitment in action comes from their co-produced Joint Strategic Needs Assessment for Multiple Disadvantage.

Surrey's Changing Futures Lived Experience Recovery Organisation (LERO) are a passionate and insightful group of people who harness the power of their lived and living experience to tackle multiple disadvantage locally. The JSNA chapter was co-created by them and arises from extensive stakeholder engagement, data analysis, and collaboration across sectors to understand the needs and experiences of people living with multiple disadvantage.

This JSNA chapter aims to provide a deeper exploration of attitudes and experiences and richer insights into the context and complexity of multiple disadvantage in Surrey. Primary research, including 86 1:1 interviews, an online survey and seven focus groups with frontline staff identified how Surrey can take action to improve both the type of support available to residents experiencing multiple disadvantage, and the way support is delivered. The report makes eleven recommendations, which emphasise the overarching need for greater integration and collaboration between local services, to enable an accessible, relational, and person-centred approach to multiple disadvantage in Surrey.

Crucial to the quality and depth of the report was whole system collaboration, supported by a cross-sector Steering Group and executive sponsorship from the Director of Long-Term Planning Delivery within Surrey Heartlands ICS.

Prevention

Prevention is a cornerstone of effective healthcare for everyone, but reducing the human and financial costs of complex unplanned care is especially important for inclusion health. Expert speakers and programme participants shared examples of how proactively and collaboratively addressing the health, care and housing needs of severely socially excluded groups can reduce demand pressures in acute care, strengthen cross-sector partnerships and ultimately save the lives of people who all too often die prematurely when health needs are identified too late.

Inclusion health services are uniquely positioned to integrate prevention into service delivery, by leveraging their ability to work flexibly and proactively to integrate health screening programs, immunisation initiatives and harm reduction support in housing and community settings. We heard about mobile health clinics, tailored drop-in services and digital tools that can bring primary care closer to underserved populations. We learnt about co-located initiatives where health services have worked with VCS and local authority partners to maximise the health offer in trusted community spaces. A key strand of discussion was the preventative role of trauma-informed and culturally competent practice, in enabling welcoming, non-judgemental and proactive service delivery.

Programme participants acknowledged the challenges of making prevention a strategic priority; local and national policy and funding pathways remain oriented towards unplanned and acute pressures that are already happening. The cost benefits of prevention can be challenging to evidence, inhibiting the scalability of tailored programmes and frustrating attempts to refocus resources towards prevention in the current operating context, where short-term outcomes are understandably prioritised.

System Insights:

- Systems can tailor prevention strategies to the unique needs of inclusion health groups, by emphasising the preventative role of cultural sensitivity, trauma-informed care, and initiatives that challenge stigma.
- Make use of the expertise and resources within existing prevention programmes to leverage inclusion health outcomes, for example the Better Care Fund and High Impact User programmes.
- The most successful preventative work values the unique role of the VCS in building trust through sustained, meaningful engagement with inclusion health populations that centres the wider determinants of health.
- Peer support initiatives can be hugely positive in helping people to attend appointments or who need support to advocate for themselves.
- Joint health and housing initiatives are central to prevention; families in temporary and asylum accommodation have benefitted significantly from specialist health visitors and on-site clinicians.
- Mobile clinics, outreach programs and digital health tools can help reduce logistical and psychological barriers to accessing healthcare.
- Using data to identify at-risk populations and monitor intervention outcomes is crucial to evidencing outcomes and building strong business cases for long term funding.

North Central London (Haringey Place) – Co-Location

Ophelia Kingshott, Localities Programme Lead from London Borough of Haringey, joined the programme as an expert speaker. She talked about a programme of work to enhance the support available in neighbourhoods, with a particular focus on addressing inequalities and maximising the use of community buildings.

One such building was identified in North Tottenham. Community members, including those from inclusion health and CORE20PLUS5 groups, came together with local authority and NHS staff over a period of months to co-design a support offer that met the communities needs and addressed key health inequalities priorities. They designed a phased plan for co-locating services that would offer local residents from all backgrounds a welcoming and inclusive space where they could seek help with multiple issues, incubate their ideas for community initiatives and access digital inclusion support.

Working with the local GP Federation, a range of co-located health initiatives were established, including NHS Talking Therapies groups, diabetes screening, child weight management, a prescribing clinic and health navigation. Other initiatives included employment, social care, debt advice, period dignity initiatives and housing support.

Ophelia shared initial findings that co-location is delivering positive outcomes around improved mental health and wellbeing, civic participation and debt reduction as well as an uptake in vaccinations and screenings for a number of priority populations. She also shared tips for others wanting to invest in co-location; make sure you afford the time to meaningfully co-design the offer, pay attention to seemingly small things like clinical waste collection and be realistic about what the space you have can sustainably facilitate!

Cheshire and Merseyside (Liverpool Place) – Citizens Advice on Prescription

Citizens Advice on Prescription Liverpool was established in 2014 as a partnership with the NHS, supporting patients with non-medical issues that impact their health. The social prescribing service is a treatment option that helps patients work towards debt reduction, financial stability, better housing and employment conditions, and reduced social isolation. It also provides a wellbeing service that aims to combat loneliness and isolation. The service has since become one of the largest health justice partnerships in England, providing over 14,000 interventions a year for around 9,000 households.

Using population insights from linked 'System P' data, this low threshold prevention service has been effective in reaching excluded communities and inclusion health populations. Data shows that 70% of service users were living below the poverty line at the time of referral, while 90% had long-term conditions, 78% had multiple conditions and 60% had a mental health diagnosis. Almost a third of all complex families in Liverpool have now been supported by Advice on Prescription. These families have higher rates of deprivation, homelessness, frequent use of urgent care services, parental drug and alcohol use, mental distress and lower rates of school attendance compared to other population groups in Liverpool.

Researchers found consistent evidence of improved mental health and wellbeing, increased household income, reduced A&E attendances and antidepressant prescribing. Importantly, the evaluation points to the scalability of projects like this and the whole system benefits of cross-sector prevention initiatives. The initiative was also cost-effective, providing the NHS with a net saving of £36 per member of each household who had been supported by Advice on Prescription.

Professor Ian Ashworth, Director of Population Health at NHS Cheshire and Merseyside, said:

"We know that low income and debt problems can exacerbate physical and mental health problems, leading to an increased reliance on health services.

"The success of the Advice of Prescription service in Liverpool shows how a collaborative approach to mitigating poverty can lead to measurable improvements in health, all the while providing a cost benefit to the NHS."

Read the full report on the NIHR website.

Cambridgeshire and Peterborough – High Impact User Programme

In 2023, Cambridgeshire and Peterborough ICS spent an estimated £28million on emergency care for the 4,500 people attending ED 5-10 times per year. A new specialist team is helping to reduce avoidable visits to Accident and Emergency (A&E) departments across Cambridgeshire and Peterborough by supporting patients who regularly visit A&E with needs that could be better met elsewhere.

Known as the High Impact Use team (HIU), the service is a partnership endeavour between NHS Cambridgeshire & Peterborough and Cambridgeshire County Council (who host the service on behalf of the Integrated Care System). Since its launch in October 2024, the HIU team have identified that many frequent A&E visitors were there due to social and environmental issues, such as loneliness, financial problems, and poor physical and mental health, rather than medical emergencies that require urgent hospital care.

The HIU team works alongside community partners to build a trusted relationship with each person identified as requiring non-clinical support through their frequent attendances at A&E, creating an open, person-centred approach to help meet the individuals' needs.

Programme participant and Programme Director for Strategic Commissioning in Cambridgeshire and Peterborough ICB, Jonathan Bartram, told us that an important focus in the team's work was on reducing health inequalities and proactively supporting people from inclusion health populations to prevent as well as respond to high-intensity use of unplanned and acute care.

This collaborative partnership between the ICB, local authority and community partners is innovative, prevention-focused and person-centred, showcasing the possibilities for improved prevention outcomes for inclusion health groups as part of mainstream-universal initiatives.

Safeguarding

The experience of risk and vulnerability lies at the heart of inclusion health, whether described as safeguarding or something else, and notwithstanding legal definitions and duties. Research shows that all inclusion health groups live with elevated and discrete risks of harm and are made additionally vulnerable to abuse and neglect because of the interplay between social exclusion and accessing support.

The NHSE framework advises that every Safeguarding Adult Board (SAB) have a named inclusion health lead, which builds on the more detailed guidance about safeguarding practice outlined in NICE Guidance 214[5]. In May 2024, a Joint Ministerial letter was sent to all Safeguarding Adult Boards and local authorities which further developed this connection, reinforcing the inclusion of people experiencing homelessness under the obligations set out by the Care Act as well as encouraging local systems to prioritise activity that prevents and responds to harm.

In session 5, we heard from the Rough Sleeping Initiative's[6] Safeguarding Lead, Bruno Ornelas. His presentation made clear the importance of legal literacy when working with people whose needs and behaviours may fall outside of traditional understandings of adult social care. He encouraged participants to make enquiries about how Care Act 2014 discretionary powers, as well as statutory duties, are being employed in their systems to prevent the escalation of need, and crisis, for inclusion health populations. Importantly, he emphasised multi-agency collaboration and advocacy when addressing the harms of abuse and neglect.

Since the conclusion of the programme, Pathway have published a Policy Paper Series on the key issues for the NHS 10-Year Plan. The safeguarding paper in that series, '1474 Reasons to Act', can be found here.

System Insights:

- Ensure your ICB/ICS is an engaged partner on the Safeguarding Adult Board, with a named Inclusion Health Lead who is equipped and supported to raise key safeguarding issues for inclusion health populations.

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[5] National Institute for Health and Care Excellence (2022) Integrated health and social care for people experiencing homelessness. Available at: https://www.nice.org.uk/guidance/ng214

[6] In Dec 2024, the Labour government announced that it was consolidating activity and resourcing for rough sleeping and single homelessness, into the new Rough Sleeping Prevention and Recovery Grant: https://www.gov.uk/government/news/largest-ever-cash-boost-to-turn-the-tide-on-homelessness. Further consolidation is expected in 2026/27, bringing the Homelessness Prevention Grant and Rough Sleeping Prevention and Recovery Grant together in an, as yet, undetermined approach.

- Make enquiries with your Safeguarding Adult Board about how it is implementing the recommendations in the Joint Ministerial letter of May 2024.
- Ensure that learning from Safeguarding Adult Reviews informs practice development in relevant areas, by making good use of the National SAR Library here.
- Consider commissioning or developing discrete safeguarding training modules for your inclusion health workforce.
- Make use of practice guides such as the Multiple Exclusion Homelessness Toolkit and Radical Safeguarding Toolkit - Homelessness.
- Ensure that learning around self-neglect and the interplay with mental capacity are a key feature in training about inclusion health populations[7].
- Ensure that JSNAs include data and learning from SABs and local authority safeguarding teams about the issues facing inclusion health groups in your area.

London Borough of Haringey – Safeguarding People Experiencing Homelessness

In 2019, Haringey Council developed a discrete approach for learning from the deaths of people experiencing homelessness. Whilst some review practice already existed, Haringey were the first to develop a fatality review process utilising powers under Section 44(4) Care Act.

Their process ensures that deaths experienced by people who were homeless are recorded and reviewed. The initial 'desktop review' considers the circumstances of someone's death, the possibility of learning for local agencies and whether or not another statutory review process should be considered i.e. Safeguarding Adult Reviews or Domestic Homicide Reviews. Where it is believed that further investigation would generate learning for agencies, a ‘full review’ is convened, which brings together written documentation, conversations with family members and a detailed multi-agency discussion about the person who died, their needs and the support available to them.

To support the implementation of the review process, the Safeguarding Adult Board adopted homelessness as a multi-year strategic priority. The Board requested an annual report about the state of homelessness and rough sleeping in the borough, to include a summary of learning from fatality reviews, information about resourcing and investment, commissioning plans and service delivery as well as relevant policy and practice updates.

For more information about developing Homelessness Fatality Reviews, contact Gill Taylor our Safeguarding and Systems Change Fellow or read about learning from the process in Adult Safeguarding and Homelessness (2022), published by Jessica Kingsley.

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[7] This guide from the London Network of Nurses and Midwives is helpful to explore the issues.

Supporting the Inclusion Health Workforce

There is little in the inclusion health landscape that hasn't been shaped and driven forward by an expert frontline workforce. Their skilful resilience, creativity and fortitude, demonstrated in the daily navigation of complex system of rights, duties and entitlements facing inclusion health populations, is at the heart of developments in the inclusion health field.

Our work with hospital Pathway teams and the Faculty for Homeless and Inclusion Health points to the pressing need for a better support offer for the inclusion health workforce. Insights from programme participants and speakers also makes the strong case for upskilling the mainstream NHS workforce to better understand the needs and experiences of excluded populations, acknowledging that specialist services are neither universally available nor necessarily the best or only approach for patients. Programme participants, guests and expert speakers shared their concerns about staff turnover, challenges with recruitment and inadequate workforce development infrastructure to ensure everyone in the system, whether working directly in inclusion health or not, has at least a rudimentary understanding of the complexities and opportunities of the field.

Our report 'Always at the Bottom of the Pile: The Homeless and Inclusion Health Barometer 2024' lays bare how the national crisis in health, housing and welfare directly impact frontline clinicians and practitioners. They report feeling unsupported, frustrated and betrayed by a system that exposes people to life threatening risks because services are not adequately funded or available to meet their needs. Importantly, and contrary to dominant narratives, 'compassion fatigue' is not what programme participants told us they and colleagues are experiencing. Despite the complexity of their need, it is not patients who are exhausting the inclusion health workforce. Instead, they shared that 'systems fatigue' more accurately describes the frustration and hopelessness that arises when attempting to navigating increasingly complex and decreasing access to support and services.

System Insights:

- Moral injury is a growing issue within the inclusion health and homelessness workforce; tools such as the BMA Moral Distress and Moral Injury report are helpful in understanding the issues and identifying solutions.

- Many inclusion health practitioners and teams work in isolation and feel distant from mainstream health systems and services. Ensuring they have time to attend events and peer learning activities can combat this.
- 1:1 and group support for frontline workers, to reflect on and process their experiences is a crucial element of inclusion health practice.
- Reflective practice and similar opportunities for collective discussion and debriefing, are hugely valued and well attended by staff.
- Support and development opportunities for the workforce should recognise and respond to the needs of staff with lived experience, considering direct as well as vicarious trauma.
- Legal literacy is vital for the inclusion health workforce, who are often working at the intersection of numerous law and policy frameworks without the knowledge they need.
- Challenging stigma is one way of reducing access and outcome inequalities and barriers. Tools that can help with reducing barriers include the Homelessness and Health Resource Pack for primary care.

Queens Nursing Institute – Inclusion Health Network

The QNI's Homeless & Inclusion Health Network has been running for over 15 years and has more than 100 members.

Inclusion Health nursing tends to be fairly autonomous with a lot of lone-working or being the only nurse in a multi-disciplinary team. The network delivers a monthly online meeting and a regular newsletter, to enable inclusion health clinicians to get to know each other, stay connected and contribute to the development of the field.

Although it started as a resource for nurses, it's now a space for professionals working across inclusion health, in statutory and voluntary organisations, to talk about shared experiences and the opportunities and challenges of their roles. Guest speakers and members share examples of best practice, discuss emerging trends and contribute to research in the field.

For those new to the area, the network also produces practice guidance and case studies as resources and learning tools for working with inclusion health populations. As the Project Lead, Kirit Sehmbi facilitates the monthly events, produces the newsletter and leads the development of learning tools. Ensuring the network has a facilitator is key to its sustainability over time.

Members says the network gives them the opportunity to meet and learn from others that work in the same field, to feel less alone and to be braver in their advocacy for patients.

West Yorks – Enhance Training

Building on reflections from the Chief Medical Officer about the crucial role of generalist skills in addressing the rise in multi-morbidity, West Yorkshire have utilised the opportunity afforded by the Enhance training programme to further their health inequalities and inclusion health priorities.

They are currently developing a training program built on learning from the Humber Generalist School trailblazer. The program adopts a two-tiered approach: Tier 1 consists of a self-directed learning offer, while Tier 2 focuses on face-to-face teaching, immersive learning experiences, and the implementation of a quality improvement project.

Participants are drawn from diverse professional backgrounds, including trainee doctors, nurses, allied health professionals, care workers, non-clinical staff, students and representatives from the voluntary and community sector. Each cohort is intentionally cross-sector and multidisciplinary, with "reducing inequalities" as a golden thread. The program is designed, delivered and overseen by a Steering Group, with governance from the systems Workforce Programme Board. Initially the program will target the workforce in two places, with plans to expand across the West Yorkshire system in future years.

This programme will bring inclusion health and health inequalities into the mainstream, embedding the skills, attitudes and behaviours crucial to improving inclusion health outcomes but through a generalist lens. An evaluation of the first year of implementation is underway by the University of Bradford to inform ongoing improvements and measure success.

Using Evaluation and Evidence

Inclusion health services have been at the forefront of some of the most pioneering practice in the NHS, amongst the first to introduce personalised and trauma-informed care, leaders in integration and joint commissioning, champions of anti-oppressive practice and leaders in health innovation.

Despite this, programme participants and speakers explored how inclusion health provision rarely fits the mould established by mainstream KPIs, service evaluations and cost-benefit analyses. As such, teams and services find themselves in a near constant battle to retain and secure funding, required to ‘prove their worth’ against universal and mainstream provision in an operating environment where even the most vital services are at risk. This is exacerbated by political short-termism that goes far beyond funding; inclusion health services are expected to demonstrate an immediate impact on health inequalities that have been generations in the making.

As a field, clinicians and researchers are acutely aware that developing a strong evidence base about what works in inclusion health is imperative to continued investment and engagement with the field. The body of evidence is growing, but much of this work has a national perspective and is unable to speak to the specificities of local systems, strategies and ways of working. Therefore, system-led evaluation and evidence generation is crucial to the ongoing success and growth of the field.

System Insights:

- Before establishing a new service, work with colleagues to establish an approach to evaluation that speaks to local strategic priorities.
- A key element of evaluation, research and evidence-building is co-production with people with lived experience.
- Service evaluations not only generate evidence about the quality and effectiveness of service delivery but also make a unique contribution to JSNA activity.
- Where possible, establish evaluation criteria as part of established KPI and contract monitoring expectations, to reduce the burden on frontline practitioners and clinicians.
- Ensure that evaluation and research consider protected characteristics and healthcare inequalities established under CORE20PLUS5 where possible.
- Look to generate evidence that ‘speaks’ to the whole system, not just to the NHS as this will strengthen opportunities for future joint commissioning etc.
- Use insights from research and evaluation to inform workforce development initiatives, not just service design and resourcing decisions.
- Engage local universities in ICS structures and partnerships to maximise opportunities for collaborative evaluations and other research studies.

We heard from Leedsgate[8] and BASIS Yorkshire[9] about how learning from their work with Gypsy, Roma and Traveller communities and sex workers has strengthened practice and improved service uptake. We also heard from London School of Economics researcher Michela Tinelli about the Out of Hospital Care data

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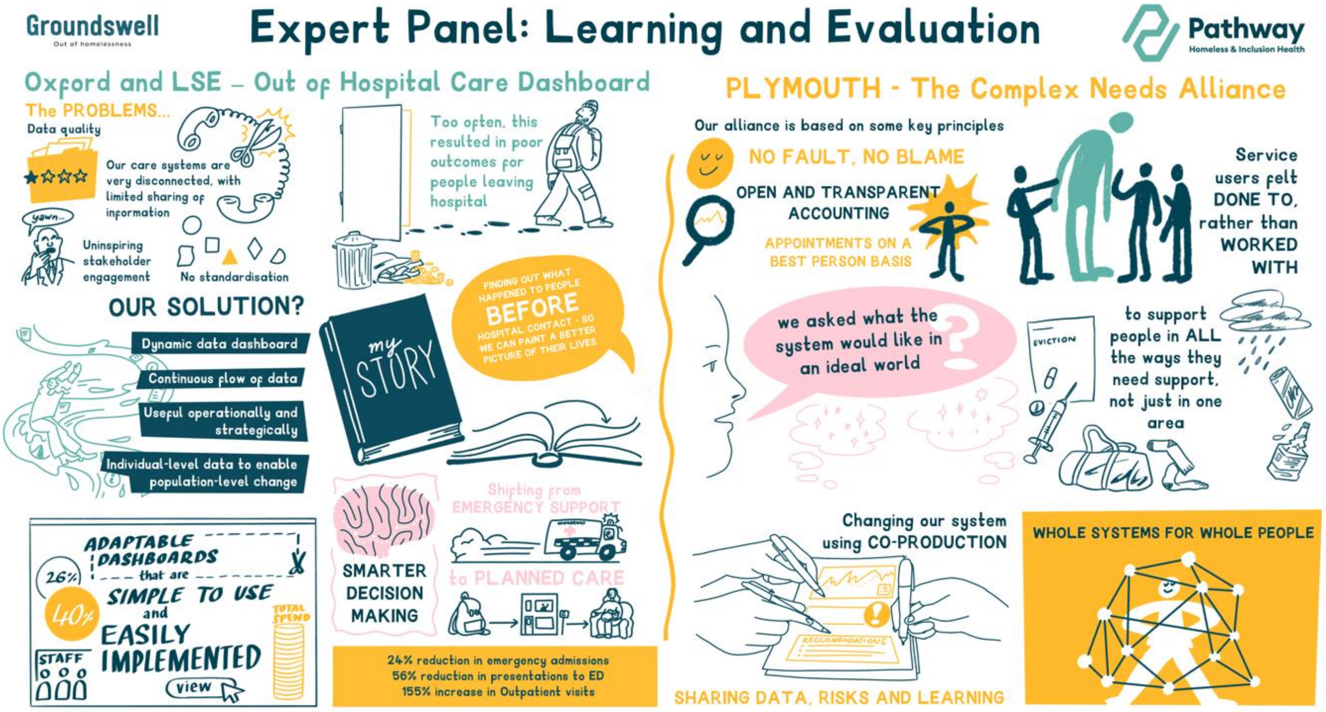
[8] https://www.leedsgate.co.uk/
[9] https://basisyorkshire.org.uk/

dashboard[10] and from Dr Kamal Patel who shared learning from the Plymouth Complex Needs Alliance[11]. The two visual notes below share some of their insights.



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[10] https://www.lse.ac.uk/cpec/assets/documents/Dashboard-Oxford-October-23rd-2023.pdf

[11] https://theplymouthalliance.co.uk/

> ***“It was a joy to share Medact's work with Pathway’s inclusion health leadership programme. The participants had such a clear vision of what they could do to affect positive change in their systems, and their passion and drive to do this was nothing short of inspiring.”***

- James Skinner, Co-Director Health & Human Rights at MedAct

Inclusion Health at Scale - Challenges

Whilst the programme focussed on positive, replicable and scalable practice to enable delivery of the ambitions in the NHSE framework, the pressurised operating context for ICSs was a consistent feature of discussions.

Participants were ambitious and energised by the opportunities around inclusion health. However, they were concerned that realising the promise of the framework requires assertive and concerted action from central government departments to create the necessary policy and resource infrastructure. The 2024 general election took place the week before the close of the programme and there was significant anticipation about what its results would mean for inclusion health and the broader welfare infrastructure; the NHS 10-Year Plan will now be the vehicle for that change.

In discussing how to transform learning from the programme into tangible action at scale, participants were clear that the new government and the emerging NHS 10-Year Plan must address some of the acute and chronic challenges local systems face in bringing about change.

The challenges they shared mirrored those shared by our first cohort of the programme, which points to the need for long-term investment in inclusion health to shift the dial on the entrenched issues that prohibit meaningful sustained change.

- Prioritisation of Inclusion Health: Participants felt that the NHSE framework did not have strong enough levers to ensure that inclusion health was prioritised alongside other pressures and responsibilities.

- Data quality and availability: Data about inclusion health populations is patchy and there is significant disparity between inclusion health groups, with data on homelessness of significantly better quality and availability than data about Gypsy, Roma and Traveller communities and sex workers. SNOMED coding was consistently highlighted as both a challenge and opportunity for inclusion health.

- Non-recurrent and uncertain funding: the majority of funding targeted to inclusion health populations, whether from NHS or other central government departments, is short-term, non-recurrent and peripheral. This has led to an inclusion health sector that is always at risk, with high staff turnover and disproportionate capacity expended on competing for scarce funding and 'getting a seat at the table'.

- Performance monitoring and evaluation: Inclusion health featured in Operational Planning guidance 24/25 but, disappointingly, was not included in the 25/26 guidance. Despite the cross-departmental nature of inclusion health activity, the absence of shared objectives and targets between NHS England, Department for Health and Social Care and the Ministry of Housing, Communities and Local Government is preventing advancements in integrated commissioning and service delivery.

- Housing & Homelessness Crisis: participants from all sectors and disciplines highlighted the challenges of improving health outcomes in a context of rapidly growing housing insecurity and homelessness. Without urgent action to build new homes, tackle rising rents and prevent street homelessness, inclusion health initiatives risk becoming 'sticking plasters'.

- Maturity of Integrated Care System Approach: ICSs are still relatively young, with many systems still establishing governance mechanisms, restructuring personnel and grappling with revised geographies. This takes place alongside the uncertainties of restructuring national agencies. Participants were uncertain about the roles and responsibilities of national and local bodies in future, and sought assurance about inclusion health leadership and its national oversight.

> ***“For Cambridgeshire and Peterborough ICS, the programme provided a revised focus on delivering better health outcomes for inclusion health groups and has ignited a passion amongst those who attended the sessions to do more. On that note, the opportunity to invite a range of system partners onto the programme, including from the local authorities, the voluntary, community, and social enterprise (VCSE) sector, and from wider NHS partners, helped to spread the learning from the programme.”***

- **Jonathan Bartram,** Programme Director, Strategic Commissioning,
Cambridgeshire and Peterborough ICB

Recommendations for Action

Delivering outcomes for inclusion health populations needs system-wide transformation and visible leadership and collaboration from government departments; local systems simply can't do this work in isolation. However, ICSs and their partners can take action in the here and now to expand on existing positive practice in the field.

Local

ICSs committed to building a stronger inclusion health infrastructure should employ the NHSE framework to develop a collaborative and comprehensive local plan for inclusion health that:

1. PRIORITISES LEADERSHIP AND GOVERNANCE

- Establishes inclusion health and health inequalities as key priorities for action by Health and Wellbeing Boards and Integrated Care Partnerships (ICPs).
- Identifies a Senior Leader who will hold overall responsibility for inclusion health and then communicate this widely.
- Work with local authority partners to strengthen collaboration across the local strategy and governance footprint, to include Homelessness Reduction Board, Combatting Drugs Partnerships, VAWG Board.
- Establish housing as a key pillar of local health and wellbeing strategy, both in respect of addressing homelessness, building new homes and making best use of public estate.
- Maximises the potential of joint commissioning by exploring opportunities within the Better Care Fund, Public Health Grant, Rough Sleeping Prevention and Recovery Grant and Changing Futures funding, amongst others.

2. BUILDS SYSTEM ENGAGEMENT

- Host an Inclusion Health Summit that brings local issues and ideas to life with cross-sector partners, establishing inclusion health as a key priority for collaborative action and showcasing existing local services and achievements.
- Establish an Inclusion Health Partnership Forum with membership from all sectors and ensuring all inclusion health populations are represented.
- Approach local VCS to map existing co-production and lived experience groups and activities that the ICS could connect with and learn from.

3. UNDERSTANDS AND EVIDENCES NEED

- Conduct or commission an Inclusion Health Needs Assessment that draws on a range of data sources and lived experience insights.
- Work with relevant Local Authorities to map local inclusion health services, partners and allies.
- Strengthen the local evidence base by committing to the evaluation of existing inclusion health services and importantly, to understanding the cost-benefit analysis of different interventions.
- Make good use of national and local 'grey data', especially that which draws on lived experience insights and from by-and-for organisations who have relationships with the most excluded populations.
- Identifies an Inclusion Health Data Lead who can work across NHS, local authority and VCS partners to map and strengthen existing data collection, reduce data gaps and quality issues.

4. EMBEDS A COMMITMENT TO SAFEGUARDING

- Work with Safeguarding Adult Boards and Local Safeguarding Children's Partnerships (LSCPs) to:
  - Identify an Inclusion Health Lead on all SABs and LSCPs within your system.
  - Review safeguarding policy and procedures to ensure the discrete needs and experiences of inclusion health groups, including children, are appropriately captured and reflected.
  - Collate and share learning from SARs, DHRs, Serious Case Reviews and other reviews related to people from inclusion health groups.
  - Agree an approach to disseminating learning between key statutory and voluntary partners. Where relevant bring together those responsible for adults and children, and reflect on relevant learning for transitional safeguarding.
  - Commit to completing the Inclusion Health and Safeguarding Self-Assessment Tool[12].

National

To do this work effectively and sustainably, ICSs and ICBs need a stronger law and policy footing that extends inclusion health beyond the NHS.

This means improved and visible collaboration between relevant government departments, not limited to NHSE, Office for Health Improvement and Disparities

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[12] For a discussion about using this tool, which is due for national launch in Autumn 2025, get in touch with Gill Taylor, Pathway Fellow for Safeguarding and System Transformation

(OHID), the Department for Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG), as well as the development of cross-departmental priorities on issues of shared concern, such as preventing premature deaths. This will require sustained investment, in both human and financial terms, but the cost of inaction is severe and the time to act is now.

The following recommendations are intended to provide an inclusion health steer to national policymakers in identifying the priorities for the NHS 10-Year Plan, in discussions about the Changing Futures Programme, the Rough Sleeping Prevention and Recovery Grant and for the purpose of operational planning and other policy development activity. As such, we have aligned the recommendations with the '*three shifts*'[13].

Note: At the time of publishing, the new operating model that merges NHS England and the Department for Health and Social Care has not been announced. In lieu of new names, structures and responsibilities, we have directed relevant recommendations to 'DHSC/NHS England'.

Recommendation 1 - DHSC/NHS England to review and update the NHSE Inclusion Health framework to:

a) Establish joint ownership of the framework between MHCLG, DHSC/NHS England and OHID.
b) Make explicit connections in the framework to the forthcoming cross-Government Ending Homelessness strategy.
c) Strengthen the focus on preventative services and activities.
d) Revise the list of inclusion health populations to include people experiencing multiple disadvantage.
e) Make explicit the interface between inclusion health and relevant legislation and strategy, such as Care Act, Equality Act and Homelessness Reduction Act.
f) Include a mandatory requirement for ICSs to conduct an Inclusion Health JSNA to inform commissioning and resource allocation.
g) Include a mandatory requirement for ICSs to complete the OHID Inclusion Health Self-Assessment Tool and to publish their findings and action plans.

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[13] **NHS (2025) The three shifts. Available at: https://change.nhs.uk/en-GB/projects/three-shifts**

Shift 1: Moving Care from Hospitals to Communities

Recommendation 2 - MHCLG to continue & expand the Changing Futures programme and to establish long-term investment in systems change around multiple disadvantage and inclusion health.

a) Explore cross-departmental ‘ownership’ of the Changing Futures programme, to give focus to health needs and outcomes as a priority for change.
a) Establish further long-term funding commitments for the programme, and other related systems change activity around multiple disadvantage.
a) Strengthen the focus of health, housing and care integration and on joint strategy and infrastructure that supports relevant frontline activity, as part of national initiatives such as Changing Futures and the Rough Sleeping Prevention and Recovery Grant.
a) Identify an approach to cost-benefit analysis and monitoring the impact of different types of spend on the outcomes of people experiencing multiple disadvantage in different Changing Futures areas[14].
a) Build on the outcomes and learning from the Out of Hospital Care Programme, including approaches to joint commissioning and long-term resourcing.

Shift 2: Making Better Use of Technology

Recommendation 3 - DHSC/NHS England to lead a cross-departmental evidence review into health inequalities and related spending, with a focus on resource allocation, individual outcomes and system-benefits for inclusion health.

a) Request and review spend data from programmes such as Health Inequalities, Better Care Fund, High-Impact User Programme, Rough Sleeping Initiatives, Enhanced Access, Out of Hospital Care Programme, Rough Sleeping drug and Alcohol Treatment Grant etc.
b) Publish an evidence review about the impact and outcomes achieved and identify priorities for further exploration and action.
c) Consult with commissioners working across health, housing and social care to explore approaches to funding that would best enable integrated service design and delivery.

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[14] Learning and evidence from places like Nottinghamshire and Surrey

d) Identify target cross-departmental funding models for inclusion health that centre integrated action to reduce health inequalities and tackle the wider determinants of health.
e) Consider trialling consolidated, ring-fenced and mainstreamed funding approaches in sufficiently mature ICSs, with expectations around agile commissioning and delivery, to generate evidence about the most efficient approach to resourcing positive change.

Recommendation 4 - NHS England Digital to refine and align EMIS and SNOMED coding for inclusion health populations:

a) Consider the recommendations made in the Pathway Policy Paper on Health Data[15].
b) Using the Pathway Recommended Housing fields within SNOMED, explore the routine capture of housing fields as a pillar of inclusion health practice.
c) Consider learning from existing work in this area, including the recommendations made by the London Homeless Primary Care Group.
d) Establish, deliver and evaluate a short-term pilot to capture learning from key NHS settings about the usefulness of the housing fields in delivering quality care to inclusion health groups.

Recommendation 5 - DHSC to create a national workforce development framework for inclusion health.

a) Creating elements that would enable a foundational understanding of inclusion health across the entire system, at all levels of clinical and non-clinical workforce groups.
b) Makes best use of existing resources and digital platforms to ensure learning opportunities are available across the statutory and voluntary systems.
c) Establish priority legal literacy learning modules for relevant teams and roles, especially those working in community settings, around duties under the Care Act, Equality Act and Housing Act.
d) This should be co-produced with the existing workforce and with people with lived experience.

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[15] Dorney-Smith, S (2024) Tackling extreme health inequalities using health data – The case for the development of routine housing status recording. Available at: https://www.pathway.org.uk/resources/health-data-policy-paper/

Shift 3: Focussing on Prevention

Recommendation 6 - DHSC/NHS England to refresh the High-Intensity User Programme.

a) Increase focus on prevention (perhaps creating 2 tiers to the programme like the approach adopted by Cambridgeshire and Peterborough).
b) Encourage person-centred and trauma-informed approaches appropriate to the needs of working-age adults from inclusion health groups.
c) Increase focus on activity outside UEC settings, e.g. in primary care and via VCSE orgs.
d) Develop national monitoring of inclusion health populations within HIU cohorts.
e) Strengthen cost-benefit analysis around this work to show the value of focussing on inclusion health.

Recommendation 7 - DHSC to review law and policy around adult safeguarding to meaningfully reflect the learning from 10 Years of the Care Act.

a) Review statutory guidance accompanying the Care Act (2014) and Mental Capacity Act (2005) to ensure that the discrete needs, risks and experiences facing inclusion health populations are articulated on an equal footing and in alignment with evidence from practice (including learning from SARs).
b) Working with the National Safeguarding Adult Board Chairs network, develop a briefing for SABs that introduces the NHSE framework and outlines the role of SABs in supporting health equity efforts.
c) Review NHSE safeguarding guidance for staff, including the existing homelessness section[16], to describe the vulnerabilities and discrete safeguarding concerns facing inclusion health populations, with an emphasis on self-neglect and discriminatory abuse.
d) Encourage local systems to use the Inclusion Health and Safeguarding Self-Assessment tool to assess and strengthen local safeguarding infrastructure.

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[16] NHS England (n.d.) Homelessness, Safeguarding Guide. Available at: https://safeguarding-guide.nhs.uk/types-of-abuse-exploitation-and-neglect/s3-16/

Conclusion

The realities of poor health facing socially excluded populations are stark: thousands of people die prematurely every year and many thousands more face marginalisation and exclusion that will have lifelong effects on their health and wellbeing. Without concerted efforts to implement the evidence and to listen to local system leaders, these inequities will persist, with profound consequences for society at large.

The findings from our second collaborative learning programme for inclusion health leaders underscore the critical importance of a comprehensive, systemic approach to reducing inequalities and improving outcomes for the most excluded people in our communities.

The programme highlighted inclusion health as a self-evidently cross-sector and multi-disciplinary effort, with significant expertise and energy in the voluntary and community sector driving forward change, as well as innovative partnerships between local authorities and ICSs. The programme's emphasis on co-producing solutions, whether with affected communities or with cross-sector partners brings to life the Framework's advocacy for person-centred, participatory and integrated approaches.

Programme participants highly valued the opportunity to collaborate and have already put their learning to work, with new and emerging initiatives embodying best practice happening in all seven participating systems. Despite the programme's successes, the urgency of action remains at the forefront of our minds.

Neither the learning programme nor the NHSE framework can drive forward the change needed in isolation. Cross-government collaborative action is needed, and we hope this report makes a useful contribution to the development of the NHS 10-Year Plan, Ending Homelessness Strategy and in restated commitments to transform adult social care pathways. Importantly, we hope this report enables policymakers to retain, restate and embed commitments to inclusion health in all these areas.

This report concludes with a call to action: we must rise to the collective challenge of ensuring that no one is left behind in the pursuit of health equity. To do that we must insist on collaboration, decisive action and creativity in everything we do.

> ***"Since completing the programme, and to ensure a data-driven approach, we have conducted needs assessments to identify key health disparities and inform targeted interventions. Securing leadership buy-in has also been essential, aligning the programme with strategic priorities for long-term sustainability."***

- Karen Chukwukaodinaka, Population Health Lead - Kent and Medway ICS

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With thanks to Bridget Meyne[17], for the beautiful visual notes and drawings in this report.

About Us

Pathway is the UK's leading homeless and inclusion health charity. We work with and alongside the NHS to improve care quality and outcomes for people experiencing homelessness and other inclusion health groups. In 2021 Pathway joined the Crisis group to create a strategic alliance to maximise our joint impact.

Pathway, 4th Floor East, 250 Euston Road, London, NW1 2PG Charity Reg: 1138741.
Company Reg: 7210798.

If you would like to talk to us about inclusion health consultancy and leadership support, please contact dee.oconnell@pathway.org.uk

If you would like information about our wider work on homeless and inclusion health, please visit our website at www.pathway.org.uk

You can join the Faculty for Homeless and Inclusion Health and receive regular email updates about our work and about inclusion health in the NHS by signing up at www.pathway.org.uk/the-faculty/support-the-faculty/

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[17] https://www.bridget-m.com/