Inclusion Health in Practice: A Co-Produced Toolkit for Commissioners and Providers

A consolidated toolkit bringing together evidence, policy and lived experience to support equitable healthcare for Inclusion Health populations

Part 1. Practical Toolkit

Part 2. Detailed Guidance

Co-produced by:

With support from:
DHSC; NHS England; UKHSA

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Executive Summary

Inclusion health addresses the stark health inequalities experienced by people facing extreme social exclusion. This co-produced toolkit supports commissioners, providers and practitioners across health, social care, housing and wider support services to plan, deliver and improve services for inclusion health groups, placing lived experience at the heart of commissioning and delivery. While developed by and for inclusion health populations, its principles are relevant to any population experiencing barriers to accessing, engaging with or benefiting from services.

The toolkit translates policy, evidence and lived experience into five practical recommendations that can be applied within both specialist services and mainstream provision:

1. Build Trust First
2. Embed Peer Roles
3. Provide Integrated, Holistic, People-Centred Approaches
4. Build in Accessibility to Increase Engagement and Uptake
5. Tailor Approaches to Increase Relevance

Together, these recommendations provide a practical framework for improving access, experience, and outcomes, supporting efforts to reduce health inequalities and deliver more inclusive, person-centred services.

Successful implementation requires strong cross-sector collaboration and a broader approach to measuring success. Traditional volume metrics alone cannot capture what matters most to people experiencing exclusion. Commissioners and providers should consider outcomes such as trust, dignity, wellbeing, recovery and independence. Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) can help ensure services are judged not only by what they deliver, but by how people experience care and whether they feel heard, supported and able to thrive.

The toolkit was developed through collaboration between VCSE organisations representing inclusion health groups, NHS England, the Department of Health and Social Care Office for Health Improvement and Disparities (OHID), the UK Health Security Agency (UKHSA) and Find&Treat, University College London Hospitals NHS Foundation Trust (UCLH). People with lived experience informed all stages of development, helping to identify priorities, shape recommendations and ensure the toolkit reflects the realities of exclusion and what works in practice.

Part 1. Practical toolkit

Toolkit Overview

Background

Inclusion health addresses the stark health inequalities experienced by people facing extreme social exclusion, including people experiencing homelessness, people in contact with the justice system, people who use drugs, sex workers, Gypsy, Roma and Traveller communities, people who are subject to modern slavery and migrants in vulnerable circumstances including people seeking asylum, refugees and undocumented migrants [1,2]. These groups experience a high burden of illness, earlier onset of disease, and significantly worse health outcomes and barriers to accessing care contributing to avoidable emergency healthcare use and premature mortality [3,4]. Further details are in **Appendix 1**.

Aim

This co-produced toolkit supports commissioners and providers across health, social care, housing and support services to plan, commission, deliver and improve services for inclusion health groups, placing lived experience at the heart of commissioning and delivery. It aims to improve health outcomes by embedding inclusion health principles with both mainstream and specialist services, promoting approaches that better meet the needs of people least likely to engage with traditional models of care.

The five recommendations

This toolkit is informed by five recommendations for effective service delivery for inclusion health groups which were originally identified through a co-produced report: Insights from people with lived experience to inform inclusive approaches to health protection (GOV.UK)[6]. The five recommendations are:

1. Build Trust First
2. Embed Peer Roles
3. Provide integrated, holistic, people-centred approaches
4. Build in accessibility to increase engagement and uptake
5. Tailor approaches to increase relevance

Who is it for?

- Commissioners across health, social care and housing
- Integrated Care Boards and NHS England
- Local authority public health and social care teams
- Housing and homelessness commissioners
- NHS providers
- Voluntary, community and social enterprise (VCSE) organisations
- Practitioners working in health, social care, housing and wider support

What will the toolkit help you do?

The toolkit helps organisations:

- Understand what effective commissioning and service delivery looks like for inclusion health groups
- Align local practice to relevant statutory duties, policy and guidance
- Apply inclusion health principles through practical actions informed by evidence and grounded in lived experience

What this toolkit adds

This toolkit brings together policy, evidence and lived experience into a single practical resource. It focuses on how to translate inclusion health principles into real-world commissioning and service delivery through practical actions and examples of good practice. It supports organisations to reduce health inequalities, strengthen co - production and deliver more accessible, responsive and inclusive services (**Box 1**).

Box 1. How this Toolkit adds value

Bringing it all together: consolidates policy, evidence and statutory duties
Focusing on implementation: translates principles into actionable steps for commissioning, service design and delivery
Putting lived experience at the heart: supports meaningful lived experience involvement in planning, delivery and evaluation
Showing what works: uses real-world examples to highlight practical solutions
Promoting coordinated approaches: recognises that responsibility for equitable access and outcomes sits across health and care, housing and wider support systems
Supporting system-wide implementation: supports system-wide adoption of inclusion health principles within everyday practice and service delivery
Linking practice to policy: provides recommendations that help organisations meet statutory duties, reduce health inequalities and deliver national policy priorities

Putting the toolkit into practice

The toolkit recognises that health inequalities are often driven by wider social and structural factors. Implementing the toolkit recommendations therefore requires partnership working across health, social care, local government and the voluntary community and social enterprise sector, alongside meaningful co-production with people with lived experience.

The toolkit can be used to:

- Inform needs assessments, service design and strategic commissioning
- Review and strengthen existing mainstream and specialist services to enable equitable access for inclusion health groups
- Support service transformation and quality improvement and assurance
- Identify resources, guidance and examples of good practice

Detailed guidance on how to use the toolkit is available in **Part 2. Detailed Guidance, Evidence and Background**

Understanding population health needs

This toolkit assumes that users have undertaken, or will undertake, a robust needs assessment to understand their target population. Needs assessments should be co-designed and informed by lived experience to ensure they reflect the realities of exclusion, barriers to care and community priorities. The Inclusion health data and intelligence resource for England[1] is an interactive inclusion health resource which contains a summary of statistics for inclusion health populations. Further guidance and resources on understanding population health need are provided in **Appendix 2**.

The Five Recommendations

The five recommendations and steps to achieve them are summarised in **Figure 1**. Detailed guidance, including practical commissioning and delivery considerations, implementation resources, and key questions for commissioners and providers, is provided in **Part 2. Detailed Guidance.**

Figure 1. The Five Recommendations and steps to achieve them

Co-produced recommendations for effective services for inclusion health groups

Understand health needs of inclusion health groups

1. Build Trust First	a. Work with trusted voluntary sector and community partners b. Build trust through relevant peer engagement c. Recognise that building trust takes time d. Make the system trustworthy
2. Embed Peer Roles	a. Develop fair and inclusive remuneration frameworks for lived experience roles b. Integrate lived experience roles into organisational structures c. Protect and support people with lived experience d. Embed co-production from the earliest stages of service design
3. Provide integrated, holistic, people-centred approaches	a. Design services to meet health and social needs together b. Use every opportunity for engagement c. Embed integrated and collaborative working d. Focus on recovery, not just treatment
4. Build in accessibility to increase engagement and uptake	a. Consider where services are delivered b. Offer flexible access c. Communicate effectively d. Be responsive to needs e. Build services around engagement f. Prioritise longer-term, larger scale commissioning footprints
5. Tailor approaches to increase relevance	a. Address structural and systemic barriers b. Develop tailored information c. Build specialist knowledge and skills

Monitoring and evaluation: measure what matters

How the Recommendations Support Policy and Commissioning

NHS England, local authorities, ICBs and NHS providers have statutory responsibilities to reduce inequalities in access to healthcare and health outcomes. National policy and guidance across government departments increasingly emphasise population health, neighbourhood services, community partnership, lived experience, accessibility and integrated care as key approaches to reduce inequalities and address multiple disadvantage.

The five recommendations translate these policy priorities, statutory duties and guidance into practical actions for commissioners and providers (**Box 2**). The recommendations align with statutory duties (**Figure 2**), support implementation of national policy and guidance (**Figure 3**) and are consistent with the Strategic Commissioning Framework (**Figure 4**).

Links to all relevant Statutory Duties, Policies and Guidance are available in **Appendix 2.**

Box 2. From policy to practice

The toolkit recommendations help users to:

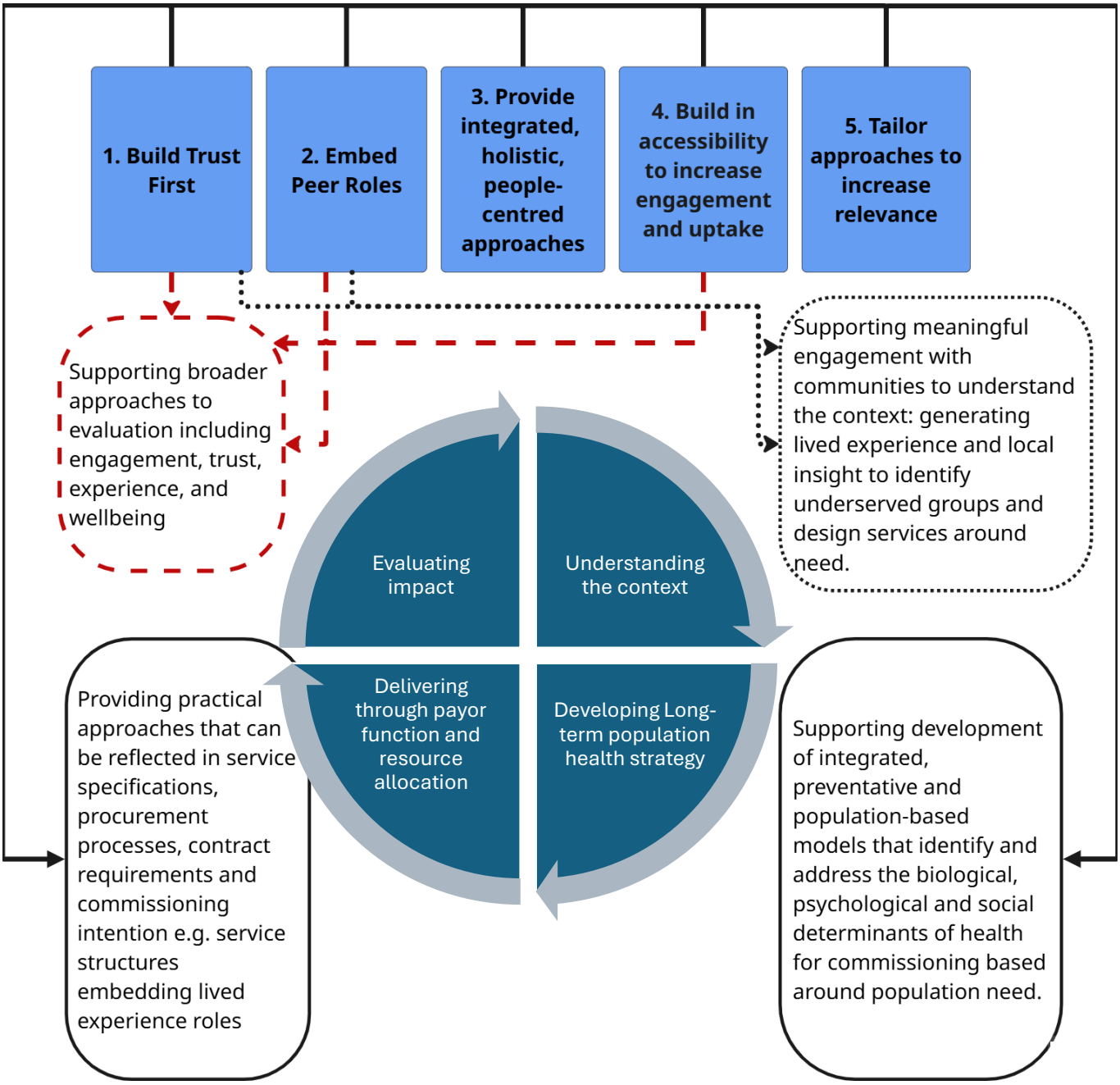
- Understand and respond to local population need
- Reduce health inequalities
- Involve people and communities in decision making
- Embed lived experience across service design and delivery
- Improve access, engagement and continuity of care
- Address health and social needs together by engaging multi-agency partners
- Develop integrated person-centred services
- Use resources more effectively to achieve long-term impact

Figure 2. Mapping the Toolkit recommendations to statutory duties

Figure 3. Mapping the Toolkit recommendations to National Policy and Guidance

National Policy and Guidance	How do the Toolkit recommendations support delivery ?	Recommendations
Inclusion Health Framework (NHSE 2023) Fit for the Future: Population Health Delivery Models (NHSE 2026)	**Neighbourhood Health Framework:** strengthening engagement, enabling community-based and preventative care, and helping services become more accessible, responsive and accountable to the communities they serve **Local Outcomes Framework:** helping services engage and improve outcomes through trusted community relationships **Changing Futures:** emphasising trauma-informed, relationship-based support by recognising trust as a prerequisite for engagement, recovery and improved outcomes. **Rough Sleeping Programme**: building a foundation that enables engagement with accommodation, healthcare, support services and long term housing sustainment	1. Build Trust First
Local Outcomes Framework (MHCLG 2026)	**NICE NG214:** supporting peer roles, peer support and lived-experience involvement in integrated care models. **Local Outcomes Framework:** involving people with lived experience in shaping services and understanding local need. **Changing Futures:** embedding people with lived experience as partners in service design, delivery, leadership and improvement.	2. Embed Peer Roles
Neighbourhood Health Framework (DHSC/ NHSE 2026) Strategic Commissioning Framework (NHSE 2025)	**Fit for the Future: Population Health Delivery Models:** supporting coordinated, person-centred services that improve outcomes and reduce fragmentation. **Neighbourhood Health Framework:** promoting integrated, preventative care delivered through partnership working. **NICE NG214:** encouraging integrated responses to health and social needs. **Strategic Commissioning Framework:** addressing the biological, psychological and social determinants of health and commissioning around population need. **Changing Futures:** integrated, person-centred, trauma-informed support to address multiple interconnected need. **Rough Sleeping Programme:** bringing together housing, health and social care support to help people remain housed	3. Provide integrated, holistic, people-centred approaches
NICE Guidance 214 (NICE 2022)	**Neighbourhood Health Framework** : supporting outreach, flexibility and services delivered closer to communities. **NICE NG 214:** supporting flexible access, outreach, multi-disciplinary working, continuity of care, adapting services to need **Changing Futures:** delivering flexible, accessible, trauma-informed services	4. Build in accessibility to increase engagement and uptake
Changing Futures (MHCLG 2026) Rough Sleeping Programme (MHCLG 2026)	**Neighbourhood Health Framework:** designing services around local population needs and reducing inequalities. **Strategic Commissioning Framework:** using population health intelligence, lived experience and local insight to identify underserved groups and design services around need. **Local Outcomes Framework:** improving outcomes through targeted, community-informed interventions. **Changing Futures:** promoting understanding and response to diverse experiences of disadvantage through tailored, locally-responsive and co-produced service design.	5. Tailor approaches to increase relevance

Figure 4. Mapping the Toolkit Recommendations to the Strategic Commissioning Framework (NHSE 2026)



Recommendation 1. Build Trust First

Trust in healthcare is often undermined by past experiences of harm, exclusion and discrimination. This creates a significant barrier to healthcare access and engagement. Building trust is therefore essential. It requires time, transparency and meaningful engagement with people and communities with lived experience.

"It's not down to the communities to build trust with you. It's the other way around. You have to earn your trust with the community"

Friends, Families, Travellers

Building trust supports organisations and providers to meet statutory duties and deliver national policy recommendations as illustrated in **Figure 2** and **3**.

For detailed guidance on implementing this recommendation, see **Part 2. Detailed Guidance.**

Checklist - Recommendation 1. Build Trust First

Key actions	Checklist
a. Work with trusted voluntary sector and community partners	**For commissioners:** ◻ VCSE organisations are involved as key partners in service design, delivery and evaluation ◻ Lived experience steering groups are involved in guiding design, delivery, and ethical decision-making ◻ Expertise and value of trusted voluntary and community sector organisations is recognised **For providers:** ◻ Communities are engaged to shape services that reflect lived experiences and priorities of communities ◻ Services are regularly reviewed with lived experience input to ensure relevance and appropriateness
b. Build trust through relevant peer engagement	**For commissioners:** ◻ Recognise that trust is built differently across people, settings and circumstances ◻ Recognise that shared identity does not automatically mean relevant shared experience ◻ Recognise that a 'one-peer-fits-all' approach risks ineffective engagement, harm, or exclusion **For providers:** ◻ Demonstrate a nuanced understanding of diversity within communities ◻ Match peers to need based on the relevance of experience, not identity labels
c. Recognise that building trust takes time	**For commissioners:** ◻ Expect providers to take time to build relationships with local communities ◻ Support activities such as community meetings, workshops, informal engagement, and lived experience steering groups
d. Make the system trustworthy	**For commissioners:** ◻ Commission services that: ○ are transparent about aims, processes and limitations ○ do not overpromise ○ clearly explain rights, choices, and entitlements ○ use trusted organisations as bridges, not shields

Case Study: Building Trust and Embedding Lived Experience with Gypsy, Roma and Traveller Communities

Friends, Families and Travellers (FFT)

Friends Families and Travellers (FFT) works with Romany Gypsy, Roma and Traveller communities across Sussex to reduce health inequalities and improve access to services. Recognising the historical mistrust many communities have experienced with statutory services, FFT's approach is centred on trust, lived experience, assertive outreach and community leadership.

FFT delivers a community-based 'assertive outreach' model that takes support directly to people through site visits, home visits, advocacy and practical assistance. Rather than expecting individuals to navigate complex systems, staff provide support with health appointments, referrals, benefits, housing and access to wider services. The model incorporates trauma-informed approaches that prioritise wellbeing, choice and safety alongside flexible engagement methods designed around community preferences and accessibility needs. FFT also acts as a "care of" address for more than 300 families without a permanent address, helping maintain access to healthcare and other essential services.

Over the last four years, FFT has provided assertive outreach to 714 families across Sussex. Lived experience is embedded throughout the organisation, including service delivery and governance. Around half of FFT staff and trustees have Gypsy or Traveller lived experience, helping ensure services are informed by community knowledge, trusted relationships and cultural understanding.

Health Champions: Peer-led community engagement. A key element of the model is the Royal Society for Public Health (RSPH)-accredited Health Champions programme, which trains community members to become peer health advocates. Champions develop health knowledge and skills and share information within their own communities, creating trusted routes into health information and services. Over the last four years, more than 270 Gypsy, Roma and Traveller community members have completed the programme.

Impact. The model demonstrates how communities can drive positive health change when lived experience is valued and embedded in service design and delivery. Combining assertive outreach with peer-led engagement has strengthened relationships between communities, VCSE organisations and statutory partners, creating more accessible, culturally appropriate and responsive services. The approach was nationally recognised through shortlisting for the 2019 RSPH Wellbeing Awards Community Health Development Award.

Key learning:

- Build trust before expecting engagement or outcomes
- Work through trusted community organisations and relationships
- Employ and develop people with relevant lived experience
- Ensure communities have meaningful influence over decisions
- Use flexible, trauma-informed approaches to engagement
- Communicate openly and follow through on commitments

Recommendation 2. Embed peer roles

Involving peers - people with relevant lived experience - in service design and delivery is an effective way to overcome barriers to care, build trust, and improve engagement with mainstream and specialist services. 'Peers' refers to people employed or engaged on the basis of relevant lived experience. Meaningful lived experience involvement requires structured investment in recruitment, training, and career progression. Lived experience roles can be emotionally demanding. Organisations recruiting lived experience roles should provide holistic support and establish ethical frameworks to protect peers, prevent re-traumatisation, and promote retention and progression.

"An audience member sometimes can hear a message clearer when somebody with lived experience is saying the same thing"

Spectra

Box 3. Summary: scope of peer roles and key enablers

Participation	Peer support	Practitioner skills	Research & Leadership	Strategic influence
Experts by experience Advisory groups Focus groups Co-production	Health promotion Peer educator Community advocates Supporting service navigation Outreach	Clinical skills e.g. vaccination, blood tests, Fibroscan Patient communication Supporting access to medication	Informing service design, delivery and evaluation Training Mentorship Management	Lived experience Advisory roles Governance Board members

Pastoral care and integration within teams

Inclusive recruitment, fair remuneration

Training, supervision, career progression

Checklist - Recommendation 2. Embed Peer Roles

Key actions	Checklist
a. Develop fair and inclusive remuneration frameworks for lived experience roles	**For commissioners:** □ Look for lived experience roles that are integrated into workforce planning, service design and budget setting □ Ensure remuneration for paid lived experience roles reflects skill, responsibility, and emotional labour involved □ Explore honorary contracts through partnerships with VCSE to facilitate paid roles in NHS services □ Recognise that volunteer programmes should complement– not replace – paid roles □ Be aware of the red flags for tokenistic involvement of lived experience
b. Integrate lived experience roles into organisational structures	**For commissioners:** □ Require clarity on Peer roles and job descriptions; recruitment and induction processes; structured supervision; career pathways; progression opportunities □ Look for integration with clinical and operational teams **For providers:** □ Ensure peer workers are fully integrated into multidisciplinary teams □ Prove appropriate training, supervision and development opportunities □ Review recruitment processes to reduce barriers related to qualifications, employment history, employment checks □ Support peer workers to navigate HR and employment processes where additional assistance may be required
c. Protect and support people with lived experience	**For commissioners and providers:** □ Provide trauma-informed wellbeing, pastoral support and supervision for lived experience staff and volunteers □ Embed career development, training and progression opportunities to support retention □ Establish clear policies and ethical frameworks for lived experience involvement □ Offer reasonable adjustments and flexible working arrangements where required □ Implement mechanisms to identify and address discrimination, stigma and exclusion within the workplace
d. Embed co-production from the earliest stages of service design	**For commissioners:** □ Require services to show how lived experience defined the problem and shaped service design, delivery and evaluation □ Look for use of lived experience steering panels with genuine influence □ Ask: *"What changed as a result of lived experience input?"*

Case Study: Embedding Lived Experience in NHS Inclusion Health Services

Find&Treat, University College London Hospitals NHS Foundation Trust (UCLH)

Find&Treat is a pan-London Inclusion Health outreach service which combines 'Lived' and 'Learned' experience to make healthcare accessible, relevant, and more effective for vulnerable and excluded people. People with lived experience are either directly employed by Find&Treat or nested within the team from voluntary, community and social enterprise (VCSE) partners.

Find&Treat has worked with NHS and VCSE organisations nationally to adapt Agenda for Change (AFC) job descriptions (Bands 3–7) and person specifications that recognise lived experience as equivalent to qualifications. Routine application processes requiring curriculum vitae and Disclosure and Barring (DBS) checks can present barriers. Transition from VCSE to NHS roles is supported through case-by-case discussions with NHS human resources using the adapted, agreed AFC competency frameworks and job descriptions. Ongoing pastoral support through supervision and reflective practice is provided through VCSE partners for as long as needed.

Peer roles involve outreach and engagement, health promotion and stigma reduction, and supporting individuals to navigate health and care services. Progression to peer practitioner roles is supported through development of clinical skills. Pathways to senior and management roles are supported through mentoring and guidance, with opportunities to collaborate at a senior level with external stakeholders. Formal and on-the-job training alongside nurses, doctors and outreach workers includes:

- Infectious disease knowledge (tuberculosis, hepatitis B, C, HIV, sexually transmitted infections)
- Communication and trauma-informed care
- Safeguarding and other NHS mandatory training
- Clinical skills: phlebotomy, FibroScan, GeneXpert®, vaccination

Impact:
Lived experience brings insight, credibility and trust that has significantly enhanced the Find&Treat service, making healthcare accessible, relevant, and more effective for vulnerable and excluded people.

Key Learning:

- Peers are fully integrated within the NHS multidisciplinary team and play a critical role in service design and delivery
- Developing clear pathways to develop skills and progress to peer practitioner roles is vital as well as providing ongoing pastoral support through supervision and reflective practice

Recommendation 3. Provide Integrated, Holistic and Person-Centred Care

People experiencing social exclusion often face multiple, overlapping health and social challenges. Further detail on health needs is available in **Appendix 1**. Effective services recognise that health needs are shaped by wider factors such as housing, income, food security, safety, mental health and substance use, and that healthcare may not always be a person's immediate priority. Integrated, holistic and person-centred services improve engagement, strengthen trust and support better long-term outcomes by working with the whole person and addressing the wider factors that shape health and wellbeing.

Opportunities for holistic health and social care assessments can help identify unmet health and care needs that might otherwise go unrecognised, enabling earlier intervention, prevention and more coordinated support. Effective integration also relies on care navigation, helping people access, understand and move between services while reducing the risk of individuals falling through gaps in the system. The most effective models combine clinical, social and lived-experience expertise to support people towards recovery, independence and sustained engagement. Recent national guidance on rough sleeping emphasises that integrated working should include shared assessments, coordinated case management, joint planning and clear accountability for outcomes, rather than a series of disconnected referrals. Services should work together to address health, housing, social care, substance use, mental health and wider support needs through a coordinated response

"Integration is about doing more than one thing. It's about that opportunity of encounter, doing the best you can in that moment…for the simple reason that as an outreach service, you're very often the one and only point of contact with the entire system"

Find&Treat, UCLH

Checklist - Recommendation 3. Provide Integrated, Holistic and Person-Centred Care

Key actions	Checklist
a. Design services to meet health and social needs together	**For commissioners and providers:** ◻ Recognise the interaction between health needs and wider determinants of health. ◻ Design services that can identify and respond to multiple needs. ◻ Enable access to healthcare, housing, welfare, mental health, addiction and social support services. ◻ Focus on people rather than individual conditions or service boundaries.
b. Use Every Opportunity for Engagement	**For commissioners and providers**: ◻ Promote flexible, opportunistic approaches to assessment and support. ◻ Enable staff to respond to needs beyond the immediate reason for contact. ◻ Develop pathways that support referral and coordination across services. ◻ Reduce the burden on individuals to navigate multiple disconnected systems.
c. Embed Integrated and Collaborative Working	**For commissioners and providers:** ◻ Develop integrated care pathways and multidisciplinary models. ◻ Embed coordinated care planning and navigation ◻ Strengthen partnerships across sectors. ◻ Support coordinated and joined-up care. ◻ Align services around the needs of populations rather than organisational structures.
d. Focus on Recovery, Not Just Treatment	**For commissioners and providers:** ◻ Support people to achieve outcomes that matter to them. ◻ Measure broader outcomes alongside clinical indicators. ◻ Address the causes of poor health and recurrent crisis wherever possible. ◻ Take a long-term view of impact and recovery.

Case Study: Integrated, Holistic, People-Centred Health Care Model

Doctors of the World (DOTW) UK Clinic and Adviceline Service model, East London, England

DOTW provides services for people with complex migration experiences who need more than clinical support to achieve access to health and wellbeing. Clinical assessments can often miss the complexities around the social determinants of health if these are not considered. DOTW therefore opted to use a holistic assessment model and mainstreamed co-production to develop services built around "what matters to the person", rather than around a single presenting problem.

The DOTW UK Clinic operated from a shared hub bringing together charitable organisations supporting vulnerable people in East London. The model combined dedicated reception and clinical rooms with separate spaces for non-clinical social support. Trained support workers conducted an initial holistic Social Needs Assessment alongside clinical care, considering immigration status, housing, safety, GP registration barriers and medical needs. This holistic, support-worker led assessment allows the clinic to make non-clinical referrals to specialised services, including immigration advice, housing support, domestic violence services, and community groups. This model brings clinical and social support together, recognising that health needs cannot always be separated from immigration, housing, safety and access to primary care groups.

Impact:
In 2024, the clinic supported 300 people, 50% of whom were undocumented and 50% with a visa, seeking asylum, or with recognised refugee status.

Key learning:

- Co-production was central to designing and improving the service. People with lived experience of using the clinic became advocates and volunteers who helped identify user needs and reshape service pathways and priorities. This collective became the National Health Advisers (NHAs), which continues to inform DOTW's policy work and community engagement priorities.
- Upskilling non-clinical staff to carry out the assessments depended on a comprehensive training package including: trauma-informed best practice, best practice in working with interpreters, cultural competency, NHS policy on GP registration, and safeguarding at level 1 for adults and children. This training infrastructure is what allows the clinic to provide holistic assessment by an appropriately equipped workforce, in order to support clinical assessment and care.

Recommendation 4. Build in accessibility to increase uptake and engagement

Service accessibility extends beyond simply being able to attend an appointment. Services should be safe, flexible, and responsive to need. Individuals should be supported to communicate effectively with providers and trust that their confidentiality will be respected. Barriers such as location, opening hours, transport costs, rigid appointment systems, and language can limit access. These can be addressed through community-based outreach (including on the street or in accommodation venues), flexible scheduling (including drop-ins), supportive re-engagement after missed appointments, and consistent provision of interpreters.

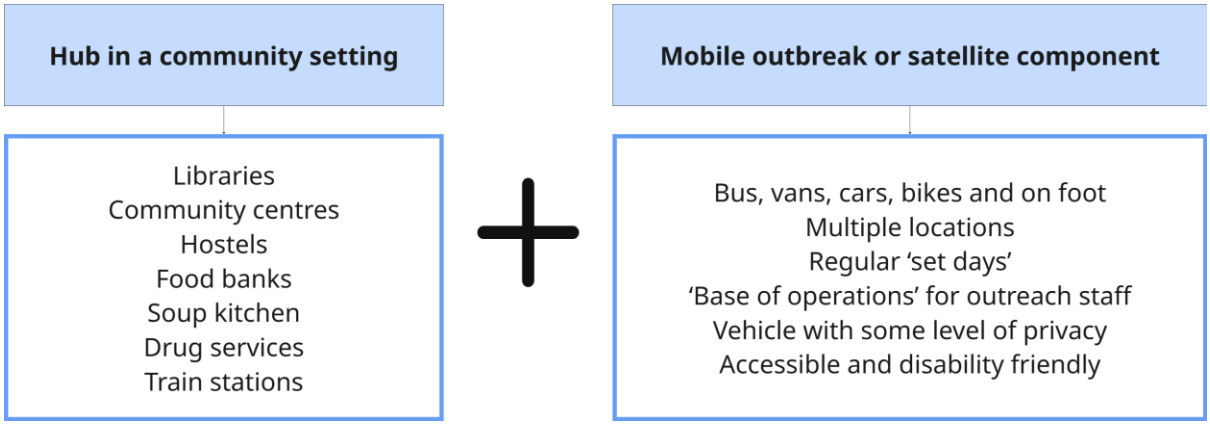
Improving accessibility also requires long-term investment. Short-term commissioning cycles can undermine relationship-building and continuity of care, particularly for marginalised groups. Longer-term, flexible commissioning arrangements enable providers to build trust, adapt services and maintain meaningful engagement over time.

"Accessibility depends not only on the availability of services, but also on where and how they are delivered"

The Do-Good Charity

Figure 5. Examples of where and how outreach services may be delivered

(Adapted from 'Insights from people with lived experience to inform inclusive approaches to health protection')



Checklist - Recommendation 4. Build in accessibility to increase uptake and engagement

Key Actions	Checklist for commissioners	Checklist for providers
a. Consider where services are delivered	◻ Fund community-based & outreach services	◻ Offer services in trusted, familiar community settings
b. Offer flexible access	◻ Support flexible delivery e.g. community, drop-in, out-of-hours ◻ Implement non-punitive approaches to missed appointments (DNAs) support healthcare navigation ◻ Require proactive outreach re-engagement approaches	◻ Offer flexible access, including drop-in & a choice of appointments ◻ Manage missed appointments supportively ◻ Proactively reconnect individuals who disengage
c. Communicate effectively	◻ Support inclusive & trauma-informed communication approaches	◻ Communicate clearly, avoiding jargon ◻ Adapt communication to individual needs, language and literacy levels ◻ Provide digital & non-digital access options ◻ Be transparent about healthcare entitlements, waiting times, service limitations
d. Be responsive to needs	◻ Commission integrated, flexible approaches that adapt to evolving needs. ◻ Act on recommendations in Joint Strategic Needs Assessments and Health Needs Assessments.	◻ Conduct holistic needs assessments ◻ Co-develop outcomes with service users, put systems in place to monitor & respond to changing needs
e. Build services around engagement	◻ Embed engagement and trust-building as explicit expectations within service specifications ◻ Prioritise approaches that create safe, respectful & inclusive environments ◻ Support relationship-based delivery models, recognise that engagement develops over time ◻ Commission services that retain flexibility to respond to people's needs & preferences	◻ Deliver trauma-informed, non-judgemental care that prioritises dignity & respect ◻ Create welcoming & safe environments where people feel able to engage ◻ Adapt delivery based on feedback & patterns of engagement, including where people disengage ◻ Use trusted relationships & consistent contact to sustain engagement
f. Prioritise longer-term, larger scale commissioning footprints	◻ Commission over longer timeframes to support continuity, relationship-building, service stability ◻ Operate across larger or aligned footprints to reflect population movement & reduce fragmentation ◻ Design funding models that support integration across services & sectors ◻ Recognise that trust-building & peer-led approaches take time, & may not align with short-term commissioning	

Case Study: Build in accessibility to increase uptake and engagement

Groundswell's Homeless Health Peer Advocacy service

Groundswell's Homeless Health Peer Advocacy (HHPA) service is delivered across 11 London boroughs by staff and volunteers who have personal experience of homelessness. Peer Advocates build trusting relationships with people experiencing homelessness, accompany them to health appointments, advocate for their rights and support them to build the confidence and motivation to manage their health. Groundswell works with more than 110 health and homelessness organisations, helping connect people to appropriate support and encouraging services to work together around the individual. This peer-led model is supported by Groundswell's Progression programme. Many people with lived experience join Groundswell as volunteers and receive structured training and shadowing before starting their role. Alongside this, they can access holistic coaching, wellbeing support, help during periods of crisis and opportunities for learning and development. Support continues as people move into paid employment, either within Groundswell or elsewhere.

Lived experience is not an addition to the service; it is central to the model. Shared experience helps Peer Advocates establish trust with people who may previously have felt judged or excluded by services. This is combined with training, strong supervision, established partnerships and ongoing Progression support, enabling people to use their experience meaningfully while continuing to work towards their own goals. Approximately 50 volunteers and staff receive Progression support each year, with people moving into employment, further training and other opportunities. The model demonstrates how commissioners can improve access to healthcare while simultaneously investing in the skills, confidence and futures of people with lived experience.

Impact:

HHPA supports more than 450 people experiencing homelessness through over 4,000 one-to-one appointments each year. An independent evaluation found that HHPA reduced missed appointments by 50–70%; in a subsequent year, 86.5% of 523 people supported successfully attended their health appointments. Progression creates impact for the people delivering this work too. An external evaluation found life satisfaction increased from 4.1 to 8.4 out of 10, employment or training increased from 27% to 60%, and secure housing increased from 33% to 87% among participants evaluated.

Key Learning:

- Peer services should invest not only in recruiting people with lived experience, but in the infrastructure that enables them to thrive
- Meaningful roles, good training, supervision, wellbeing support and individual progression opportunities help create a sustainable workforce and avoid lived experience becoming tokenistic.

Case Study: Building accessibility into modern slavery and trafficking support

The Do-Good Charity (formerly known as St John of God Hospitaller)

People recovering from modern slavery and trafficking can face significant barriers to healthcare, including trauma, language barriers, long waiting times immigration-related uncertainty. Their needs can change over time, meaning that fixed service pathways or rigid timescales risk interrupting recovery. Through the Modern Slavery Victim Care Contract, The Do-Good Charity provided person-centred support to 1,601 people in 2025, addressing interconnected health, housing, legal, education and employment needs. Accessibility was embedded through:

- Language and culturally responsive support: 115 practitioners spoke 42 languages and supported people from over 84 nationalities.
- Flexible, trauma-informed delivery tailored to individual circumstances
- Person-centred planning that promoted participation, choice, control over decisions affecting their recovery.
- Continuity of care, including extensions where needs remained unresolved (82% of people received an extension to support plans in 2025)

Case example. After fleeing threats in their home country, T. arrived in the UK experiencing immigration insecurity, homelessness and exploitation. Referred to The Do-Good Charity while recovering from severe tuberculosis, they received stable accommodation and coordinated healthcare, counselling, welfare and immigration support. Through trusted relationships, flexible support and partnership working, they were able to continue treatment, rebuild their health and independence, and avoid homelessness when ongoing immigration issues threatened their stability. Today, they contribute as a volunteer, peer supporter and lived-experience advocate, demonstrating how accessible, compassionate services can support recovery and enable people to contribute to their communities.

Impact: In 2025, 96% of 714 'move-ons' were successful, with people moving into stable accommodation, secure financial arrangements and ongoing health and wellbeing support.

Key Learning: People experiencing multiple forms of exclusion rarely fit neatly within organisational or service boundaries. Commissioners should ensure services can:

- Provide language and culturally responsive support
- Respond flexibly to changing health and wellbeing needs
- Extend support where rigid timescales could undermine recovery
- Help people navigate and remain engaged with healthcare
- Maintain continuity between services, particularly during transition

Recommendation 5. Tailor approaches to increase relevance

Effective services are designed around the needs, experiences and circumstances of the populations and the individuals they serve. This requires understanding both structural factors (such as policies, eligibility criteria, and service design) and individual circumstances that influence health and access to care. Combined health and social care assessments and care coordination that focuses on individual need can support this. Services should recognise differences within the groups they serve and adapt delivery to ensure individuals feel safe, understood, and able to engage.

When designing services, commissioners and providers should ask:

- Who feels safe using this service, and who might not?
- Who tends to disengage, and why?
- How can we support people to re-engage?

"It's a long shadow that bad institutional encounters casts on future engagement"

National Ugly Mugs

Checklist - Recommendation 5. Tailor approaches to increase relevance

Key actions	Checklist
a. Address structural and systemic barriers	**For commissioners:** ◻ Recognise what the systemic and structural barriers to healthcare are and prioritise approaches that address them ◻ Ensure needs assessments consider wider determinants of health and barriers to access. ◻ Support partnership working across health, local authority and VCSE sectors. **For providers:** ◻ Meaningfully involve communities and people with lived experience in service design ◻ Identify and address organisational processes that create barriers to engagement. ◻ Adapt services in response to feedback from the populations they serve.
b. Develop tailored information	**For commissioners and providers**: ◻ Co-produce materials with people with lived experience ◻ Regularly review and update information to maintain relevance
c. Build specialist knowledge and skills	**For commissioners and providers:** ◻ Co-produce training with VCSE organisations and people with lived experience ◻ Provide VCSE-led and peer-led training for all staff ◻ Identify and address skills gaps in staff knowledge and skills relating to target populations ◻ Ensure staff are equipped to recognise and response to complex, holistic needs ◻ Support ongoing learning and reflective practice to maintain specialist expertise

Case study: Tailor approaches to increase relevance

The Hepatitis C Trust (HCT): Working with women service users in the criminal justice system and the community

The HCT delivers peer-led services in prisons and communities across the UK. The programme engages people who face exclusion from mainstream services, in particular people who have experienced homelessness, injecting drug use, and/or the criminal justice system. HCT services are designed to take care to communities. Teams deliver healthcare on-site in key local services such as hostels, food banks, and drug and alcohol services, coupled with outreach vans providing a mobile clinical space to reach communities that don't readily access local services.

Whilst most services are commissioned to address single health issues, staff have a combination of lived experience and professional training to enable them to deliver holistic support, typically including housing, food, social care and wider health needs. HCT teams also routinely provide preventative services including sterile injecting equipment. Across the prison estate, HCT teams work in partnership with prison staff and healthcare to support health promotion and access to Blood Borne Virus testing and treatment.

Women in prison often have more complex needs than men, and many have experienced domestic violence, mental health and trauma. The stigma attached to many of the issues the women have experienced can be a substantial barrier to care. HCT's women's prison service seeks to provide a safe environment for the women they work with. The service was developed and is led by women with their own experience of the criminal justice system and centres of specialist peer workers providing regular prison-based support and recruiting and training women as volunteer health champions in prisons, enabling a 24/7 presence within each prison. The women's peer programme prioritises one-to-one support, reflecting the stigma and fear women can experience. The model also has a strong family focus and builds strong links between the prison and the community. This includes a specialist prison-to-community tracing contact tracing intervention, and a 'through the gate' through which women leaving prison are met by a female peer and given a mobile phone to enable them to stay in contact with HCT peers and healthcare.

Impact:
Using these approaches HCT's peer teams have built systems that work at scale to engage excluded populations. In 2025-6, they engaged almost 125,000 people and delivered 55,000 tests for blood-borne viruses.

Key Learning:

- The service was developed and is led by women with their own experience of the criminal justice system, prioritising one-to-one support
- Staff with a combination of lived experience and professional training can deliver holistic support including for housing, social care and wider health needs.

Monitoring & evaluation: Measure what matters

Traditional activity and volume metrics do not always reflect what matters most to people experiencing exclusion. They can overlook meaningful progress such as building trust, improving wellbeing, strengthening engagement or supporting long-term engagement and recovery.

Commissioners should work with people with lived experience and community partners to define outcomes that reflect what matters to the populations being served. Measures of success should extend beyond activity and volume metrics to capture progress towards inclusion, engagement and recovery.

Outcomes such as dignity, trust, wellbeing, independence and sustained engagement should be considered alongside traditional performance measures. Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) can help ensure services are assessed not only by what they deliver, but by whether people feel heard, supported and able to thrive.

This aligns with priorities set out in Fit For the Future: 10 Year Health Plan which emphasises outcomes that matter to people and communities, and the Local Outcomes Framework (MHCLG 2026) which highlights the importance of measuring progress for people experiencing multiple disadvantage where needs overlap and conventional data sources may not fully capture impact.

“Someone says it’s a really successful programme—but success for who?”

Friends, Families, Travellers

“For me, a positive outcome might be that someone got out of bed and came to see me today.”

Expert Focus

Commissioners and providers should consider outcomes such as:

- Trust and re-engagement with care
- Continuity of contact and sustained engagement
- Feeling respected, listened to and understood
- Improved confidence, agency, or stability
- Recovery and wellbeing and quality of life
- Progress towards personal goals identified by the individuals

For inclusion health groups, trusting relationships, peer support and meaningful engagement may be the mechanisms for achieving improved health outcomes. These should be recognised as important outcomes in their own right, as well as key contributors to reducing exclusion and health inequalities.

Key questions for commissioners include:

- Who actually feels safe using this service? Who might not?
- Who tends to drop out, and have we ever asked why?
- Are staff or volunteers with lived experience properly remunerated?
- Does accessing support require disclosure?
- Were communities meaningfully involved in design?
- Are commissioning outcomes built around institutional convenience or actual access?
- How can we evaluate outcomes such as building trust in services and creating a sense of belonging?
- How can we contribute more effectively to public debate around health inequalities?

"Outcomes are about dignity, recovery, people regaining their independence, reconnecting, getting back into the labour market and going on to thrive."

Find&Treat

'No research about us, without us'

National Ugly Mugs

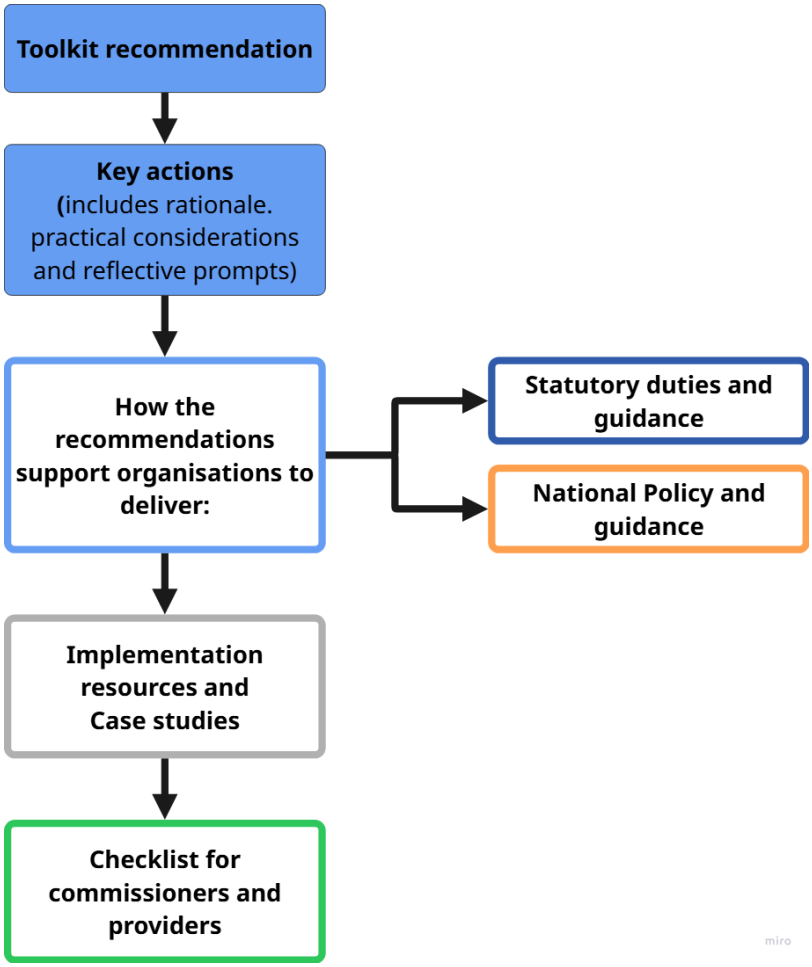
Part 2. Detailed Guidance

How to use this toolkit

The toolkit is organised around five evidence-informed recommendations to inform inclusive healthcare access for inclusion health groups (5,6). The recommendations are mutually reinforcing components of a whole-system approach to inclusion health. Successful implementation depends on strong partnerships, co-production, population health intelligence and sustained investment.

Each section outlines the recommendation, practical steps to support implementation and links to relevant statutory duties, policy and guidance (**Figure 6)**

Figure 6. How to use this toolkit



For each recommendation, the toolkit explains how implementation can support organisations to meet statutory responsibilities, delivery national policy priorities and support health equity through improved access to mainstream and specialist health, care and wider services. It includes practical commissioning and service delivery considerations, reflective prompts, case studies and implementation resources.

How to implement the five recommendations – detailed guidance

Recommendation 1. Build Trust First

Trust in healthcare is often undermined by past experiences of harm, exclusion and discrimination. This creates a significant barrier to healthcare access and engagement. Building trust is therefore essential. It requires time, transparency and meaningful engagement with people and communities with lived experience.

"It's not down to the communities to build trust with you. It's the other way around. You have to earn your trust with the community"

Friends, Families, Travellers

a. Work with trusted voluntary sector and community partners

Meaningful and ongoing community engagement is essential to understand what matters to people and to shape services that are culturally relevant, acceptable, and trusted. Communities may have internal dynamics that influence who is trusted, who feels safe and whether services are used or avoided. Voluntary, community and social enterprise (VCSE) organisations often hold longstanding relationships with communities, have valuable insights into local needs, and can play a critical role in facilitating meaningful engagement and peer involvement.

Commissioners should:

- Recognise VCSE organisations as key partners in service design, delivery and evaluation.
- Establish and involve lived experience steering groups to guide design, delivery, and ethical decision-making
- Recognise the expertise and value of trusted voluntary and community sector organisations

Providers should:

- Engage communities to shape services that reflect lived experiences and priorities of communities
- Regularly review services with lived experience input to ensure continued relevance and appropriateness

Table 1. Building Trust: supporting statutory duties and national policy delivery

Public Involvement Duties	Trust is essential for meaningful involvement. People are more likely to participate in service design, engagement activities and decision-making when they feel respected, listened to and confident their views will influence outcomes.
Working in Partnership with People and Communities (Statutory Guidance)	Building trusted relationships with communities, VCSE organisations and people with lived experience supports ongoing partnership working and meaningful co-production rather than one-off consultation.
Triple Aim Duty	Trust supports improved population health and wellbeing through better engagement and earlier access to care, improves experience of services, and can contribute to more effective use of resources through reduced crisis-driven care and avoidable service use.
Neighbourhood Health Framework	Trust strengthens engagement with underserved populations, enabling community-based and preventative care, and helping services become more accessible, responsive and accountable to the communities they serve
Local Outcomes Framework	Trust helps services engage disadvantaged populations and improve outcomes through trusted community relationships
Changing Futures	Recognising trust as a prerequisite for engagement, recovery and improved outcomes.
Rough Sleeping programme guidance	Trust supports delivery of person-centred, trauma-informed support, recognising that progress is non-linear

b. Build Trust Through Relevant Peer Engagement

Lived experience brings insight, credibility and trust that can significantly enhance service delivery. Involving people with lived experience can help build trust when their experiences are relevant to the needs and context of those being supported. Shared identity alone does not guarantee trust or understanding. Trust is shaped by the intersection of lived experience, social position and previous interactions with services, and varies across individuals and communities. A ‘one size fits all’ approach to peer engagement risks being ineffective or causing unintentional exclusion.

“Shared identity does not equal shared experience. ‘Skin folk are not always kinfolk’”
Spectra

“Having staff who are knowledgeable about you as a person and the footsteps that you've walked in before you've come to meet them is absolutely massive”

EP:IC

Commissioners should recognise that:

- Trust is built differently across people, settings and circumstances
- Shared identity does not automatically mean relevant shared experience
- A ‘one-peer-fits-all’ approach risks ineffective engagement, harm, or exclusion

Commissioners should require providers to:

- Demonstrate a nuanced understanding of diversity within communities, including differences in age, gender, culture, power, stigma, and past experiences of services
- Match peers to need based on the relevance of experience, not identity labels

c. Recognise that Building Trust Takes Time

Trust develops through sustained personal connection, not single interactions.

“Trust grows through personal and sustained connection and it's not often by one interaction. You've got to build that trust”

Friends, Families, Travellers

Commissioners should:

- Expect providers to take time to build relationships with local communities
- Support activities such as community meetings, workshops, informal engagement, and lived experience steering groups

d. Make the System Trustworthy

Mistrust of services is often rooted in real experiences of exclusion, discrimination, stigma or harm. Building trust requires more than encouraging people to engage; it requires services and systems to be trustworthy. This includes being transparent about what support can be offered, communicating clearly about rights and choices, responding consistently to concerns and working alongside trusted VCSE organisations.

“Many of us are working with communities who don't want to be detected by state bodies and institutions.”

National Ugly Mugs

“Mistrust translates into the perception that the system is broken…nobody cares and people feel they are not in control of their lives. Listening is a simple step to address this”

The Do-Good Charity

Commission services that:

- Are transparent about aims, processes and limitations
- Do not overpromise
- Clearly explain rights, choices, and entitlements
- Use trusted organisations as bridges, not shields

Recommendation 2. Embed peer roles

Involving peers - people with relevant lived experience - in service design and delivery is an effective way to overcome barriers to care, build trust, and improve engagement with services. 'Peers’ refers to people employed or engaged on the basis of relevant lived experience.

Meaningful involvement of people with lived experience requires structured investment in recruitment, training, and career progression. Lived and learned experience should be recognised as complementary forms of expertise. Together, they can strengthen engagement, improve service relevance and help organisations respond more effectively to people’s circumstances and needs.

Lived experience roles can be emotionally demanding. Organisations recruiting lived experience roles should provide holistic support and establish ethical frameworks to protect peers, prevent re-traumatisation, and support wellbeing, retention and progression.

“An audience member sometimes can hear a message clearer when somebody with lived experience is saying the same thing”

Spectra

a. Develop fair and inclusive remuneration frameworks for lived experience roles

Lived experience roles provide essential expertise. These roles should be formally recognised through fair and flexible participation and employment models aligned to

individual circumstances and preferences. This may include paid employment (including through honorary contracts), volunteering opportunities and - where appropriate - vouchers or other forms of in-kind recognition. Volunteering and voucher-based participation can provide valuable routes into training, employment and career progression. However, they require substantial investment and should not be used as a substitute for fair remuneration where individuals undertake substantive service, leadership, research or delivery responsibilities. Expecting lived experience contributions without appropriate recognition or reward reproduces inequity.

"Peer work is often undervalued and just tokenistically paid for… it's a skill. It's a job."

The Hepatitis C Trust

Commissioning requirements

Commissioners should:

- Ask providers to demonstrate that lived experience roles are integrated into workforce planning, service design and budget setting
- Ensure remuneration for paid lived experience roles reflects skill, responsibility, and emotional labour involved
- Explore honorary contracts through partnerships with voluntary sector organisations to facilitate paid roles in NHS services
- Recognise that volunteer programmes should complement - not replace – paid roles involving substantial responsibilities.

Be aware of the red flags for tokenistic involvement of lived experience:

- Reliance on voucher payments as the sole form of recognition for substantial contributions
- 'Volunteer-only' opportunities where paid roles would be more appropriate
- Unpaid advisory, leadership or delivery roles replacing funded staff positions
- Limited opportunities for training, progression or influence on decision-making
- Lived experience involvement that is consultative only, with no meaningful role in service design, delivery or evaluation

Table 2. Embedding Peer Roles: supporting statutory duties and national policy delivery

Public Involvement Duties	Peer roles provide a practical mechanism for involving people with lived experience in service planning, design, delivery and evaluation, supporting meaningful participation rather than one-off consultation
Working in Partnership with People and Communities	Embedding peer roles supports co-production and partnership working by ensuring that people with lived experience are involved as active contributors, leaders and decision-makers within services.
Triple Aim Duty	Peer roles can improve population health and wellbeing through increased engagement and earlier access to support, improve the experience and quality of care, and contribute to more effective use of resources through better retention and continuity of care.
Strategic Commissioning Framework	Supports commissioners to use lived-experience insight alongside population health intelligence to understand unmet need, identify barriers to care and design services around the needs of underserved populations.
Neighbourhood Health Framework	Strengthens neighbourhood and community-based approaches through peer-led engagement, trusted relationships and community participation in service development.
Fit for the Future: Towards Population Health Delivery Models	Supports population health approaches by ensuring services are informed by the experiences of the populations they serve, helping to improve engagement, trust and uptake of services among groups experiencing the poorest outcomes.
NICE NG 214	Directly supports NICE recommendations on peer support, lived-experience involvement and co-production in service design, quality improvement and service delivery.
Local Outcomes Framework	Supports improved outcomes by involving people with lived experience in identifying priorities, shaping interventions and ensuring services reflect local needs and circumstances.
Changing Futures	Supports commitment to lived experience leadership through embedding people with lived experience as partners in service design, delivery and improvement.
Rough Sleeping programme guidance	Embedding peer roles can enhance trust, improve understanding of individual needs, support navigation of services and contribute to person-centred support required for sustained recovery

b. Integrate Lived Experience Roles into Organisational Structures

Peer roles are most effective when they are core to delivery, not treated as an optional add-on. Commitment to peer work integration starts at leadership level. Ensuring that teams fully understand the benefits of peer roles is critical to their successful integration. Commissioners and providers should establish clear pathways for recruitment, support, progression, and integration of peer workers within wider multidisciplinary teams, recognising peer workers as having valuable expertise.

Recruitment processes should be inclusive and proportionate. Requirements such as formal qualifications, curriculum vitae (CV)-based applications and standard recruitment processes may unintentionally exclude people with lived experience. Organisations should review recruitment process to ensure they identify potential and lived-experience expertise rather than creating unnecessary barriers to employment.

Demonstrating the impact of peer roles and making them a routine part of service delivery can help overcome organisational resistance and ensure lived experience is valued across the system.

"Good peer services invest in people; they don't just recruit them"

The Hepatitis C Trust

Commissioners should require clarity on:

- Peer roles and job descriptions
- Recruitment and induction processes
- Structured supervision
- Career pathways and progression opportunities
- Integration with clinical and operational teams

Providers should:

- Ensure peer workers are fully integrated into multidisciplinary teams
- Prove appropriate training, supervision and development opportunities
- Review recruitment processes to reduce barriers related to qualifications, employment history and employment checks
- Support peer workers to navigate HR and employment processes where additional assistance may be required

c. Protect and Support People with Lived Experience

Peer roles can be emotionally demanding and may be retraumatising, especially if poorly supported. Appropriate support, supervision and development opportunities are essential to sustain wellbeing, enable meaningful involvement, and support the retention and progression of people with lived experience. Creating inclusive workplace environments also helps ensure peer contributions are recognised, valued and acted on.

"Peer roles can be emotionally demanding and really complex."

The Hepatitis C Trust

"People don't feel like they belong in these spaces sometimes because everybody's talking over them ...making people feel that they're not part of the gang"

Friends, Families, Travellers

Commissioners and providers should:

- Provide trauma-informed wellbeing, pastoral and supervision arrangements for lived experience staff and volunteers.
- Embed career development, training and progression opportunities to support retention.
- Establish clear policies and ethical frameworks for lived experience involvement, for example through the Lived Experience Charter.
- Offer reasonable adjustments and flexible working arrangements where required.
- Implement mechanisms to identify and address discrimination, stigma and exclusion within the workplace.

d. Embed Co-production from the Earliest Stages of Service Design

People with lived experience must be involved before questions are set, not just consulted once solutions are chosen. Where formal lived experience roles are not available, opportunities to embed lived experience co-production include involvement of experts by experience, advisory councils and forums, working within a system that translates people's feedback into concrete actions.

"It can't be that sort of participation ladder which is tokenistic. It's got to be embedded… even at the beginning: what questions you're going to ask, what do you want, what do you think is important?"

Friends, Families, Travellers

"Are peers involved in every stage? ...are they in the design, the delivery, the evaluation?"

The Hepatitis C Trust

Commissioning actions

Require services to demonstrate:

- How lived experience shaped:
  - The problem definition
  - Service design
  - Delivery model
  - Evaluation approach
- Use of lived experience steering panels with genuine influence

Practical commissioning test

Ask:

- *"What changed as a result of lived experience input?"*

Providers should be able to give specific examples of decisions, service features, or delivery approaches that were directly influenced by lived experience contributions. Vague or general responses may indicate tokenistic involvement rather than meaningful co-production.

Implementation resources

Lived Experience Charter - Career Matters

Achieving Charter status demonstrates a commitment to quality standards, best practice, and the inclusive recruitment, retention, and progression of people with lived experience.

Payment guidance for researchers and professionals | NIHR

Outlines payment arrangements that remove barriers to participation and recognise the value of lived experience expertise.

Recommendation 3. Provide Integrated, Holistic and Person-Centred Care

People experiencing social exclusion often face multiple, overlapping health and social challenges. Effective services recognise that health needs are shaped by wider factors such as housing, income, food security, safety, mental health and substance use, and that healthcare may not always be a person's immediate priority. Integrated, holistic and person-centred services improve engagement, strengthen trust and support better long-term outcomes by working with the whole person and addressing the wider factors that shape health and wellbeing. The most effective models combine clinical, social and lived-experience expertise to support people towards recovery, independence and sustained engagement.

"Integration is about doing more than one thing. It's about that opportunity of encounter, doing the best you can in that moment…for the simple reason that as an outreach service, you're very often the one and only point of contact with the entire system"

Find&Treat, UCLH

a. Design services to meet health and social needs together

Services should be designed around people rather than conditions, recognising the interconnected nature of physical health, mental health, addiction, housing and social needs. A single issue is rarely experienced in isolation, and opportunities to engage people should be used to address wider needs wherever possible. Figure 5 provides an example of a co-designed, outreach integrated care model.

Commissioners and providers should:

- Recognise the interaction between health needs and wider determinants of health.
- Design services that can identify and respond to multiple needs.
- Enable access to healthcare, housing, welfare, mental health, addiction and social support services.
- Focus on people rather than individual conditions or service boundaries.

"Health might not be the priority for the people that we're serving. For them, priorities are very often around security, food, money, housing and addictions."

Find&Treat, UCLH

Table 3. Integrated, Holistic Care and Person-Centred Care : supporting statutory duties and national policy delivery

Public Involvement Duties	Encouraging services to work alongside people to identify goals, priorities and outcomes that matter to them, supporting personalised and person-centred care.
Working in Partnership with People and Communities	Supporting collaborative working across services, communities, VCSE organisations and people with lived experience to design coordinated responses to complex needs.
Triple Aim Duty	Supporting improved population health and wellbeing by addressing physical health, mental health and wider determinants of health together. Improves quality and experience of care through person-centred approaches making better use of resources through earlier intervention, prevention and reduced fragmentation of care.
Strategic Commissioning Framework	Supporting commissioning around population need, addressing the biological, psychological and social determinants of health, and commissioning across pathways rather than individual organisations or conditions.
Neighbourhood Health Framework	Supporting neighbourhood-based and community-focused models that bring together health, social care, local authority and VCSE partners to meet local population needs.
Fit for the Future: Towards Population Health Delivery Models	Supporting integrated, population-based models of care that bring together services around defined populations, address prevention and improve outcomes through coordinated care.
NICE NG 214	Directly supporting recommendations for integrated multidisciplinary care, coordinated pathways, and services that address health and social needs together.
Local Outcomes Framework	Supporting improved outcomes through coordinated, person-centred approaches that address wider factors affecting health and wellbeing.
Changing Futures	Reflecting core objective of delivering integrated, person-centred and trauma-informed support that addresses the multiple and interconnected needs experienced by people facing multiple disadvantage.
Co-occurring mental health and substance use delivery framework	Supporting delivery through integrated, person-centred care, coordinated service delivery, and improved partnership working across mental health, substance use, health, housing and social care services.
Rough sleeping programme guidance	Supporting integrated local offers, shared needs assessments, coordinated case management and multi-agency working

b. Use Every Opportunity for Engagement

For many inclusion health populations, contact with services may be infrequent. Each interaction may be a rare opportunity to identify needs, build trust and connect someone with support.

Integrated care is often about making the most of that opportunity for contact by addressing multiple needs rather than focusing on a single presenting problem.

Commissioners and providers should:

- Promote flexible, opportunistic approaches to assessment and support.
- Enable staff to respond to needs beyond the immediate reason for contact.
- Develop pathways that support referral and coordination across services.
- Reduce the burden on individuals to navigate multiple disconnected systems.

c. Embed Integrated and Collaborative Working

No single organisation can meet the full range of needs experienced by inclusion health populations. Effective services require collaboration across healthcare, housing, public health, local authorities, social care and VCSE organisations. This enables services to work together around the person, reducing the need to navigate fragmented systems.

Commissioners and providers should:

- Develop integrated care pathways and multidisciplinary models.
- Embed coordinated care planning and navigation
- Strengthen partnerships across sectors.
- Support coordinated and joined-up care.
- Align services around the needs of populations rather than organisational structures.

d. Focus on Recovery, Not Just Treatment

Success should not be measured solely through clinical outcomes. Effective services help people achieve wider recovery goals, including stability, independence, social inclusion and wellbeing.

Commissioners and providers should:

- Support people to achieve outcomes that matter to them.
- Measure broader outcomes alongside clinical indicators.

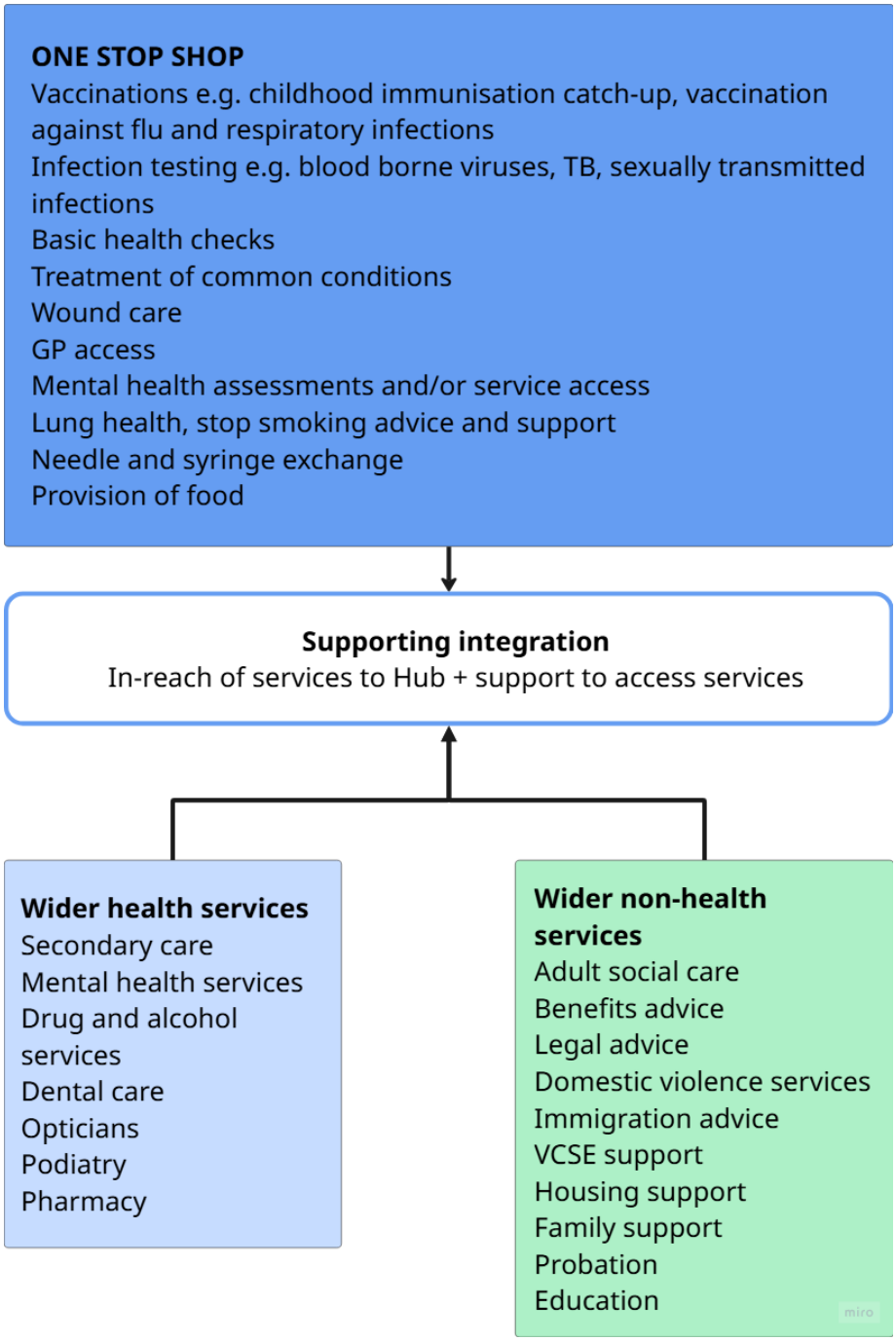
- Address the causes of poor health and recurrent crisis wherever possible.
- Take a long-term view of impact and recovery.

" 'Cured' means that we've actually done our best to address the root cause, the risks that put people in that situation in the first place."

Find&Treat

Figure 5. Co-designed integrated care model

(Adapted from Insights from people with lived experience (UKHSA 2025))



Recommendation 4. Build in accessibility to increase uptake and engagement

Service accessibility extends beyond simply being able to attend an appointment. Services should be safe, flexible, and responsive to need. Individuals should be supported to communicate effectively with providers and trust that their confidentiality will be respected. Barriers such as location, opening hours, transport costs, rigid appointment systems, and language can limit access. These can be addressed through community-based outreach, flexible scheduling (including drop-ins), supportive re-engagement after missed appointments, and consistent provision of interpreters.

Improving accessibility also requires long-term investment. Short-term commissioning cycles can undermine relationship-building and continuity of care, particularly for marginalised groups. Longer-term, flexible commissioning arrangements enable providers to build trust, adapt services and maintain meaningful engagement over time.

"Accessibility depends not only on the availability of services, but also on where and how they are delivered"

The Do-Good Charity

Table 4. Accessibility: supporting statutory duties and national policy delivery

Public Involvement Duties	Improves opportunities for people to engage with services and decision-making by reducing practical, communication and accessibility barriers.
Working in Partnership with People and Communities	Supports services to work with communities to understand barriers to access and design services that are responsive to local needs.
Triple Aim Duty	Improves population health and wellbeing through facilitating earlier engagement with services, enhances experience through more responsive and person-centred care, and supports more effective use of resources by reducing avoidable crises and disengagement.
Strategic Commissioning Framework	Supports equitable access to healthcare by helping commissioners identify barriers to engagement and commission services that are responsive to population need.
Neighbourhood Health Framework	Supports community-based, outreach and neighbourhood models that bring services closer to people and improve engagement with underserved populations.
Fit for the Future: Towards Population Health Delivery Models	Supports population health approaches by improving access, preventing people from becoming excluded from care, and enabling earlier intervention for populations at highest risk of poor outcomes.
NICE NG 214	Supports recommendations for flexible access, outreach, multidisciplinary care, continuity of care and reducing barriers to engagement for people experiencing homelessness.
Local Outcomes Framework	Supports improved outcomes for disadvantaged populations by reducing barriers to service access and engagement.
Changing Futures	Supports ambition to improve engagement among people experiencing multiple disadvantage through flexible, accessible and trauma-informed service delivery
Rough sleeping programme guidance	Supports 'Routes off the street' through flexible access designed to strengthen uptake, responding to need and prioritising prevention and early intervention wherever possible

a. Consider where services are delivered

Services are more accessible when they are delivered in familiar, community-based, or non-clinical settings. Mobile and outreach services can reduce financial, time, and logistical barriers.

Neighbourhood and outreach models enable services to reach people where they are, work alongside trusted community partners, and address both health needs and the wider social factors affecting health and engagement.

Commissioners should:

- Fund community-based and outreach services

Providers should:

- Offer services in trusted, familiar community settings

b. Offer flexible access

Unstable circumstances can make attending appointments difficult, as basic needs like housing and food often take priority. Flexible delivery – including regular sessions, drop-ins and out of hours provision– can improve access. Offering a choice of time, location and format supports engagement by restoring a sense of agency and control. Managing missed appointments ('Did Not Attend' or DNA) in a supportive, non-punitive way, alongside proactive outreach, supports engagement.

Commissioners should:

- Support flexible delivery models (community, drop-in, out of hours)
- Implement non-punitive approaches to missed appointments (DNAs) and provide health navigation support for people who miss or struggle to attend appointments
- Avoid creating unnecessary evidential, eligibility or administrative barriers to accessing support
- Require proactive outreach re-engagement approaches

Service providers should:

- Offer flexible access, including drop-in and a choice of appointments
- Manage missed appointments supportively
- Proactively reconnect individuals who disengage

c. Communicate effectively

NHS organisations, including commissioners and trusts, have legal duties to provide accessible and inclusive health communications for patients and the public. Services must meet diverse communication needs, including language, literacy, cultural context and digital access. People with experience of trauma or exclusion may not use clinical language and may express needs in other ways. Services should be flexible and responsive to different forms of communication. Clear communication about healthcare entitlements, waiting times, service limits and expectations is essential to build trust.

Commissioners should:

- Support inclusive and trauma-informed communication approaches

Providers should:

- Use qualified interpreters, with longer appointments needed
- Communicate clearly, avoiding jargon
- Adapt communication to individual needs and literacy levels
- Provide digital and non-digital access options
- Be transparent about healthcare entitlements, waiting times and service limitations

d. Be responsive to needs

Accessibility improves when services adapt to individuals' changing needs. Fragmented pathways, delays, and repeated assessments can lead to disengagement. A holistic, flexible, combined with co-developed outcomes and strong monitoring can support long-term engagement.

Commissioners should:

- Commission integrated, flexible approaches that adapt to evolving needs.
- Act on recommendations in Joint Strategic Needs Assessments and Public Health Needs Assessments.

Service providers should:

- Conduct holistic needs assessments

- Co-develop outcomes with service users
- Put systems in place to monitor and respond to changing needs

e. Build services around engagement

Services designed around people – not systems – are more accessible and effective. Trauma-informed, culturally aware, and non-judgemental approaches help remove barriers and support engagement.

"Engagement grows when people feel respected, informed and safe"

The Do-Good Charity

Trust is central to accessibility. Many individuals have significant mistrust of services and authority, which can affect whether they access care. Commissioners and services must recognise this and take active steps to address it.

Commissioners should:

- Embed engagement and trust-building as explicit expectations within service specifications
- Prioritise approaches that create safe, respectful and inclusive environments, particularly for groups with low trust in services
- Support relationship-based delivery models, recognising that engagement develops over time
- Commission services that retain flexibility to respond to people's needs and preferences

Providers should:

- Deliver trauma-informed, non-judgemental care that prioritises dignity and respect
- Create welcoming and safe environments where people feel able to engage
- Adapt delivery based on feedback and patterns of engagement, including where people disengage
- Use trusted relationships and consistent contact to sustain engagement over time

f. Prioritise longer-term, larger scale commissioning footprints

Short-term, small-scale commissioning footprints can limit impact for inclusion health groups. Building trust and supporting sustained service engagement takes time, while populations often move across traditional commissioning boundaries, interrupting continuity of care and limiting integrated approaches. Sustainable, effective services require commissioning models that reflect the realities of these populations.

Commissioners should:

- Commission over longer timeframes to support continuity, relationship-building, and service stability
- Operate across larger or aligned footprints to reflect population movement and reduce fragmentation
- Design funding models that support integration across services and sectors
- Recognise that trust-building and peer-led approaches take time, and may not align with short-term commissioning cycles

Key Questions for Commissioners

- Can people understand the information we provide?
- Are communication, language or digital barriers preventing access?
- Do services provide professional interpretation and accessible communication support?
- Are outreach and neighbourhood-based approaches needed to reach underserved populations?
- Do commissioning arrangements support providers to build trust and engagement over time?

Implementation resources

Health Literacy Toolkit (NHSE 2023)

Practical tools to improve communication, understanding and shared decision-making.

Inclusive Digital Healthcare Framework (NHSE 2024)

Provides practical actions to reduce digital exclusion through access to devices, connectivity, skills development and digital support.

Health Resource Hub – Groundswell

Resources co-produced with health practitioners and people with lived experience of homelessness.

Community Language Translation and Interpreting Services Framework (NHSE 2025)

Supports the commissioning and delivery of high-quality interpreting and translation services for people with limited English proficiency

Reducing Did Not Attends (DNAs) (NHSE 2023)
Guidance outlining principles to reduce DNAs in acute settings, diagnostics, primary, community and mental health.

Recommendation 5. Tailor approaches to increase relevance

Effective services are designed around the needs, experiences and circumstances of the populations they serve. This requires understanding both structural factors (such as policies, eligibility criteria, and service design) and individual circumstances that influence health and access to care. Services should recognise differences within the groups they serve and adapt delivery to ensure individuals feel safe, understood, and able to engage.

When designing services, commissioners and providers should ask:

- Who feels safe using this service, and who might not?
- Who tends to disengage, and why?
- How can we support people to re-engage?

"Many service users exist outside formal systems entirely ...this is why it is even more important that accessibility must be approached broadly and inclusively"

The Do-Good Charity

"Trauma-informed ...is understanding that a lot of service users don't just have a history of interpersonal violence, but also state violence, and … structural vulnerabilities, social exclusion."

National Ugly Mugs

"It's a long shadow that bad institutional encounters casts on future engagement"

National Ugly Mugs

Table 5. Tailoring approaches to increase relevance: supporting statutory duties and national policy delivery

Public Involvement Duties	Encourages meaningful involvement of people and communities in identifying local needs, barriers and priorities, ensuring services are informed by those they are intended to serve.
Working in Partnership with People and Communities	Promotes co-production, community engagement and asset-based approaches that include practical actions to ensure services are shaped by lived experience and local insight rather than for communities.
Triple Aim Duty	Supports improved population health and wellbeing by ensuring services are relevant, responsive and effective for underserved populations, while helping resources be targeted where they can have the greatest impact.
Strategic Commissioning Framework	Supports the use of population health intelligence, lived-experience insight and community engagement to identify underserved populations, understand local need and commission services around defined populations.
Neighbourhood Health Framework	Supports the design of neighbourhood services around local population needs, community assets and the experiences of people most likely to experience poor outcomes.
Fit for the Future: Towards Population Health Delivery Models	Supports population-based approaches by ensuring services are tailored to the needs of specific populations, informed by local intelligence and able to respond to wider determinants of health.
NICE NG 214	Supports recommendations on lived-experience involvement, tailoring services to local populations, and designing integrated responses based on the needs of people experiencing homelessness.
Local Outcomes Framework	Supports improved outcomes for disadvantaged populations through targeted, community-informed interventions that reflect local needs and priorities.
Changing Futures	Promotes understanding and responding to diverse experiences of multiple disadvantage through tailored, locally-responsive and co-produced service design.
Rough Sleeping programme guidance	Promotes person-centred, trauma-informed and needs-led approaches that recognise individual circumstances, reduce barriers to engagement and provide tailored support for people at different stages of rough sleeping and homelessness

a. Address structural and systemic barriers

Structural factors - such as legislation, entitlement rules, service thresholds, and organisational process - can create barriers to care and contribute to exclusion. These barriers may result fear of services, concerns about disclosure, stigma or conditional access to services. Services become more relevant when they recognise and address these realities and work with communities develop flexible, responsive models. Coordinated, collaborative working across sectors increases opportunities to identify and address wider needs.

Commissioners should:

- Recognise what the systemic and structural barriers to healthcare are and prioritise approaches that address them
- Ensure needs assessments consider wider determinants of health and barriers to access.
- Support partnership working across health, local authority and VCSE sectors.

Service providers should:

- Meaningfully involve communities and people with lived experience in service design
- Identify and address organisational processes that create barriers to engagement.
- Adapt services in response to feedback from the populations they serve.

"Many people who are affected by exploitation remain hidden, unsupported and excluded from healthcare systems"

The Do-Good Charity

b. Develop tailored information

Services can improve relevance by co-producing tailored messaging and materials with people with lived experience. This helps ensure communication is relevant, accessible, and non-stigmatising.

Commissioners and providers should:

- Co-produce materials with people with lived experience
- Regularly review and update information to maintain relevance

c. Build specialist knowledge and skills

Specialist knowledge enables services to respond effectively to the needs of inclusion health populations. Training should support staff to understand the wider social, structural and health factors that affect engagement with healthcare, including housing, safety, legal issues, and physical and mental health. Training in applying inclusion health principles and adopting a trauma-informed approach should be available for all staff and volunteers. Co-produced learning, informed by VCSE organisations and people with lived experience, can strengthen understanding and improve practice.

Commissioners and providers should:

- Co-produce training with VCSE organisations and people with lived experience
- Provide VCSE-led and peer-led training for all staff
- Identify and address skills gaps in staff knowledge and skills relating to target populations
- Ensure staff are equipped to recognise and response to complex, holistic needs
- Support ongoing learning and reflective practice to maintain specialist expertise

Appendix 1. Understanding the high burden of unmet health needs among inclusion health groups

People experiencing homelessness, people who use drugs, people in contact with the criminal justice system, and sex workers experience substantially worse health outcomes than the general population. These inclusion health groups face high rates of chronic disease, mental ill health, substance dependence, infectious diseases and premature mortality, much of which is preventable through timely access to healthcare, vaccination, screening, and evidence-based treatment [3].

Barriers to healthcare access

Inclusion health groups experience multiple barriers to healthcare. These barriers are shaped not only by individual circumstances but by wider structural factors, including poverty, insecure housing, restrictive policies, and the criminalisation of certain behaviours and populations.

Criminalisation and hostile system interactions can deepen stigma, erode trust, and discourage engagement with health services. Combined with discrimination and previous negative experiences, this contributes to low confidence in services and delayed presentation with more advanced illness. Practical barriers—such as rigid appointment systems, fragmented services, and competing priorities like securing food and shelter—further limit access. As a result, engagement with healthcare can be inconsistent and inequitable [1,3,4,6-9, 11].

Facilitators to healthcare access

Evidence shows that the most effective approaches to delivering support are compassionate, flexible, and inclusive—particularly those that are outreach-based, integrated across services, and informed by lived experience [5-9]. These approaches promote more efficient and effective use of resources by strengthening engagement, reducing avoidable crises, and ensuring greater continuity of care.

Chronic Disease and Cancer

Inclusion health groups experience a disproportionately high burden of non-communicable disease and related mortality. International evidence demonstrates that they are nearly three times more likely to die from cardiovascular disease, almost five times more likely to die from respiratory disease, more than seven times more likely to die from digestive disease, and more than twice as likely to die from cancer than the general population [3].

People experiencing homelessness in England have significantly increased rates of hospital admission for cardiovascular disease, chronic respiratory disease, diabetes, liver disease, chronic kidney disease and cancer [12]. Screening programmes have also identified high levels of untreated hypertension, atrial

fibrillation, smoking-related risk factors and diabetes within this population [13].

People who use illicit opioids experience substantially elevated mortality from cardiovascular disease, chronic obstructive pulmonary disease and liver disease. In a large English cohort, chronic diseases and cancer were among the leading causes of death following long-term follow-up [14].

Although evidence relating to chronic disease among sex workers is limited, available studies demonstrate high prevalence of smoking, substance use, cervical abnormalities and other risk factors associated with long-term morbidity and mortality [15,16].

Mental Health, Addiction and Safeguarding

Mental ill health, substance dependence, injury, violence and safeguarding concerns are highly prevalent across inclusion health populations. International evidence shows inclusion health groups are 24 times more likely to die from external causes such as injury, poisoning and homicide, and four times more likely to die from mental and behavioural disorders than the general population [3].

People experiencing homelessness have exceptionally high rates of hospital admission related to injury and mental ill health [12]. In England, almost half of all deaths among people experiencing homelessness are attributable to drugs, alcohol and suicide [17].

People who use illicit opioids are at markedly increased risk of death from drug poisoning, accidents and suicide [14]. Sex workers experience high rates of substance use, homelessness, violence and homicide, particularly those involved in street-based sex work [16, 18].

These findings support the need for integrated commissioning approaches that combine physical healthcare, mental healthcare, addiction services, safeguarding and wider social support.

Infectious Diseases

Infectious diseases remain a major cause of morbidity and mortality among inclusion health groups. Standardised mortality rates from infections are estimated to be 14 times higher than in the general population [3]. People experiencing homelessness are significantly more likely to be admitted to hospital with infectious diseases, while people who use illicit opioids experience a substantially higher risk of infection-related mortality [12, 14].

Tuberculosis

Tuberculosis (TB) remains an important marker of health inequality. Rates of TB disease among people experiencing homelessness are more than 20 times higher than among the White UK-born population, with studies also demonstrating high prevalence of TB infection [19, 20]. Individuals experiencing homelessness who develop TB are more likely to have drug-resistant disease, present with infectious pulmonary disease,

experience treatment non-adherence and become lost to follow-up [21].

People who use drugs and people with experience of imprisonment also have substantially elevated TB risk [22, 26]. Recent surveillance data demonstrate high rates of TB among prison populations [23,24].

Blood-borne Viruses

The burden of blood-borne viruses is high across inclusion health groups. People experiencing homelessness have increased rates of hepatitis B, hepatitis C and HIV, together with low levels of hepatitis B immunity [25, 26]. Outreach screening programmes continue to identify significant unmet testing need and previously undiagnosed infection [26].

Among people who inject drugs, hepatitis C remains highly prevalent, with ongoing transmission and gaps in treatment uptake [14,27.] Evidence also demonstrates high rates of reinfection following successful treatment, particularly among women in prison [19, 24.]

Sexually Transmitted Infections

Recent studies demonstrate a substantial burden of sexually transmitted infections (STIs) among vulnerable populations, particularly among street-based sex workers and individuals with overlapping experiences of homelessness and substance use [29,30]. Screening programmes have identified high prevalence of syphilis, chlamydia and gonorrhoea, with important implications for both individual and population health [30].

Invasive Bacterial Infections

People experiencing homelessness and people who inject drugs are at particularly high risk of severe bacterial infections. These include skin and soft tissue infections, bloodstream infections, osteomyelitis and infective endocarditis [12]. Studies and surveillance data consistently demonstrate rates of invasive bacterial infection many times higher than those observed in the general population [14].

Vaccine-Preventable Disease

Inclusion health groups experience significantly higher rates of influenza, pneumonia, hepatitis B and other vaccine-preventable infections [12,14]. Despite this, vaccine uptake remains substantially lower than in the wider population. Outreach services have demonstrated low hepatitis B immunity and poor uptake of seasonal influenza vaccination among people experiencing homelessness [26, 31].

Implications for Commissioning

The evidence demonstrates a substantial burden of preventable disease, avoidable hospital admission, premature mortality and health inequalities across inclusion health groups. Many of these conditions can be effectively addressed through targeted outreach, opportunistic case-finding, vaccination, screening, early diagnosis and integrated care pathways. Commissioners therefore have a significant opportunity to

improve health outcomes, reduce avoidable healthcare utilisation and contribute to reducing health inequalities through tailored inclusion health approaches[3].

Appendix 2. Understanding Population Health need

Understanding local population need is a core responsibility of ICBs, local authorities, NHS providers and wider system partners. It provides the foundation for effective strategic commissioning, service design and resource allocation.

Statutory duties

The Triple Aim Duty requires NHS organisations to consider the impact of decisions on population health and wellbeing, health inequalities, quality of care and sustainable use of resources. The Public Involvement Duties and Working in Partnership with People and Communities statutory guidance require organisations to combine quantitative data with meaningful engagement and lived-experience insight when planning and improving services. Together, these duties create a clear expectation that services should be designed around a robust understanding of local need, particularly for underserved and inclusion health populations.

Policy and Guidance

The NHS Planning Framework, Strategic Commissioning Framework, Fit for the Future: Towards Population Health Delivery Models, Neighbourhood Health Framework all emphasise the importance of understanding local population need and reducing inequalities through data-driven, evidence-based planning, prioritisation and commissioning.

Commissioners are expected to use population health intelligence, risk stratification, community insight and lived-experience evidence to identify underserved groups, target resources effectively and design services around defined populations. Needs assessments are therefore a key mechanism for delivering these policy expectations.

What this means in practice

Integrated Care Boards (ICBs) should develop and maintain an Integrated Needs Assessment covering their local population. This should draw on population health data, service utilisation, community intelligence and lived experience to identify health inequalities, unmet need and priority populations across the ICB geography. The assessment should be shared with providers, local authorities and other partners and reviewed regularly as part of annual planning cycles.

Local Authorities undertake Joint Strategic Needs Assessments (JSNAs) through Health and Wellbeing Boards (HWBs). JSNAs provide a shared assessment of local health and wellbeing needs and should inform commissioning across health, public health, social care and wider determinants of health. Inclusion health populations should be explicitly considered within JSNAs. Examples include Surrey's co-produced Inclusion Health JSNA chapter [32], which combines population data with lived-experience insight to identify priorities and service gaps.

Providers and Place-Based Partnerships should use Integrated Needs Assessments, JSNAs and local intelligence to design and adapt services, ensuring they respond to the needs of underserved populations and contribute to reducing inequalities. A summary of the statutory duties, policy and guidance alongside implementation resources that can support health needs assessments is provided in **Resource box 1**.

Resource box 1.

Statutory duties and guidance	• Triple Aim Duty (Health & Care Act 2022) • Public Involvement Duties (NHS Act 2006 as amended by the Health & Care Act 2022) • Working in Partnership with People and Communities
Policy frameworks and national guidance	• NHS Planning Framework • Strategic Commissioning Framework • Fit for the Future: Towards Population Health Delivery Models • Neighbourhood Health Framework • Rough Sleeping Programme
Implementation resources	• Inclusion Health Data and Intelligence Resource • Spotlight Tool • Surrey's co-produced Inclusion Health JSNA chapter [32]: Example of a co-produced JSNA chapter

Appendix 3. How the toolkit was produced

This toolkit was co-produced by nine VCSE organisations from across the spectrum of inclusion health groups, with input on relevant policy frameworks and data on disease burden provided by NHS England, DHSC Office for Health Improvement and Disparities (OHID), UK Health Security Agency (UKHSA) and Find&Treat University College London Hospitals NHS Foundation Trust (UCLH).

People with lived experience were involved throughout toolkit development, helping to identify priorities, shape recommendations and ensure the toolkit reflects the realities of exclusion, barriers to care and what works in practice.

Participating VCSE organisations included Doctors of the World; EP:IC; Expert Focus; Friends, Families and Travellers; Groundswell; National Ugly Mugs; Saint John of God Hospitaller Services; Spectra; The Hepatitis C Trust.

All participating VCSE organisations contributed to development of the *Insights from people with lived experience to inform inclusive approaches to health protection* (GOV.UK). Information about participating VCSEs and links to their reports which informed the Insights report is available.

This toolkit was developed through a structured, collaborative process involving three co-production workshops, chaired on a rotating basis to ensure shared ownership. Participating organisations presented their perspectives, fostering a broad and inclusive understanding of challenges and solutions. The process was iterative, with ongoing refinement through joint discussion and feedback at each stage. This approach ensured the final toolkit reflects a diverse range of expertise and lived experience.

Toolkit development, write-up and publication was led by Find&Treat UCLH with Biomedical Research Centre funding.

The VCSE organisations contributing to this toolkit are listed below:

Doctors of the World
Focus: Refugees, people seeking asylum and other migrants in vulnerable circumstances
Their report: Doctors of the World submission to UKHSA National Integrated Inclusion Health Outreach Service

EP:IC
Focus: People in contact with the justice system
Their report: BBV, STI and TB Screening in Prison and Access to Health on Release: Views from Prison

Expert Focus
Focus: People with experience of homelessness
Their report: Feedback report by Expert Focus of insights from people experiencing homelessness

Friends, Families and Travellers
Focus: Gypsy, Roma and Traveller communities
Their report: Test Treat and Trace for Gypsy Roma and Traveller communities

Groundswell
Focus: People with experience of homelessness
Their report: UCLH national service codesign: Groundswell's engagement with people with lived experience of homelessness

Hepatitis C Trust
Focus: People with lived experience of Hepatitis C including people who use drugs
Their report: Designing Inclusive Health Services Reports 1 and 2

National Ugly Mugs
Focus: Sex workers
Their report: Fighting for Fair Treatment. Sex Workers Share Insights to Inform Inclusion Health Initiatives

The Do-Good Charity (formerly **Saint John of God Hospitaller Services**)
Focus: People subject to modern slavery and trafficking
Their report: Exploring access to health support and treatment for people subject to modern-day slavery and trafficking

Spectra
Focus: Sex workers
Their report: Sex Worker Health Inclusion Report: a community-led overview

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