



Health Bill Public Bill Committee Evidence submission: Improving health inequalities by giving a voice to underserved communities

Introduction

We are a group of leading homelessness and inclusion health charities who challenge housing injustice and the deep health inequalities that arise as a result. Through our work at the frontline, we see the deep harms caused by the failure of the health and social care systems to meet the needs of people facing homelessness.

The NHS Modernisation Bill proposes significant changes to how patient voice and experience are represented within the health system. We welcome this as an opportunity to deliver on the ambitions of the National Plan to End Homelessness and the 10-year Plan by creating an NHS that properly cares for people facing homelessness and other people experiencing huge health inequalities and housing precarity ([inclusion health groups](#)).

As the Bill progresses through the House of Commons, we believe that there are areas that warrant further scrutiny to ensure that the Bill delivers on the Government's promise to ensure the experiences of "seldom heard" groups and diverse communities inform service design and delivery, helping to improve outcomes and reduce inequalities.

Why this matters

1. **People are dying needlessly.** The mean age of death for someone sleeping rough is in their 40sⁱ and a third of people who die lose their lives from treatable conditionsⁱⁱ.
2. **Needless pressure is being placed on the NHS:** There are insufficient services to meet the health needs of people facing homelessness and in other inclusion health groups, driving them to use expensive hospital services more intensively. People experiencing homelessness have higher emergency hospital admissions, longer stays, and more frequent readmissionsⁱⁱⁱ.

3. **People are not counted.** People experiencing homelessness and other inclusion health groups are currently invisible in healthcare data and underrepresented in local needs assessments, commissioning decisions and national policymaking. This perpetuates the cycle of patchy services, run on short-term, piecemeal funding, that fail to meet their needs.
4. **People are ignored.** Inclusion health patients face structural barriers - stigma, no fixed address, digital exclusion, and institutional mistrust - that standard consultation and commissioning processes systematically fail to overcome. This means that their experiences are not taken into account, which is a missed opportunity for services to improve.
5. **The NHS can help end homelessness.** The Department of Health and Social Care has signed up to the National Plan to End Homelessness, but we will not achieve its objectives to end the scandal of people being discharged from hospital into homelessness or halve long-term rough sleeping without change in how people who are homeless are involved in decision making.

Clause 65, Schedule 10, paragraph 8

The Bill aims to transfer the local Healthwatch function into ICBs and local authorities, giving them new responsibilities for collecting, analysing and acting on patient feedback. This will be mirrored at national level by the creation of a new national patient experience directorate within DHSC, led by a National Director of Patient Experience, replacing Healthwatch England.

Government has stated that the new arrangements will ensure the experiences of “seldom heard” groups and diverse communities inform service design and delivery, helping to improve outcomes and reduce inequalities. **However, there are no statutory duties or provisions in the Bill to ensure this.**

Removing independent oversight and relying on ICBs to reach inclusion health groups themselves, without making it a legal requirement, risks marginalising people experiencing homelessness and other inclusion health groups even more. This is exacerbated by the difficulties these communities face in using generic consultation mechanisms.

The Bill’s changes to patient voice mechanisms could instead be an opportunity to strengthen the voices of the country’s most marginalised communities, leading to service improvements, better accountability, efficiencies for the NHS and lives saved.

Recommendation: To improve the quality of services for people facing homelessness and in inclusion health groups, and to ensure there is genuine accountability, ICBs should be required to:

- **Make specific, documented arrangements** to engage inclusion health populations, beyond generic public consultation exercises;
- **Use proactive and outreach-based methods** when consulting on service design and commissioning priorities, drawing on the expertise of the local VCSE;
- **Demonstrate** that engagement has taken place with inclusion health groups through a reporting requirement in their annual plan;
- **Ensure paid, supported participation** for people with experience of inclusion health circumstances, addressing barriers to involvement such as transport.

For further information or briefing, contact dee.oconnell@pathway.org.uk .

ⁱ [Deaths of homeless people in England and Wales - Office for National Statistics](#)

ⁱⁱ [A third of homeless deaths are from treatable conditions | UCL News - UCL – University College London](#)

ⁱⁱⁱ [Homeless Hospital Care - Health Research Authority](#)