Public Health Devon

Devon County Council

UNDERSTANDING ACCESS TO PRIMARY CARE FOR PEOPLE EXPERIENCING HOMELESSNESS IN TORRIDGE, DEVON

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Executive Summary

Homelessness and rough sleeping are significant issues in Torridge, a predominantly rural and coastal region of north-west Devon. Two local organisations working with PEH (people experiencing homelessness) in Torridge, Taw and Torridge District Voluntary Services (TTVS) and Encompass Southwest (Encompass SW) report much higher numbers of rough sleepers than are reflected in local authority records. TTVS and Encompass SW have recognised that PEH in Torridge face challenges accessing universal health care services in the area, including primary care, pharmacy, and dental care. There are several specialist primary care medical services for PEH in Devon, however, in Torridge PEH predominantly rely on mainstream primary care. TTVS partnered with a range of local organisations and individuals with lived experience of homelessness to set up a four-week pilot in Bideford running in January and February 2025. The project aimed to identify barriers and enablers for PEH in accessing primary care in Torridge and explore how these insights could inform existing mainstream services. The project also assessed the need for a specialist inclusion health service and explore what such a service could look like in Torridge. Key survey findings highlighted that adverse personal circumstances such as substance misuse, poor mental health and complex lives were major barriers to making initial contact with primary care. Negative experiences of primary care were related to feelings of being judged, not listened to and for some a deep mistrust in healthcare providers, and the wider healthcare system. Dental care was perceived to be non-existent and prohibitively expensive. An ideal primary medical service would be a flexible, drop-in model that takes a holistic approach in which medical care, housing needs, mental health, and substance misuse issues could be addressed at the same time in the same place. Based on this work, a set of practical recommendations has been developed to improve equitable access to primary care for PEH in Torridge, that can be applied to the wider primary care system across Devon. Key recommendations include:

- Recognising the vital role of VCSE organisations in identifying unmet health needs.
- Expanding specialist primary care inclusion health service to Torridge.
- Implementing trauma-informed care training for all staff working in general practice.
- Reframing reception roles as care navigators to support access.
- Implementing the Pathways standards for reception teams.
- Promoting leadership that champions equity and flexibility in care.
- Improving coding of inclusion health patients to better identify individuals that may require reasonable adjustments.

Introduction

People experiencing homelessness (PEH) have significantly poorer health outcomes than the most deprived individuals in the UK. In the UK, the mean age of death for a homeless male is 45 years and a homeless female is 43 years[1]. The inverse care law first coined by the GP, Julian Tudor Hart in 1971, perversely states that those who need healthcare the most are the least likely to receive it[2]. Unfortunately, the inverse care law could not be truer for PEH.

Despite high levels of poor health, PEH often engage with healthcare services in a way that does not support their long-term health and well-being. Barriers to accessing primary care services mean that problems remain untreated and become more serious and complex. Consequently, PEH use acute and emergency services more than the

general population and present with high levels of need when doing so[3]. One study demonstrated that up to 70% of PEH individuals presented to the Emergency Department with problems that were deemed to be urgent, very urgent, or requiring immediate resuscitation by medical staff[4].

Primary care services in England include general practice, community pharmacy, dental, and optometry services. These services are focused on prevention of ill health, diagnosis, and treatment of common conditions, as well as referral to specialist services when required. The current structure of primary care services in England normally relies upon individuals being able to proactively seek care, access the GP during standard working hours, provide a fixed address, and be reachable by phone or email. This places the responsibility for protecting one's health with the individual. However, PEH are often required to prioritise shelter, safety, and basic survival over their healthcare needs. This, combined with frequent relocation, especially if re-housed in a different area, makes accessing primary care challenging. Many GP surgeries utilise a range of digital services to communicate with patients, that may include texts, access to the NHS app and online triage platforms. One study found that only 54% of PEH had a working phone, making digital exclusion another barrier to accessing primary care[5]. These are just a few of the factors that make it challenging for PEH to access and engage with primary care services

Non-attendance is often framed as an individual's choice; to the detriment of the service in terms of cost and efficiency[6]. However, the non-attendance problem can be re-defined by applying a 'missingness' lens to health policies, in which services need to adapt to meet all patients needs and are committed, resourced, and incentivised to identify and address barriers. This 'missingness' lens is reflected in the NICE guidelines for Homelessness, and emphasises that outreach, low-threshold services, drop-in clinics, flexible opening times, 'one-stop shops' and trauma-informed care have been shown to improve access and engagement to healthcare services for PEH [7].

Background

Specialist primary care for people experiencing homelessness (PEH) is typically located where demand is greatest, often in urban settings. Within Devon County Council's locality, Exeter has the largest number of PEH. Data from Exeter local authority in 2022 recorded 811 single homelessness applications and 189 verified rough sleepers[8]. Primary care commissioning is the responsibility of NHS Devon and in 2024 it commissioned a newly established Community Interest Company, Inclusion Health Devon, to deliver primary care services to PEH within Exeter and Barnstaple, as the areas identified as having the greatest need. Services are provided at Collab in Exeter and the Freedom Centre in Barnstaple. In Exeter, Inclusion Health Devon operates within a multi-agency wellbeing hub alongside mental health, drug and alcohol services, outreach and navigator teams. It has been widely praised by staff, service users, and external reports as a centre of excellence and a model of good practice[9].

The National Centre for Rural Health and Care and the All-Party Parliamentary Group (APPG) joint inquiry argues that tackling health inequalities must address urban-rural divides. The inquiry highlights that service provision in rural, remote, and coastal UK areas lags behind that of urban centres, leading to poorer health outcomes. The report argues that a delivery model that concentrates services in urban areas fails to meet rural needs, and that primary, community, and social care services have been poorly designed for these populations[10]. The APGG parliamentary inquiry also observes that

rural deprivation is often hidden because of current health and social care indicators used, which tend to reflect urban realities more visibly. The Chief Medical Officers (CMO) 2021 annual report concluded that a better understanding of health and social care needs of coastal communities was needed and that addressing lack of data and actionable research was a priority[11].

In Ilfracombe, a coastal town in North Devon, a 12-month project was launched in response to the health needs of the local homeless and vulnerably housed population. Funded by Devon ICS and NHS England's Innovation for Health Inequalities Programme, the initiative established a twice-monthly GP-led clinic at Belle's Place, running from October 2023 to October 2024. The project recognised that homelessness and rough sleeping are not confined to urban centres like Exeter but are also pressing issues in rural and coastal areas such as Ilfracombe. The project was hosted by Belle's Place, a well-established community hub run entirely by volunteers that supports many individuals that are homeless or living in insecure rental housing. Belle's place provides hot meals, showers, clothing, and support services, including help with housing, substance use, and alcohol issues. Positive outcomes from the 12-month project included patients reconnecting with their regular GPs and participating in national screening initiatives, such as bowel cancer screening. Over a 10-month period, the clinic, delivered at a cost of £3,420, significantly improved access to primary care for many PEH[12]. The project introduced an innovative model in Ilfracombe, highlighting the vital role of community hubs like Belle's Place in supporting vulnerable populations. However, its long-term impact has been constrained by the short-term nature of the funding.

Torridge, a rural and coastal district in North Devon, is marked by high levels of hidden deprivation. Data from 2021 reported 482 single homeless approaches in the area, with 15% resulting in temporary accommodation placements[13]. Torridge District Council's 2020–2025 homelessness strategy identifies two to three rough sleepers at any one time[14]; however, frontline insights from Encompass Southwest, a local organisation supporting PEH indicate that the true scale is significantly underestimated. Recognising the extent of unmet need, Taw and Torridge Voluntary Services (TTVS) and Encompass Southwest approached the Devon Public Health team in November 2024 to explore whether a specialist commissioned primary care service for PEH could be introduced in Torridge, building on the existing Inclusion Health Devon model. The organisations reported a growing number of individuals experiencing homelessness or insecure housing who were struggling to access mainstream healthcare services, and that the provision of specialist inclusion health service was required. While commissioning responsibility lies with NHS Devon, there was shared system agreement on the importance of better understanding how PEH currently engage with primary care services in Torridge, and the potential to use learning from Torridge as a case study for considering more broadly how the Devon system can increase equity of access to primary care for inclusion health populations. These insights would help strengthen both universal service delivery and the case for future specialist provision. The pilot project was designed not only to gather these insights but also to explore how people with lived experience of homelessness would prefer to access healthcare. Bideford was chosen for the location of the pilot due to strong VCSE (voluntary, community and social enterprises) sector involvement and established community partnerships.

This report was produced by a GP registrar as part of a year-long population health fellowship focused on addressing health inequalities in primary care. It contributes to a broader piece of work exploring how access to primary care for inclusion health groups in Devon can be made more equitable. Informed by clinical experience in

mainstream general practice, the author acknowledges both the current systemic pressures and the strong on-going commitment within primary care to reduce local health disparities. The report highlights examples of effective practice and identifies areas for improvement, guided by insights from individuals with lived experience of homelessness. It aims to support reflection on how small, sustainable changes can be embedded into routine care to improve access for marginalised populations.

Aims and Objectives

The objectives of this project:

1. Identify barriers preventing PEH from accessing and engaging with mainstream primary care in Torridge.
2. Consider strengths and areas for improvement of current primary care services.
3. Assess the local need for a specialist inclusion health service and explore what such a service could look like in Bideford.

Insights gained could help to inform future health provision for PEH in Torridge, and potentially more broadly throughout Devon via the Inclusion Health Action Plan and partnership.

Methodology

Project Design

The pilot was spearheaded by TTVS and designed and implemented by representatives from local organisations supporting PEH. Representatives from the following organisations were invited to attend each session.

- Taw and Torridge Voluntary Services (TTVS): a Torridge-based charity that delivers projects aimed at building healthier, more resilient communities.
- Encompass Southwest: a charity operating across North Devon, Torridge, and West Devon that provides services including rough sleeping support and housing advice.
- Harbour-Bideford: a day centre providing food, shelter, support, and information for PEH and vulnerably housed individuals.
- Together Drug and Alcohol Support: provides support for adults in Devon dealing with drug and/or alcohol use, with outreach services in Bideford. Their services include counselling, advice, and treatment.
- Bideford Lighthouse Project: provide supported accommodation for people with substance misuse seeking to maintain abstinence-based recovery.
- Torridge District Council Housing Team.
- The Hepatitis C Trust: national charity aiming to eliminate Hepatitis C infection via community testing and treatment.

The pilot was advertised via posters at Harbour-Bideford and TTVS, as well as through social media and word of mouth. The pilot was hosted at Harbour-Bideford whereby a drop-in service, providing hot food, drinks, and showers was operated. Individuals from the Lighthouse Project with lived experience of homelessness prepared meals and acted as peer mentors. Sessions ran on January 7th, 14th, 28th, and February 4th, 2025, from 10:00 AM to 2:00 PM.

Survey design

Survey questions were developed collaboratively by the participating organisations and were refined after the first two sessions to better reflect participant concerns. The survey was designed using Microsoft Forms and circulated to peer mentors prior to each session. The surveys were conducted in a private and confidential setting at TTVS by peer mentors. Conversations were not recorded or transcribed. The survey was designed to be used as a prompt to explore challenges in an informal way.

Participants

Participants were individuals who came to Harbour-Bideford for food and shelter and were approached by peer mentors to take part in the project. Participants had experience of being homeless or vulnerably housed. Participants were provided with an information sheet outlining the aims of the project and were required to sign a consent form before participating. The project adhered to Devon County Council's governance guidelines.

Funding

A £500 grant was provided by Devon Public Health team which helped towards food and printing costs. TTVS and Encompass SW also contributed £150 each towards the project.

Survey analysis

Thematic analysis was used to examine survey responses using the methodology described in Braun and Clark's paper [15]. Responses were read multiple times to ensure familiarity with the data. Distinct codes were identified and grouped into meaningful categories. Four broad themes were generated: GP appointments, attitudes towards healthcare providers, mental health, and dental care. The number of supporting quotes for each theme was calculated.

Results

Quantitative results

22 surveys were completed.

Figure 1: Respondents currently registered with a GP practice

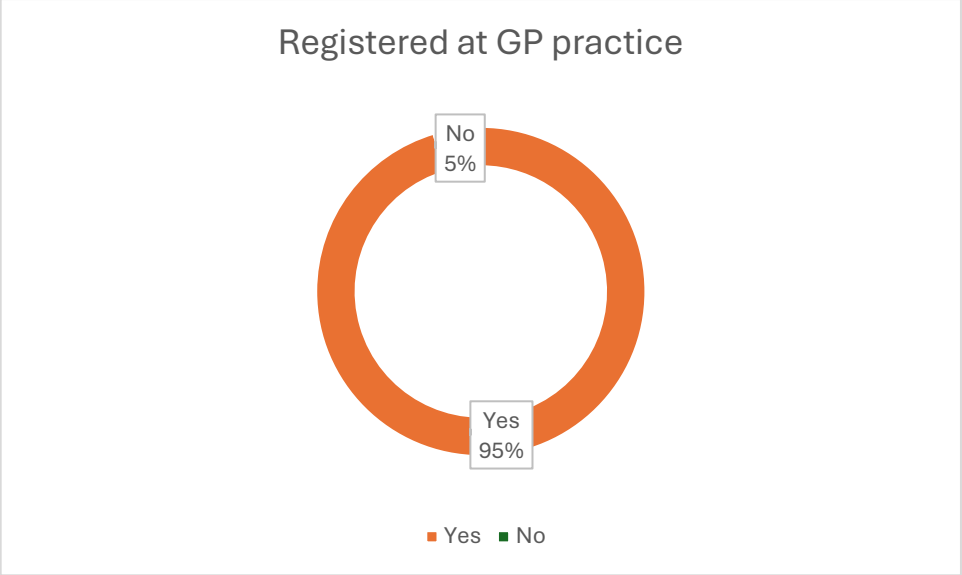
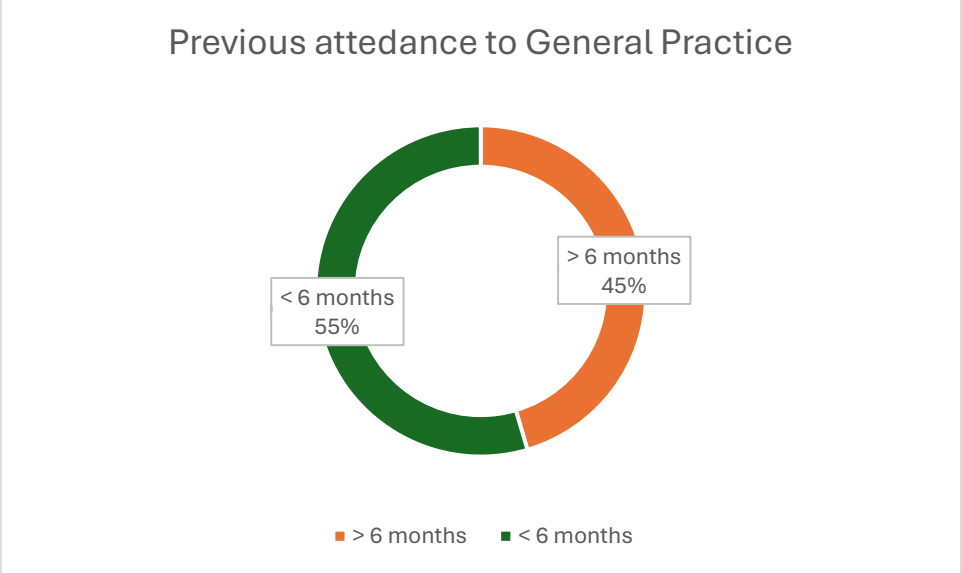


Figure 2: Time since previous engagement with General Practice.



Qualitative findings

GP registration and appointments

95% of respondents were registered with a GP. Approximately a third of respondents found registering with a GP practice easy and straightforward. However, respondents faced significant challenges with GP booking systems, particularly the 8am call-in which many found restrictive. Some preferred phone or face-to-face booking over online apps and triage systems. Appointments were often scheduled weeks in advance, making future attendance difficult due to unpredictable personal demands. Reception staff were perceived to play a pivotal gatekeeping role, serving both as facilitators and for some a hindrance. These findings highlight their role as navigators, with the capacity to help guide patients through the healthcare system.

“I do find it hard with Receptionists. They appear to get very offended, very quickly. Especially if I accidentally use bad language, or I am in an aggravated state... If I know a certain receptionist is there, it would stop me wanting to go, or alternatively, I would misbehave with them and want to show them up.”

Respondents cited a range of personal factors as significant barriers to booking or attending appointments. These included social disorganisation, mental health struggles, and reluctance to call due to multiple health concerns.

“I get easily frustrated through inability to communicate properly. Difficult to keep appointments because life gets unmanageable.”

“I struggle to make appointments due to mental health issues. When made, I will attend.”

Key enablers included digital appointment reminders and support from family, partners, support workers, and housing staff. Without this assistance, many found accessing care nearly impossible.

One respondent said: *‘staying in supported housing and so was assisted to register by key worker. Would have struggled without assistance.’*

The responses highlight an additional requirement over and above what the general population receive to help PEH book and attend GP appointments. Without this extra support challenging life circumstances, such as drug and alcohol dependence, or poor mental health made attendance unattainable for many.

Attitudes towards Healthcare providers

Responses highlighted positive and negative experiences with healthcare providers in primary care and the wider healthcare system and that these experiences shaped future engagement. Many respondents reported supportive interactions with pharmacists, nurses, and GPs, and described feeling valued and being able to build trust with staff.

“The pharmacist has a really good attitude towards everyone who goes there. Actually talks to you like a human, not a piece of scum that has walked off the street. It humanises the problem.”

“I find it very easy with the doctors.”

“No problems at all, Doctors and Nurses very friendly.”

Others shared more negative experiences alongside structural issues such as lack of continuity of care and short appointment times. One respondent was reluctant to make an appointment in the first place due to wanting to discuss multiple issues and felt that they would not be addressed at the same time. Female respondents also expressed a concern regarding no choice of clinician, preferring a female GP when discussing personal issues.

“It took nine contacts with nurses and GP: speaking to a different one each time. I found this whole experience upsetting. Had I been able to speak to one GP I'm sure it

would have been less stressful, also, I had so many different responses each time I spoke to someone."

"Struggled to make appointments due to several issues and feel they can't be addressed at the same time."

A strong sense of mistrust in healthcare providers, and feelings of being judged and not listened to repeatedly emerged in discussions. While structural barriers posed challenges, the perceived attitudes of healthcare providers seemed to have a more profound impact on respondents. Many respondents felt dismissed by doctors, leading to frustration and disengagement from care. Some felt embarrassed by how they were treated and avoided seeking help again.

"I think they are dismissive, so I just give up."

Mistrust was related to a lack of trust in doctors, but also the wider NHS, with many feeling let down by mental health providers and secondary care. Some respondents cited past misdiagnoses or clinicians not seeking a second opinion as reasons for an erosion in trust, making them hesitant to engage with healthcare services again.

"Cannot put any trust into the process, never mind the people...."

"They guinea-pigged me on loads of antidepressants and none of them worked."

Many respondents felt judged, and believed healthcare providers viewed them through the lens of their past behaviour rather than their current needs, reinforcing their reluctance to seek help. Some thought that health care providers were being actively prejudiced and felt that they were not being taken seriously or treated with respect.

"Not very comfortable. The last time I went I told them he was prejudiced. Every time I come here, I can see the shutters going down. So I don't bother engaging. If you tell them the truth, they shut down and don't want to help you."

"I feel like they just look at my past behaviour and don't want to help in a new way."

These findings underscore the importance of compassionate, trauma-informed care to rebuild trust and improve engagement with primary healthcare services for PEH. Without efforts to address these concerns, many will continue to feel alienated from the services meant to support them.

Mental Health Services

Survey responses revealed a widespread lack of suitable mental health support for PEH, with most respondents feeling services did not meet their needs. Many were frustrated by the perception that help was only available in crisis, requiring them to be in a "real bad way" before receiving support. Many reported that long waiting lists prevented timely interventions which for some individuals resulted in harmful behaviours such as attempting suicide or using drugs.

"There was no support for the last 2 years, the waiting period is too long, so I would use again before receiving support."

“If intervention had been quicker, I would have not attempted suicide.”

Even when psychological therapy was provided, many felt it was too short to be effective, leaving them without ongoing support.

“You would be seen for 5 sessions, and then that's it. It should be what you need from it.”

Another challenge was the exclusion of individuals with substance use issues from mental health services. Many described their struggle with substance use as a direct response to their mental health problems yet were denied support because of it. Many felt trapped in a cycle of being passed between different agencies, with no single service taking responsibility for their care.

“Talkworks referral was made, but help was stopped because I was drinking.”

“I was using drugs so I haven’t ever had support for my mental health. Mental health services won’t see me because I use drugs, but I use drugs because of my mental health.”

Dental care

Dental care was highlighted as being virtually non-existent in Torridge.

Access to emergency dental care was a ‘nightmare’ with the closest emergency NHS dental provider located in Barnstaple, ten miles from Bideford. The cost of dental care was described as totally unaffordable, even for those working. Many respondents had visible decay that was noted by peer mentors in survey responses. Many respondents reported severe issues with their dentition, as described dental care as a ‘real issue’.

“I have problems with all my teeth”

“ …. looking to make a claim against an assault on me that knocked out 7 teeth.”

Oral health is linked to overall health, with poor dentition leading to numerous issues such as malnutrition, pain and low self-esteem[16]. These findings show that for PEH in Torridge, NHS dental care is absent and prohibitively expensive.

Ideal health provision for PEH

Local organisations supporting the pilot project were able to provide specialist support for survey respondents at Harbour-Bideford. The Hepatitis C Trust was able to provide Hepatitis C testing and treatment to one individual. Another individual confided in wanting to seek medical advice about an issue they were embarrassed about, and was reassured that their issue was legitimate, and signposted to the GP. Peer mentors from the Lighthouse Project with lived experience were able to share their own personal stories with participants, and were able to discuss journey to recovery from alcohol and substance abuse in a meaningful way. Numerous survey respondents reported that Bideford lacked a multi-agency centre in which all their needs could be met at the same time. Several survey responses noted that a drop-in clinic where pre-booked appointments were not required would better enable them to access medical care.

One respondent commented:

“I would like to talk to someone when I am able to, when I feel I can, I can’t make all the appointments and I can’t remember to keep them.”

“Somewhere all someone’s health needs could be met in one place, like the Freedom Centre in Bideford, or the Clocktower surgery in Exeter”

Respondents supported holistic, multi-agency healthcare models of care, that operated a flexible approach whereby multiple needs could be addressed in one place. There was evidence of respondents wanting to engage with multiple services at Harbour- Bideford.

Limitations

The conversations with peer mentors and participants were not recorded and transcribed, limiting the depth of analysis. This was due to the project's short timeframe of two to three months. Data collection was done in a quick and practical way, rather than adhering to a detailed research methodology.

The Primary Care Network (PCN) was invited to have a representative at the pilot, but due to prior commitments, no one was able to attend.

Implications and Recommendations for Primary Care

The findings of this pilot project, conducted in Bideford, Torridge, have broader implications beyond the local context. They are particularly relevant to general practices and PCNs operating in rural and coastal regions, where specialist services for PEH and other marginalised groups are often lacking. While this project focused primarily on PEH and those who are vulnerably housed, wider research evidence corroborates that the barriers identified are similarly experienced by other groups facing social exclusion, including individuals affected by substance dependence, refugees and vulnerable migrants, people in contact with the criminal justice system, sex workers, and Gypsy, Roma, and Traveller communities. Collectively referred to under the umbrella of inclusion health, these populations often face complex and overlapping health challenges, compounded by systemic barriers to healthcare access.

The lessons learned and recommendations developed through this project offer a framework that can be applied to improve access to primary care for PEH, and also inclusion health populations.

Accurate Identification and Coding

A foundational step in addressing access disparities is the accurate identification and coding of patients from inclusion health groups within GP electronic systems. Data demonstrates that these populations are often missing from primary care datasets, limiting practices' ability to proactively support their needs[17]. In Torridge PCN, existing GP registration forms already collect some relevant information, such as whether a patient has ‘no fixed abode’ or requires an interpreter and include ethnic categories such as ‘Gypsy or Irish Traveller’. GP practices should ensure that this information is systematically transferred into a patient’s electronic health record and is visible to clinical and non-clinical staff to inform practice. In addition, practices should explore

additional methods to identify and document individuals who are homeless, and/or considered to be in an inclusion health groups, given that standard GP registration forms do not routinely collect this data. Accurate coding would enable practices to flag individuals who may benefit from additional support and help clinical and non-clinical staff to apply reasonable adjustments when engaging with these patients. This approach also supports targeted population health management strategies and improves data quality for the commissioning and planning of services.

Key Points:

- Improve identification and coding of inclusion health patients in GP systems.
- Ensure registration data is integrated into electronic health records.
- Use accurate coding to flag vulnerable patients that may require reasonable adjustments.

Enhancing the Role of Reception Staff

Reception staff are often the first point of contact, and their ability to guide patients effectively through the system can significantly influence engagement and outcomes. In this pilot, they were often perceived as the 'gateway' to care. Their role was identified as pivotal, either enabling access or, inadvertently obstructing access to services. One approach suggested in the literature is reframing their role as "care navigators," reflecting the broader, more supportive function that reception staff can serve in guiding patients through the primary care system, particularly for individuals unfamiliar with, or who feel marginalised by primary care[18]. This project found that the involvement of a patient advocate, or support worker can help patients to make and attend appointments, navigate the system, and act as trusted intermediaries, thus improving engagement with healthcare. The GP registration forms used within Torridge PCN in their current format do not allow the contact details of a support worker to be recorded. Consideration of how procedures may need to be amended so these details can be added to the patient record is needed. For example, follow-up communication from reception staff, or amendment of the current GP registration forms. In addition, Pathway standards recommend offering longer appointments with a named GP, recognising that PEH often present with multiple and complex health conditions[19]. Continuity of care is particularly important for this population and contributes to more meaningful and effective clinical interactions. Introducing such adjustments can reduce missed appointments, enhance patient outcomes, and help to build more trusting relationships between patients and healthcare providers.

To facilitate such changes, the practice leadership team plays a critical role in shaping a culture that empowers its staff to recognise that PEH and inclusion health groups face substantial barriers to accessing healthcare and may require additional support beyond what is typically offered. However, balancing the needs of all patients in the practice given the current pressures that primary care face is not without its challenges. Despite this, recognising that PEH may need more flexible approaches is not about offering preferential treatment but rather ensuring equitable access to care in the face of multiple and complex disadvantage. Flexible approaches should be considered for all patients in inclusion health groups. Given their independent structure, GP practices are well placed to implement operational changes quickly.

Key Points:

- Consider re-framing the role of reception teams to act as 'care navigators' to support patient access.
- Implement the Pathway standards for reception teams.
- Practice leadership should foster a culture that recognises the additional barriers faced by PEH and inclusion health groups, promoting flexible, equitable approaches to care while balancing the needs of all patients.

Embedding Trauma-Informed Practice

A recurring theme in the pilot was that individuals experiencing homelessness often felt judged or unheard by healthcare professionals. While not necessarily intentional, these perceptions may reflect a lack of understanding of the complex and multiple disadvantages that these individuals face. Adopting a trauma-informed approach across the practice team can help address this gap. Trauma-informed care involves recognising the prevalence of trauma, understanding its impact, and integrating this knowledge into all aspects of service delivery. Trauma-informed reflective training for all staff, clinical and non-clinical, can help practices become more inclusive, reduce stigma, and build trust with patients who have historically experienced marginalisation. Delivery of trauma-informed reflective workshops are available through local trauma networks in some areas of the country, however, these are currently not universally funded and GP practices may need to apply for funding in order for them to be delivered. Embedding a trauma-informed approach in parallel with operational changes will help practices to deliver a low-threshold and more inclusive model of care.

Key points:

- Implement trauma-informed care across all staff roles.

The Case for Specialist and Integrated Services

The pilot project in Torridge demonstrated the critical role of the Voluntary, Community and Social Enterprise (VCSE) sector as a vital community asset in identifying and responding to the needs of PEH. Through a grassroots approach, local VCSE organisations, including TTVS, Encompass Southwest, and Harbour, collaborated to shed light on the significant barriers PEH face in accessing and engaging with mainstream primary care services. The strength of local partnerships, particularly the extensive networks fostered by TTVS, enabled the pilot to progress rapidly from concept to delivery. This approach not only underscored the sector's responsiveness and coordination but also its capacity to bring the voices and experiences of marginalised populations to the forefront of public health planning.

Findings from the pilot reinforced the value of integrated, multi-agency models of care. Participants in the pilot consistently expressed the need for a single, accessible location where health, housing, mental health, and substance misuse services could be delivered at the same time. While such integrated provision exists in Barnstaple and

Exeter through Inclusion Health Devon, the absence of a similar model in Torridge presents a compelling case for extending this approach to the area.

Key points:

- VCSE organisations are key partners in identifying unmet needs.
- Integrated services for PEH should be expanded to include areas like Torridge.

Conclusion

This pilot project has highlighted the complex and interconnected barriers that PEH face in accessing primary care in Torridge. Insights gathered through qualitative engagement with service users reveal how structural and interpersonal challenges intersect to create an environment that is often difficult for PEH to navigate.

Mental health services were commonly described as inaccessible, characterised by long waiting times and a focus on crisis intervention rather than prevention. Individuals with substance use issues often felt excluded from mental health support, while access to dental care was widely reported as limited to emergencies, unaffordable, or unavailable altogether.

Although nearly all participants were registered with a GP, a gap persists between registration and meaningful engagement with care. Barriers such as rigid appointment systems, limited flexibility, and digital booking platforms hindered individuals already facing significant adversity. While many respondents praised healthcare staff, others felt judged or dismissed, leading to mistrust and disengagement from primary care. Such responses often reflect years of negative experiences from across the broader healthcare system, compounded by mental health issues and substance use. It is crucial that all general practice staff recognise how past trauma influences current health-seeking behaviour. Services may appear inclusive from a provider's perspective, but without a deeper understanding of the complex and overlapping challenges PEH face, significant barriers to access remain. Delivering truly inclusive, low-threshold care requires a trauma-informed approach across all staff roles.

Despite these challenges, the pilot also identified clear enablers of access. Support from family members and key workers played a crucial role in facilitating engagement. Simple adaptations such as those recommended by the Pathway standards for reception staff could help GP practices foster a more inclusive service.

The project demonstrated the critical role of the VCSE sector in connecting with and supporting marginalised individuals. Listening to lived experience is a foundational step in designing services that meet real needs. Respondents consistently called for holistic, flexible, and integrated models of care that can accommodate the multiple and overlapping challenges they face.

The findings offer important lessons for adapting primary care provision to better meet the needs of PEH. While the broader system continues to face substantial pressures it remains essential to ask how care models can evolve to become more inclusive and

responsive. Proactively addressing the needs of society's most vulnerable must remain central to the future development of primary care.

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