

HEALTHBUS TRUST MIXED METHODS EVALUATION PROJECT

FINAL EVALUATION REPORT 2026

Prepared by the University of Southampton in partnership with HealthBus Trust

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HEALTHBUS

Specialist Healthcare for People Experiencing Homelessness

EXECUTIVE SUMMARY

This report presents the findings from a 24-month mixed methods evaluation of the HealthBus Trust, a mobile, nurse-led healthcare service providing outreach care to people experiencing homelessness. During the evaluation period, HealthBus evolved from a GP-supported model towards a strengthened nurse-led model, reflecting the charity's ability to adapt to changing clinical, financial and operational realities. The evaluation set out to understand the impact of the service across individual, community, and system levels, while also developing a robust framework for capturing outcomes in inclusion health populations.

The findings provide strong evidence that individuals supported by HealthBus are making meaningful improvements in their lives. These improvements are most clearly seen not only in clinical indicators, but in patterns of engagement, emotional stability, and gradual movement toward independence. In line with national programmes such as the Making Every Adult Matter (MEAM) Approach (MEAM, n.d.), the evaluation demonstrates that progress is best understood as a staged and non-linear journey, rather than a set of fixed endpoints.

Many individuals initially present in a position of disengagement, where accepting support is difficult and health needs are often unmet. Over time, however, patients frequently begin to engage more consistently, develop trust, and demonstrate changes in behaviour and emotional regulation.

A central contribution to this evaluation has been the development of an Outcome Observation Framework, designed to capture these more nuanced forms of change. This framework reflects the realities of working with populations experiencing multiple disadvantage and enables the service to evidence its impact in a more meaningful and systematic way.

This report highlights the importance of relational, flexible, and person-centred approaches, conceptualised as working at the pace of trust, in which the development of trust and safety is prioritised as a prerequisite for effectively addressing health inequalities and supporting recovery among people experiencing homelessness.

1. THE HEALTHBUS NURSE LED MODEL

The HealthBus Trustee Board's decision to move from a GP-led model to a nurse-led model reflects the charity's ongoing ability to adapt, pivot and respond to the realities of the external environment and the resources available to it. Operating within a challenging and often turbulent funding, operational and political landscape, the Board recognised during 2025 that the existing GP-dependent model was becoming increasingly difficult to sustain. Limited GP availability, pressure within drop-in clinics, delays around prescriptions, and reliance on a single Primary Care Network for a significant number of patients all exposed the charity to growing operational and governance risk. The Board also acknowledged that those practitioners closest to the care should lead so it can maintain being patient focused.

Rather than standing still, the charity responded in a practical and forward-thinking way. The Board supported the strengthening of nurse-led protocols, reduced dependence on on-site GP presence, and began reshaping the service around advanced nursing practice, supported by appropriate clinical oversight where required. This was not simply a cost-saving exercise, but a careful response to changing circumstances, enabling HealthBus to continue delivering safe, effective and compassionate care to people facing significant barriers to mainstream healthcare.

Financial pressures also played an important part in this decision. During 2025, trustees were navigating a reduced budget, uncertainty in grant funding, and the wider pressures affecting the voluntary and health sectors. In that context, the Board had to consider how best to protect frontline delivery while maintaining organisational resilience. The ending of the Medical Director post for economic reasons reinforced the need to build a model that was more sustainable and less vulnerable to external instability.

Importantly, the shift to a nurse-led model did not mean stepping away from medical support. Instead, it marked a redesign of leadership and governance. Responsibilities previously held within one role were redistributed across a Nurse Consultant, CQC Manager and Medical Advisor, creating a clearer and more modern structure. This strengthened accountability, empowered experienced nurses and advanced practitioners to lead care, and retained access to GP expertise for strategic advice, supervision and escalation.

While the transition brought challenges around oversight, governance and staff confidence, it also created new opportunities. The nurse-led model offers greater flexibility, improved responsiveness, stronger commissioning readiness, and a more sustainable foundation for the future. It demonstrates how HealthBus continues to evolve with purpose, ensuring the charity remains resilient, effective and responsive to the needs of those it serves.

2. BACKGROUND AND CONTEXT

At least 382,000 people were reported to be homeless in England in December 2025 (Shelter, 2025). This includes people in temporary accommodation (a large and growing group), people sleeping rough and many forms of hidden homelessness e.g. sofa surfing and overcrowded or insecure housing.

Rough sleeping in 2024 was 164% higher than 2010 with 4,667 people reported to be sleeping rough on a given night (Greaves, Barton, et al., 2025). It is well established that the rough sleeping count is much lower than actual numbers as it is based on a single night in the autumn. Hidden rough sleeping is easily missed, such as sleeping in cars, tents in secluded areas, stairwells, derelict building and rural areas (Homeless Link, n.d.). Therefore, we can be confident that numbers of people rough sleeping across the year are much higher.

Although there was a partial fall during the COVID19 pandemic, rough sleeping is now back at pre-pandemic levels and continuing to rise (Greaves et al., 2024). Wider homelessness is also rising, with 132,410 households in temporary accommodation in 2025, nearly three times higher than 2011 and an increase of 7.6% in one year (Greaves, Kirk-Wade, et al., 2025).

In the South West, including Bournemouth, rough sleeping and temporary accommodation use follows the national trend, with additional pressures on housing and services due to high numbers of seasonal visitors, high private rents, seasonal employment and shortages of affordable housing.

People experiencing homelessness have poor access to healthcare despite having higher need and poorer health outcomes compared to the general population (NHS England, 2023). Health inequalities together with missed opportunities for prevention and support are particularly prevalent in this population (Hertzberg et al., 2025). Characteristically, emergency care use is far higher with people experiencing homelessness 60 times more likely to attend A&E in a year and hospital admissions are two and a half times higher than the general population. Long term illness is common with 63% of the homeless population experiencing long-term illness or disability (Homeless Link, 2025).

Systemic barriers to healthcare include GP registration barriers, services designed for stable lives, stigma and poor previous experiences, and fragmented care. Although it is not necessary to have proof of address or identification documents to register with a GP, Health Education England training resources specifically note that this is often misunderstood, and patients are denied registration without these items (Health Education England, 2026). Services often utilise online booking systems, long phone queues, attending appointments at a future date, complex referral pathways, and provision of regular contact details; all of which create potential barriers to access (NHS England, 2023). Evidence submitted to Parliament highlighted stigma experienced by people experiencing homelessness leading to delayed health seeking, alongside mistrust of practitioners and services (Crisis, 2021). Rough sleeping and temporary accommodation lead to continued moves, including between streets, prison, hospital, hostels, and different areas which can disrupt healthcare records, prescriptions, referrals and follow-up appointments.

The HealthBus Trust delivers a specialist nurse-led CQC registered outreach healthcare service for people sleeping rough or otherwise excluded from mainstream services. Rather than expecting people to navigate complex systems and travel to a variety of places, HealthBus brings healthcare directly to the people who need it in accessible places with flexibility in appointments and clinics, reducing the barriers to receiving care. This model overcomes many of the barriers discussed by removing the need for a fixed address, offering walk-in appointments as needed, delivering care in accessible locations, supporting those distrustful or anxious of formal settings, and flexible contact for people with chaotic or changing circumstances. HealthBus offer immediate and flexible care, including basic health assessments and treatment, wound care and management of acute conditions, support with long term health issues, mental health support and signposting, and advice on substance use and harm as appropriate.

This evaluation was commissioned to provide a comprehensive assessment of the impact of this model, both in terms of individual outcomes and its contribution to the wider health and social care system.



2.1. AIMS AND OBJECTIVES

The evaluation was designed to assess the effectiveness and impact of the HealthBus service over time, with a particular focus on understanding how meaningful change occurs within a population experiencing multiple disadvantages.

A central aim was to evaluate whether the service contributes to a reduction in pressure on NHS services, particularly in relation to emergency admissions and crisis-driven care. Alongside this, the evaluation sought to identify the mechanisms through which HealthBus facilitates change, with a particular emphasis on relational and engagement-based processes, delivered at the pace of trust.

Recognising the limitations of the existing output measures in this context, the project also aimed to develop a more appropriate framework for capturing change. This involved redefining outcomes in a way that reflects the complexity of patients' lives, incorporating both observable behaviours and lived experience.

The evaluation was guided by the following objectives:

- Evaluate the effectiveness of HealthBus provision in reducing emergency admissions and referrals to NHS services among homeless individuals.
- Identify key factors contributing to the success of HealthBus services in alleviating pressure on NHS services.
- Provide evidence-based recommendations for optimising HealthBus operations and improving outcomes for homeless populations.
- Disseminate findings with other homeless services to support knowledge sharing, partnership working, and improved access to care.

3. METHODS

This evaluation adopted a mixed methods approach, drawing primarily on routinely collected service data from the HealthBus Trust. Quantitative data included information recorded through the organisation's existing patient record system (PatientSource), capturing details on service activity, clinical interventions, referrals, and patient characteristics. These data provided an overview of service delivery, patterns of engagement, and the health needs of the population accessing HealthBus.

To address limitations in how outcomes were previously defined and measured, the evaluation also involved the development of an Outcome Observation Framework (OOF). This framework was designed in collaboration with HealthBus staff and informed by existing models, including the Homelessness Outcomes Star and stages of change theory (Prochaska & DiClemente, 1983). The OOF was introduced as an additional component within routine data collection processes, enabling staff to record observable changes in areas such as engagement, emotional regulation, self-care, and motivation. As the framework is in the early stages of implementation, the data presented in this report reflects initial use and should be interpreted as indicative rather than longitudinal.

Ethical considerations were addressed through the use of routinely collected service data. All data were collected, stored, and managed by HealthBus in accordance with their organisational governance procedures and shared with the University of Southampton through a data sharing agreement. The evaluation utilised anonymised, non-identifiable data, and did not involve direct contact with patients for research purposes.

4. FINDINGS

2024-25 HEALTHBUS IMPACT SNAPSHOT:

- **2,552** clinical interactions
- **1,039** outreach nursing appointments
- **880** mental health appointments
- **382** social prescribing appointments
- **251** GP sessions
- **391** individuals seen and treated
- Delivered while operating around 3 days per week

2025-26 HEALTHBUS IMPACT SNAPSHOT:

- **3,338** clinical interactions
- **1,012** outreach nursing appointments
- **1,290** mental health appointments
- **496** social prescribing appointments
- **408** advanced nurse practitioner consultations
- **132** diabetes specialist appointments
- **532** individuals seen and treated
- Delivered while operating around 3 days per week

Data from The HealthBus Clinical Impact Report

4.1 ACCOMMODATION STATUS

Figure 1 presents the distribution of patient accommodation status at the point of HealthBus appointments over time, distinguishing between individuals who are rough sleeping and those in temporary accommodation. Across the reporting period, the data consistently show that the majority of patients accessing the service are residing in temporary accommodation, with a smaller but significant proportion experiencing rough sleeping.

Importantly, the continued engagement of individuals who are rough sleeping demonstrates the accessibility and reach of the HealthBus model, particularly for those who may face the greatest barriers to accessing mainstream healthcare services.

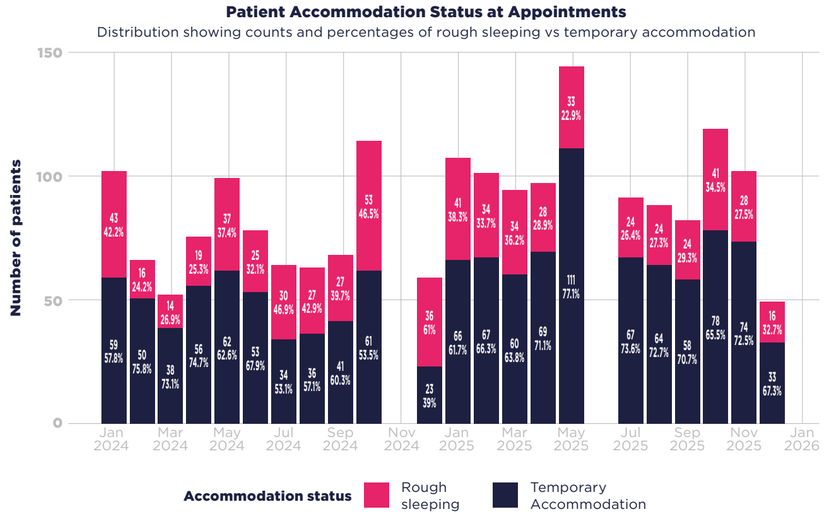


Figure 1. Patient Status at Appointments

Figures 2 and 3 present the distribution of anxiety and depression severity among patients accessing the HealthBus service, measured using the GAD-7 and PHQ-9 respectively. Across both measures, the data indicates a high prevalence of moderate to severe mental health difficulties within the patient population.

For anxiety, over half of patients (58.1%) fall within the severe category, with a further 20.9% experiencing moderate anxiety and 18.6% mild anxiety. A similar pattern is observed for depression, where 56.7% of patients fall within the severe range, and an additional 30% within the moderately severe category. Very few individuals fall within the mild or minimal symptom ranges, and no patients in this sample reported an absence of depressive symptoms.

These findings highlight the extent of mental health needs within the HealthBus population, particularly when compared to general population estimates. National data indicates that around one in six adults (approximately 16–20%) experience symptoms of a common mental health problem, such as anxiety or depression, at any given time. However, within this general population, the majority of individuals experience symptoms in the mild to moderate range. For example, prevalence estimates suggest that 22.3% of the general population meet the threshold for moderate-severe depression while 16.3% of the general population meet the threshold for moderate-severe anxiety (Centre for Mental Health, 2021). In contrast, within the HealthBus cohort, the majority of patients present symptom levels in the moderate to severe range. This indicates a substantially higher burden of mental health need, reflecting the complex interplay between homelessness, trauma, physical health conditions, and social disadvantage.

Importantly, these findings should be interpreted within the broader context of service engagement. High levels of anxiety and depression are likely to act as significant barriers to accessing and sustaining engagement with healthcare. As such, the ability of HealthBus to engage individuals despite these challenges represents a critical component of its impact.

Furthermore, these data reinforce the importance of integrated, trauma-informed approaches to care. The high prevalence of severe mental health difficulties suggests

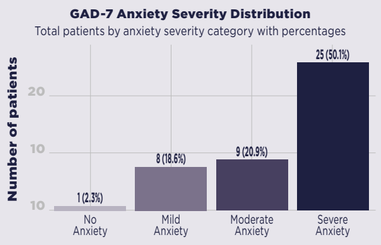


Figure 2. GAD-7 Severity Distribution

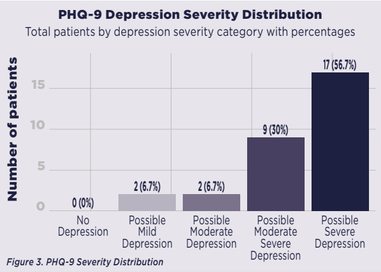


Figure 3. PHQ-9 Severity Distribution

that interventions focused solely on physical health are unlikely to be sufficient. Instead, ongoing support delivered at the pace of trust, which addresses emotional regulation, psychological wellbeing, and relational engagement is essential in supporting individuals along their recovery journey.

Although these measures have been useful in providing an initial indication of distress and helping to guide conversations about areas of difficulty, the HealthBus is increasingly moving away from relying heavily on standardised scoring systems alone and is instead developing more comprehensive, trauma-informed approaches to understanding mental health and recovery. This reflects recognition that quantitative measures can sometimes be applied in ways that feel arbitrary or fail to capture the complexity of people's lived experiences.

4.2 MENTAL HEALTH - CASE STUDY 1

Toby engaged with the HealthBus service while living in supported accommodation, presenting with complex needs including substance use, emotional instability, and patterns of involvement in high-risk and chaotic environments. Engagement was initially inconsistent, reflecting both the impact of substance use and the challenges which Toby faced in managing internal emotional distress.

Work with Toby focused on understanding and addressing both substance use and the underlying emotional drivers of behaviour. This included recognising how engagement in chaotic situations functioned as a means of avoiding difficult internal experiences. Over time, a strong therapeutic relationship was developed, enabling consistent work around emotional regulation, coping strategies, and risk management, including periods where suicide intervention was required.

Following eviction from supported accommodation, Toby was supported with housing and applications for rehab. It was recognised that past trauma was likely present but not safe to explore without a more contained environment, and engagement in a rehab placement was consistently encouraged.

Toby has since reduced his substance use and is preparing to attend rehab. He is engaging well with a range of community support, including recovery meetings and faith-based groups. Contact has reduced, but he continues to access support through the HealthBus drop-in and remains able to seek support during times of crisis.

Outcome measures completed across multiple domains showed a clear improvement over time, from low baseline scores to substantially higher scores at follow-up, reflecting both self-reported and practitioner-assessed progress. This improvement occurred despite ongoing life stressors and periods of difficulty coping without substances.

This case highlights the importance of relational, flexible care in supporting individuals with complex mental health needs. While there remains a long way to go, particularly in relation to longer-term stability and physical health, the progress observed demonstrates how sustained engagement, emotional regulation, and reduced risk-taking behaviour represent meaningful outcomes and a foundation for recovery.

4.3 CLINICAL ACTIVITY

Figure 4 illustrates the monthly distribution of clinical treatments delivered by HealthBus, including acute conditions, chronic condition management, and wound care. Across the reporting period, chronic condition management consistently represents the largest proportion of activity, reflecting the high burden of ongoing and complex health needs within the patient population. Acute presentations and wound care also remain substantial, with fluctuations over time that likely reflect both seasonal variation and the instability associated with homelessness.

The combination of acute, chronic, and wound care interventions highlights the breadth of clinical need addressed by the service. Importantly, the sustained level of chronic condition management suggests that HealthBus is not only responding to immediate health crises but is also supporting ongoing care and continuity of treatment which is an area where this population typically faces significant barriers within mainstream healthcare systems.

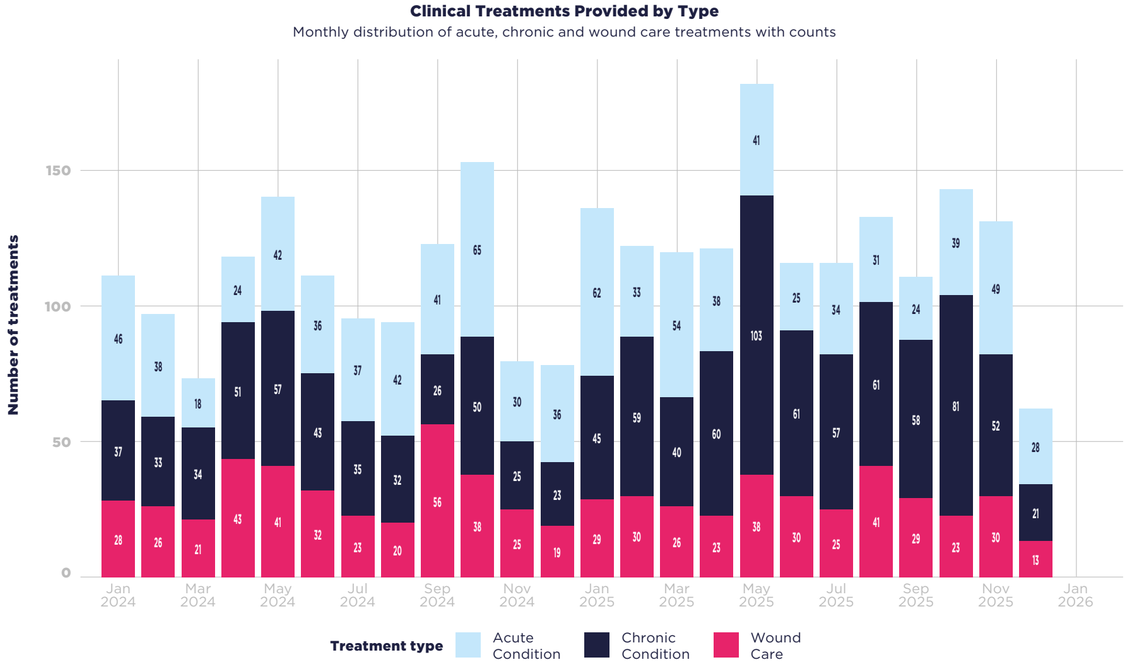


Figure 4. Clinical Treatments Provided by HealthBus Trust

4.4 ENGAGEMENT

Engagement at the Thursday drop-in over time, demonstrating an upward trend in engagement is shown in Figure 5. While attendance fluctuates month to month, there is a noticeable increase from early 2024 through to late 2025, with attendance consistently exceeding the baseline average in the latter period. Peak attendance in recent months suggests growing awareness of, and trust in, the service.

This pattern indicates that the drop-in model is successfully engaging an increasing number of individuals over time, including those who may not access more formal healthcare settings. The sustained rise in attendance reflects the importance of low-threshold, relationship-based spaces in supporting engagement, which often serves as a gateway to wider health and support services.

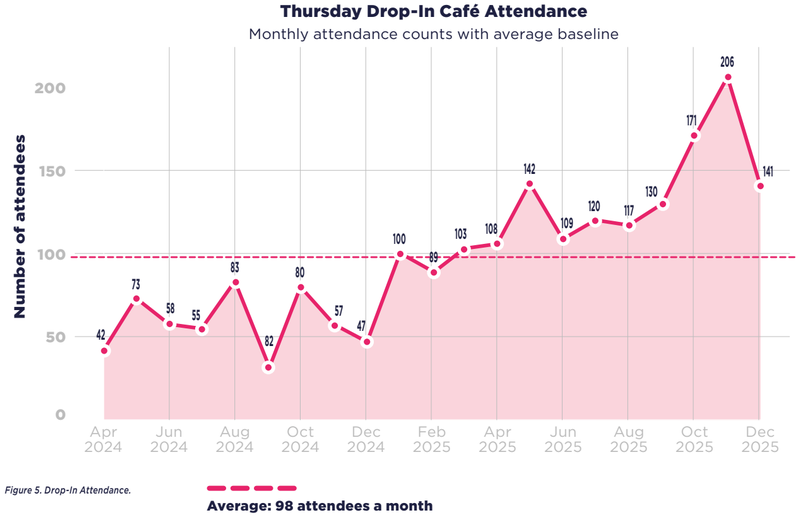


Figure 5. Drop-In Attendance.

CASE STUDY 2

William engaged with the HealthBus service following initial contact from the outreach RGN (Registered General Nurse), who had supported his physical health needs. William had previously declined support from other services, and this early engagement helped create an opportunity for further involvement.

Work began through weekly outreach at his rough sleeping site, focusing on building rapport and trust. Initially, William was resistant to moving into accommodation due to his long history of rough sleeping. Through coordinated work between HealthBus and other services, William was supported to transition into accommodation, where regular sessions continued.

Despite ongoing alcohol use, William made consistent efforts to engage, often limiting his drinking prior to sessions to enable meaningful conversations. This level of commitment was notable given his previous history of non-engagement. Over time, the work focused on building a therapeutic relationship and exploring his childhood and adult experiences, leading to a shared formulation that linked early experiences with patterns of coping, including substance use and long-term rough sleeping.

Support was also provided to encourage wider engagement, including involvement from the HealthBus social prescriber and encouragement to attend community activities such as AA meetings. While William initially responded positively, fear around this increased over time.

During the course of the work, a significant increase in William's state benefits led to increased alcohol consumption and a subsequent decline in both physical and mental health. Outcome measures reflected this complexity. While William's self-reported scores decreased over time, practitioner ratings indicated improved insight and awareness, suggesting meaningful psychological progress despite deterioration in other areas.

William reported that this was the first time he had spoken in depth about his life in this way, describing the experience as making his "head feel freer." His engagement in this work was thoughtful and reflective, demonstrating a high level of commitment despite ongoing challenges.

This case highlights the importance of relational, consistent engagement, particularly for individuals with a history of disengagement from services. William continues to remain in contact with HealthBus's social prescriber and mental health nurse, and while William may need further support with physical health or crises, this is still a foundation for future intervention. In this context, sustained engagement, increased insight, and willingness to access support represent significant outcomes, even in the absence of immediate behavioural change.

4.5 PREVENTATIVE CARE AND NHS IMPACT

Preventative care and NHS impact is displayed in Figures 6 and 7, illustrating the range of preventative healthcare delivered through the HealthBus service, with a strong emphasis on drug and alcohol support, lifestyle advice, and health screening.

A core strength of HealthBus is its integrated multidisciplinary team (MDT) model, which brings together nursing, medical, mental health, social prescribing, and partner agency expertise to deliver holistic, coordinated care for people experiencing homelessness. This model enables comprehensive assessment, shared decision making, and timely interventions for individuals with complex and overlapping physical, mental health, and social needs. MDT working reduces fragmentation, improves access to care, and supports personalised, strengths based approaches aligned with wider system priorities.

Clinical delivery is underpinned by NICE best practice guidance for inclusion health and specialist homeless healthcare, ensuring care is evidence based, safe, and responsive to need (NHS England, 2019;Public Health England, 2018). Services are also closely aligned with NHS England's Core20PLUS5 framework, supporting targeted action to address health inequalities. A strong focus on prevention and population health — including immunisation, screening, hypertension monitoring, smoking cessation, and infection management — remains central to improving outcomes for a high risk, underserved population.

Analysis from the NHS Confederation (2024) highlights that the top 20 interventions by return on investment are all community-based, in areas such as housing improvements, smoking prevention and exercise initiatives, with returns ranging from approximately £6.90 to £34.75 for every £1 invested.

Many of these interventions directly correspond to activity delivered by HealthBus. For example, substance misuse interventions and reductions in harmful drinking are strongly associated with improved health outcomes and reduced demand on acute services, while broader lifestyle interventions, including smoking cessation and physical health advice are linked to reduced incidence of long-term conditions such as cardiovascular disease and respiratory illness.

In particular, preventative approaches targeting suicide and self-harm, including reducing harmful alcohol use, have been estimated to deliver returns of approximately £19.60 for every £1 invested. Given the high prevalence of severe mental health need and substance use identified within the HealthBus population, the delivery of drug and alcohol support and harm minimisation advice represents a key mechanism through which the service may contribute to both improved outcomes and NHS cost savings.

By delivering these interventions within an outreach setting, HealthBus is reaching individuals who are least likely to engage with traditional preventative services. This is significant, as unmet need within this group often results in late presentation, crisis intervention, and higher-cost care pathways (Aldridge et al., 2018). Supporting earlier engagement through preventative advice and intervention therefore has the potential to reduce avoidable hospital admissions, emergency presentations, and long-term treatment costs.

Taken together, the profile of preventative activity delivered by HealthBus suggests that the service is operating in areas of established economic value, contributing not only to improved health outcomes but also to the long-term sustainability of NHS resources.

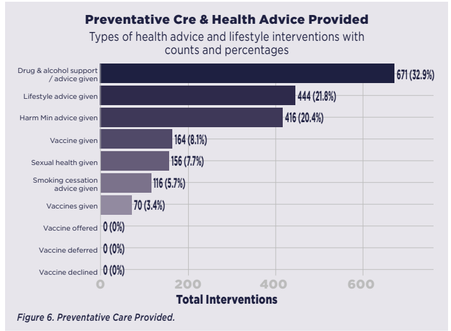


Figure 6. Preventative Care Provided.

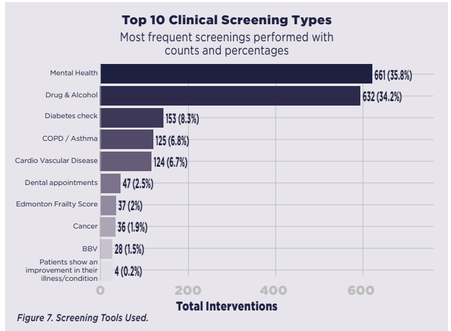


Figure 7. Screening Tools Used.

CASE STUDY 3

This case study highlights the impact of a trauma-informed, person-centred approach in supporting individuals experiencing high levels of vulnerability. Abbi initially engaged with the HealthBus service while rough sleeping and in a highly unstable position, requiring intensive support.

Through sustained engagement and close collaboration between the HealthBus team and external partners, Abbi was supported into a "Somewhere Safe to Stay" (SStS) property, providing immediate safety and stability. This formed a critical foundation for further progress.

Over time, Abbi was supported to secure a tenancy agreement for their own permanent accommodation. While the move-in date has been delayed due to property repairs, the reassurance of continued placement within SStS, alongside the security of a signed tenancy agreement, has been vital in maintaining stability and supporting ongoing wellbeing.

Alongside housing support, the HealthBus social prescriber worked closely with Abbi to address wider barriers to independence. This included supporting the renewal of commercial driving licences and enabling them to pursue employment opportunities. Demonstrating increased confidence and motivation, Abbi independently approached a local employer and received a provisional job offer, contingent on completing a medical assessment and obtaining necessary equipment. With no financial means to meet these upfront costs, the social prescriber successfully secured grant funding, removing these final barriers to employment. This support has been instrumental in enabling Abbi to move toward financial independence and longer-term stability.

Through consistent relationship building, practical assistance, advocacy, and coordinated care, the team has helped this patient move from rough sleeping to safe accommodation, financial and functional stability, and now employment opportunities — all within a few months.

4.6 PATIENT EXPERIENCE

Patients are invited to describe their experience of care from HealthBus as routinely collected feedback. These perspectives give some context to the quantitative findings presented throughout this report, indicating possible mechanisms behind the positive outcomes in care. This qualitative data adds value by explaining how or why the service is working. Additionally, it enables patients' voices to be present and heard in this report. The themes were used to present patient experiences.

Dignity and trust lead to health-seeking behaviours

People experiencing homelessness often avoid health services due to anticipated, or prior, experiences of shame or judgement. However, HealthBus creates a different environment in which patients feel they are treated with respect and patience, and given time to build a positive relationship. Being treated 'like a human being' and not feeling like 'a burden' is not simply a nice experience, but is what makes care possible.

"The HealthBus team treated me like a human being again. I felt listened to, not judged."

"You make it easy for people like me to get help. I never feel embarrassed or like a burden."

Trust is explicitly named and built through consistent, non-judgmental interactions, and this enables people to feel safe enough to engage with healthcare, even after many years without. This emotional safety is a precondition for the outreach model to work.

"This is the first time in a long time that I've felt safe enough to talk about my health."

"The nurses are kind, patient, and always explain things so I understand. I trust them completely."

Outreach is key to meet people where they are

For many people experiencing homelessness, the barriers to accessing healthcare can be both physical and psychological. HealthBus removes those barriers by coming to people rather than expecting people to navigate different sites and appointment times, reducing the effort and anxiety of attending an unfamiliar clinic.

"If it wasn't for the HealthBus, I wouldn't have gone to a doctor in years. You came to me when I couldn't go to you."

"I look forward to Thursdays now — it's the only time I feel someone genuinely cares how I'm doing."

This is not just a logistical convenience but a fundamentally different model of care, and the regular provision means patients feel known and cared for. When access and trust are in place, the impact can extend well beyond a single health episode.

Impact reaches beyond the clinic with recovery and hope

The perspectives and experiences of patients help us understand what the outcomes mean to people. There are practical changes, such as housing and medication, but also personal changes, in terms of hope, confidence and the feeling of 'moving forward'.

"They helped me sort my medication and my housing appointment in one visit — I finally feel like things are moving forward."

"You don't just fix problems — you give hope. That means everything when you're struggling."

These changes lead to longer-term change as people feel their lives are 'changed' and they are getting 'back on track'. Hope and confidence are named as outcomes for people who have experienced profound difficulty and yet are now experiencing consistent and longer-term care. This effect is life changing.



4.7 HEALTHCARE ACCESS AND SYSTEMS IMPACT

Figure 8 illustrates referral patterns to A&E and secondary care over time, providing insight into how patients are accessing healthcare services. While both referral types fluctuate across the reporting period, engagement with secondary care is often sustained or increases during periods where A&E referrals remain lower.

This pattern may suggest a shift in how individuals are interacting with the healthcare system, moving away from crisis-driven access via emergency departments toward more planned care pathways. This provides early indicative evidence that HealthBus may be supporting earlier intervention and facilitating access to care before conditions escalate to crisis point. In doing so, the service has the potential to reduce avoidable emergency presentations and contribute to alleviating pressure on acute NHS services.

Importantly, these trends should be understood alongside broader findings on engagement. Increased access to secondary care is likely underpinned by the relational and outreach-based model of HealthBus, which supports individuals to navigate healthcare systems more effectively.

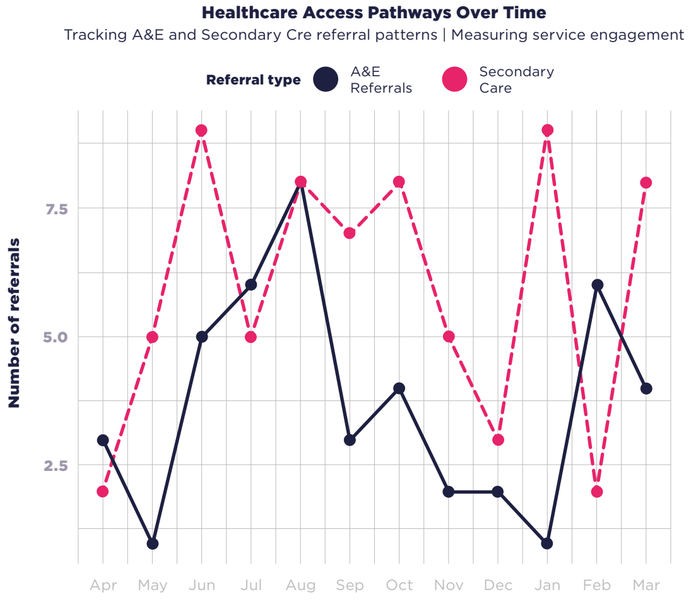


Figure 8. Healthcare Referrals.

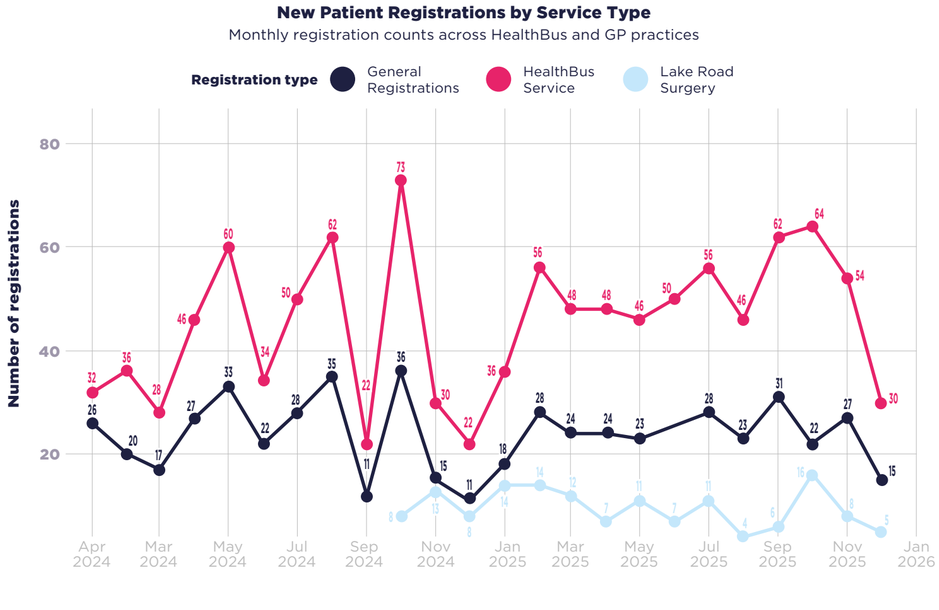


Figure 9. GP Registration.

5. OUTCOME OBSERVATION FRAMEWORK

Routinely collected data within HealthBus primarily captured service outputs, such as activity and interventions delivered, rather than outcomes that could be assessed over time. While these data provide valuable insight into service provision and likely impacts on local health and community services, they do not capture change at the individual level, highlighting the need for a framework capable of measuring patient outcomes longitudinally.

Quantitative data collection was therefore centered on the development of an Outcome Observation Framework, informed by existing tools such as the Homelessness Outcomes Star (Triangle Consulting Social Enterprise, 2019) and grounded in recovery-oriented models of change.

This framework captures progress across multiple domains, including physical health, self-care, emotional regulation, engagement, motivation, substance use, and offending behaviour. Progress is conceptualised through a five-stage "Journey of Change," ranging from being "stuck" to achieving "self-reliance."

The findings of this evaluation indicate that HealthBus is supporting meaningful and sustained change among individuals who are often excluded from mainstream healthcare systems. Consistent with evidence from national programmes such as the MEAM Approach (MEAM, n.d.)., progress is most evident when viewed over time and across multiple domains of an individual's life.

As the Outcome Observation Framework has only recently begun to be embedded within routine practice, the current dataset should be understood as an initial snapshot of patient needs and engagement rather than a longitudinal analysis of change. While this constrains the ability to assess progression over time at this stage, it represents an important foundational step in establishing a consistent and meaningful approach to outcome measurement. With continued implementation, the framework will enable robust tracking of individual and cohort-level change in future reporting periods.

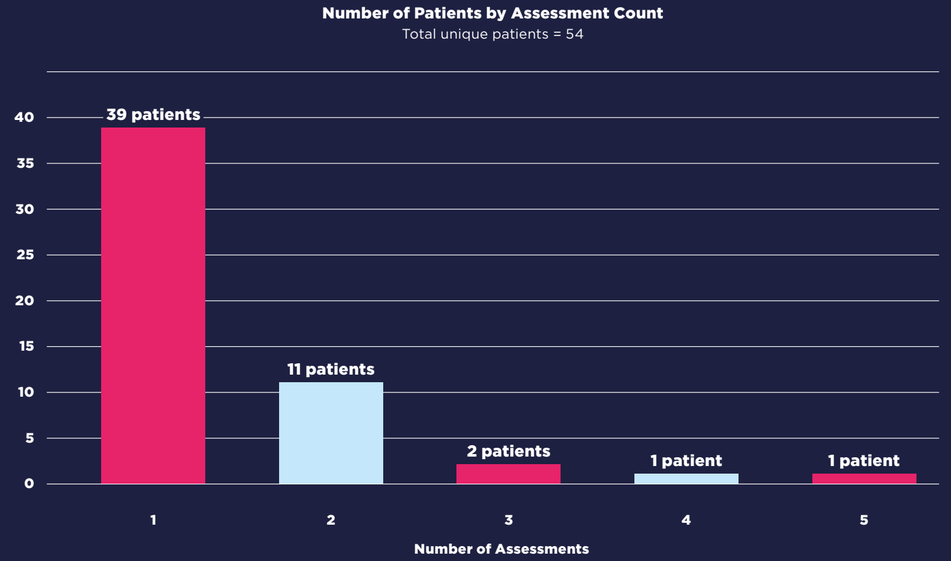


Figure 10. Patient Count for Outcome Observation Framework.

A key finding is that engagement with the service represents a significant and meaningful outcome in its own right. For many individuals, the initial barrier is not a lack of available services, but an inability or reluctance to access them. In this context, returning to the service, maintaining contact, and beginning to build trust with staff are critical indicators of progress. These early stages of engagement often lay the groundwork for subsequent improvements in health and wellbeing.

The evaluation also highlights the importance of understanding change as a journey rather than a linear progression. Individuals frequently move between different stages of readiness, and periods of improvement may be accompanied by setbacks or deterioration. This pattern is consistent with wider research in the field and reflects the complex realities of living with multiple disadvantage.

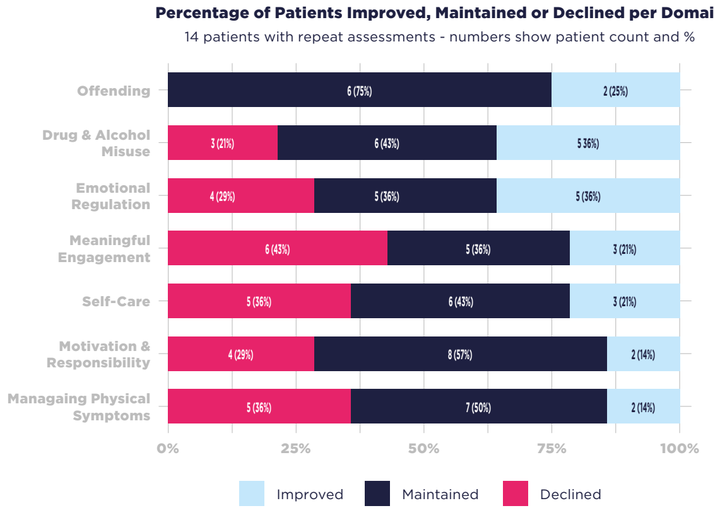


Figure 11. Patients Development for the Outcome Observation Framework.

A subset of fourteen patients completed the Outcome Observation Framework at two timepoints, allowing for an initial assessment of progression. Across this group, improvements were observed in key areas including drug and alcohol misuse and emotional regulation. While these changes may appear modest, they reflect significant behavioural shifts that are critical in enabling sustained engagement with healthcare and support services, and are often precursors to longer-term improvements (Prochaska & Clemente, 1983; See Figures 11 and 12.)

Even in preliminary data, this shift is still significant within this population, where engagement with mainstream services is often limited and emergency care is frequently used as a last resort. These findings therefore provide tentative evidence that HealthBus may play a role in alleviating pressure on acute NHS services by supporting earlier and more appropriate access to care.

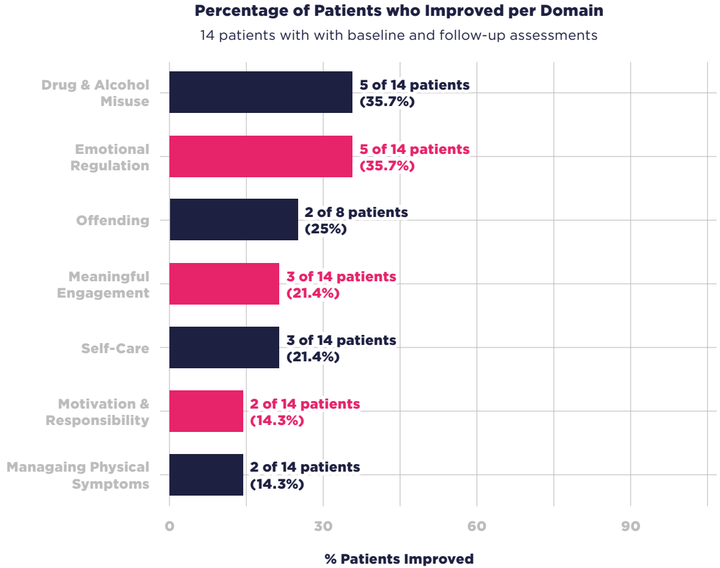


Figure 12. Patients Improvemnts for the Outcome Observation Framework Domains.

6. DISCUSSION

Across the quantitative data, several consistent patterns support this interpretation. High levels of moderate to severe anxiety and depression highlight the significant psychological barriers to engagement within this population. Despite this, increasing attendance at drop-in services and sustained engagement across accommodation types demonstrate that HealthBus is successfully reaching individuals who may otherwise remain excluded from care.

The breadth of clinical activity further reinforces the complexity of need being addressed. The predominance of chronic condition management, alongside acute care and wound care, reflects a population with both immediate and ongoing health needs. The delivery of preventative interventions including substance misuse support, lifestyle advice, and health screening indicates that the service is not solely reactive, but actively working to reduce future health risk.

The qualitative data bring patient voices into this report, illustrating how and why the service is working for this population. The development of trust through treating people with dignity and creating a safe space in which to seek help was particularly important for HealthBus patients. This enabled people to seek healthcare and continue with treatment preventing the escalation of ill-health. Outreach was key to overcoming some of the barriers associated with healthcare. As HealthBus serves in the community, they are able to bring healthcare to people, with a flexible and adaptable approach. This then leads to longer term recovery as patients are able to complete treatment plans and build confidence and resilience to continue positive health-seeking behaviours.

The findings of this evaluation reinforce a fundamental challenge in evaluating services for people experiencing homelessness: traditional outcome measures do not adequately capture the nature of change in this context. Instead, outcomes must be understood as part of a broader process that includes engagement, trust-building, and incremental behavioural change.

This perspective aligns closely with the MEAM Approach (MEAM n.d) , which conceptualises progress as movement along a "Journey of Change." Individuals often begin in a position where they are unable to engage with support, and progress involves gradual shifts in motivation, belief, and behaviour. The findings from this evaluation suggest that HealthBus is effectively supporting individuals through these stages, particularly in the early phases of engagement.

7. RECOMMENDATIONS

1. Fully embed the Outcome Observation Framework within routine practice. Continue building on the progress made during this evaluation by ensuring the Framework is consistently applied across all relevant interactions. Sustain the collaborative work undertaken with PatientSource to keep the Framework integrated within existing systems, minimising additional burden on staff.

2. Invest in data infrastructure to support longitudinal outcome tracking. Develop the systems and processes needed to capture patient outcomes consistently over time. As Framework use becomes more routine, this will create the opportunity to demonstrate patient progression across multiple contacts, including how engagement with HealthBus relates to changes in outcomes. This will help build a stronger, cumulative evidence base for HealthBus' impact.

3. Develop a clear methodology for calculating return on investment (ROI). To demonstrate the economic value of the service, HealthBus should identify the specific data inputs required for an ROI calculation, including cost-per-contact, intervention type, and outcome achieved, and map these against the nationally recognised unit costs associated with preventable conditions and emergency care (for example, using NHS reference costs or NICE-endorsed economic models such as those underpinning the Prevention Concordat).

4. Explore integration of HealthBus data with national datasets. Investigate opportunities to link routinely collected HealthBus data with national health and social care datasets such as NHS Digital records, local authority public health data, or Integrated Care Board population health management tools. This would enable more robust analysis of downstream outcomes and support a compelling economic case aligned with national preventative health priorities.

5. Position HealthBus explicitly within the national preventative health agenda. Given the strong alignment between HealthBus activity and high-return preventative interventions identified nationally, develop communications and reporting that explicitly articulate this contribution, both to demonstrate value to commissioners and to strengthen future funding bids. HealthBus has already begun taking steps in this direction by becoming a member of Homeless Link and seeking guidance on how to maintain homelessness as a priority issue for ministers.

8. CONCLUSION

This evaluation provides strong evidence that HealthBus is successfully engaging individuals who are often excluded from traditional healthcare systems and supporting meaningful improvements in their lives.

The findings highlight the importance of redefining outcomes in this context, moving beyond clinical indicators to capture the broader processes of engagement, trust-building, and recovery. Patterns observed across service activity, preventative care, and referral pathways suggest that HealthBus is not only addressing immediate health needs, but may also be contributing to more appropriate and cost-effective use of NHS services.

By prioritising relational care, flexibility, and accessibility, and working at the pace of trust as a core principle, HealthBus is able to engage individuals with high and complex needs who are otherwise multiply excluded. In doing so, the service plays a critical role in supporting earlier intervention, reducing reliance on crisis-driven care, and improving access to healthcare pathways.

All names have been replaced with pseudonyms to ensure the anonymity and confidentiality of clients.

REFLECTIONS

A series of reflective pieces from Bels, Homelessness Health Research Lead

What is our real value?

Our collaboration with Southampton University on the Mixed Methods Evaluation Research Project has been transformative. Their insights into recognizing small steps of positive change—both outputs and outcomes—have challenged us to rethink how we measure the true value of the HealthBus.

"Mixed methods" sounds like a simple term until you apply it to a complex service. Its breadth can be both a blessing and a curse. Traditionally, we focus on "stories and stats" (qualitative and quantitative data), but research encourages us to look for what is not immediately there—the patterns that only emerge over time. The challenge lies in building a framework that asks the right questions without anticipating the results. We find ourselves asking:

- **How long should the measurement timeline be?**
- **How much data is needed to demonstrate a genuine outcome?**
- **What does "good" actually look like—is it "better," or simply "less bad"?**
- **What is the real-world impact on both the individual and the organization?**

In traditional healthcare, success often relies on a patient getting "better" or managing symptoms. However, for our demographic—people experiencing homelessness—that isn't always the reality. We need different metrics. For example, if a patient returns to us consistently, is that a sign of a "trusted relationship" (success) or a sign that they remain "chronically unwell" (failure)?

By capturing often-overlooked outcomes through more uniform questioning, we can attribute real value to our work—and even calculate cost savings, such as prevented hospital admissions. A "yes/no" on hospital attendance doesn't tell the full story. But if we can show that a patient accepted advice, attended a scheduled appointment, and therefore prevented a worse outcome or promoted an earlier discharge, we have a measurable saving for the NHS.

To capture this "whole person" perspective, we are using a model named the Outcome Observational Framework, based on the Outcome Star. This allows us to observe how a person manages specific areas of their life, such as physical symptoms, emotional regulation, self-care, and substance use. We even use the "one less f-off scale" to measure engagement and offending behaviour.

By tracking a journey from 1 ("stuck") to 5 ("self-reliant"), we can visualize the "bumpiness" of a patient's life. Showing this progress over time doesn't just fulfil our moral purpose; it proves that our methodology works, feeding into a much-needed wider conversation about systemic change.

How to "research" with academics and communities

It is well documented that working collaboratively is better than in isolation; but how do you manage different people working with different timeframes, different locations, online meetings, conversations in the community - on the street or mobile clinic to create tangible outputs. How is something that provides meaningful results showing progress from the potential chaos and well-intended project descriptions created?

I try and think of things in threes to focus my thoughts and get them to paper or document my approach. This particular subject seemed to bring out collaboration, humility and curiosity.

Know right from the outset you do not have the answers.I come from a systems background, and problem-solving experience in financial services. It is hard not to try and predict what you think may happen, what will be the "A-ha, I knew it" and what will be the "I didn't see that coming" even though you thought you did. To know that you are working alongside people in all areas of the project who have the same curiosity and humility and are open to sharing their experience and expertise whilst knowing they don't have the entire answer is key to getting closer to actually capturing everything.

Having people with the right experience is key. Whether that is lived experience from the community you are working with or the

particular demographic within that community e.g. women or rough sleepers, or via experts in the field of research,the relevant experience and humility to listen to each other with open minds and curiosity to learn from the conversations, methods used previously or new ones being proposed are all essential for the research to be truly inclusive and be whole.If you have amazing data or have captured experiences or journeys from the community but have no good way of documenting it or reporting on it, no value can be assigned to the work you are doing.Equally, if you have amazing methods of capturing and analysing data but nobody wants to talk to you or engage with you then you have no data!

I have been incredibly fortunate to work with both Bournemouth University and The University of Southampton. Their teams have a wealth of experience in our particular field of work, providing healthcare to those experiencing homelessness. They have guided me and encouraged me in how to see, hear, capture, and categorise our work and the outcomes we achieve in different ways. This goes both ways. By having the relationships, we have fostered through trust and time, I know I now have the confidence to speak up on their behalf, and push back against some ideas or outdated methods of research approaches. The shift by entities such as the National Institute of Health and Research to truly want to include minorities and be open to new ways of conducting research has helped not only hear from those who would otherwise be excluded but open their ways to thinking about what barriers are really being faced by an individual. I say individual as whilst working together is important, identifying that each person has a different experience or needs ensures we really address the people within a community and not just "The Community".

This all sounds great, but you need funding to do this. Without this you have no allocated resources which can mean you either stretch your existing team and are treating the research as a nice add on or for the people taking part in the research or helping with the lived experience in put do not feel valued.If I am being paid to this, so should everyone who is working alongside me on the project.Showing people that their time is of equal value to mine is important not just because it prevents the feeling of having research done to you but ethically everyone's time is as important, even if the perception may be that someone is more or less busy than someone else.Asking how someone would like to be compensated for their time is far more empowering and compassionate than saying "you'll get a voucher for taking part".The answers even to that may surprise you, I bought a dustpan and brush for someone recently housed and that was what they really wanted.

Attribute equal worth to people's expertise, time, and the curious questions.Really listen and try and note down all the little learnings.If you are working with the right people the data is then able to speak for itself and produce outputs of value to your stakeholders and reflect the real voices of your community.

The Infrastructure of Change — Systems, Soft Skills, and the Art of Patience

In my previous reflections, I've explored how we redefined "success" through mixed methods and the power of collaborative humility. But as we move from research into reality, we face the final, most daunting hurdle: Embedding it.

How do you take these academic insights and make them part of the "day-to-day" for a team already working at full tilt on the frontline? It isn't just a matter of good intentions; it requires a deliberate alignment of our internal hardware, our team's software, and a heavy dose of radical patience.

The Hardware: Evolving our Digital Backbone

One of the most sobering lessons of this journey is that you cannot capture complex, nuanced human journeys on systems that aren't built to be flexible. To track the "Outcome Observation Framework" or measure "preventative savings" to the NHS, we needed a clinical system that could speak that language.

We were already using PatientSource, but our usage was limited with some of our patient records to free-text notes—a digital version of a paper diary. To truly embed our research findings, we had to move toward a more uniform data-capture framework. We have been incredibly fortunate to work with the PatientSource development team; they are true trailblazers and an "alternative" system in the best sense of the word.

Because they took the time to understand the "how" and "why" of the HealthBus, they showed a level of flexibility that is rare in healthcare tech. They didn't just give us a product; they worked alongside us to ensure the system actually reflected the "bumpiness" of our patients' lives. However, this level of bespoke development requires funding. You cannot ask a team to deliver high-level research data without investing in the tools that make that data accessible and meaningful.

The Software: Educating the Ecosystem

Systems, no matter how advanced, are only as good as the people navigating them. A huge part of "making it stick" has been the ongoing education of our team and our external partners.

We've had to be crystal clear about our methods. It's about moving away from research being a "nice-to-have" add-on and making it the pulse of our service. When the team understands that their notes aren't just an administrative chore, but are the evidence needed to advocate for systemic change, the culture shifts from "compliance" to "commitment." We are educating everyone on our "how" and "why" so that great patient experience becomes a maintained standard, not a happy accident.

Coming from a systems and financial services background, I'm wired to want results now. But working with the University of Southampton and our unique patient demographic has taught me the value of patience.

Embedding change is not a linear event. You have to allow time for:

- The Learning Curve: Letting the team move from the comfort of free-text notes to a structured framework.

- The Data to Mature: Changes to any data capture mean that you need to allow the new way of working to be used over a period of time, for trends to show. Waiting for the patterns of "1s" (stuck) to slowly climb toward "5s" (self-reliant) matters when you want to show that you are helping people's lives move from a 1 to a 5 or at the very least is "better".

Conclusion: From Project to Practice

As this research project concludes, the work of the HealthBus continues, but it is fundamentally changed. By securing the right funding, partnering with flexible partners like PatientSource and the University of Southampton, and fostering a culture of constant learning, we have moved beyond "doing research."

We have embedded a new way of seeing—and proving—the value of our work. Working with developers and academics to tweak the systems until they fit the reality of the street. We now have the tools to show that every hospital admission prevented, and every observation of emotional regulation, addiction and health captured is a data point of success. It takes time, it takes money, and it takes a lot of heart but that is how you turn a research project into a lasting legacy.

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