Homeless Link

Cancer screening and homelessness

Bridging the gap in screening rates among people experiencing homelessness

Introduction

Experiences of homelessness place a person at much higher risk of developing cancer, and evidence shows that cancer is among the leading causes of death for people experiencing homelessness. The extreme damage that homelessness causes to health, the exposure to cancer risk factors, and the inaccessibility of preventative healthcare all mean that measures to prevent and detect cancers should be a core healthcare initiative for people experiencing homelessness.

Despite this, cancer screening rates are much lower among people experiencing homelessness that the general population. Practical barriers in screening access combine with the wider picture of health exclusion and stigma to mean that people experiencing homelessness are much less likely to get through the door of a screening service in the first place and are more likely to be diagnosed with cancer once it has reached a more advanced and less treatable stage.

Project outline

This project aims to help homelessness and health providers to bridge the gap in cancer screening rates. Evidence surrounding cancer and homelessness is limited, but there is a relatively robust understanding of the barriers which prevent people from engaging in screening. What is less robust is evidence of what works to overcome those barriers.

The frontline homelessness sector plays a crucial role in supporting people to engage in healthcare; people experiencing homelessness are frequently perceived as ‘hard to reach’, but often hold positive, continuous and long-term relationships with key workers or specialist support services. As identified in Homeless Link’s Bridging the Health Gap report, these relationships can unlock engagement in healthcare where health systems may fail to access people alone.[1]

This project aims to join the dots on what works to improve cancer screening, including how the frontline homelessness sector can support increased uptake for people experiencing homelessness, identifying opportunities for joint work with screening teams and how each can lean on the other’s specialities to improve the screening experience. Alongside this, the project explores how system barriers currently support or prevent best practice, presenting a range of recommendations for policy-makers on how access to screening can be made more equitable for people experiencing homelessness.

This paper begins with an examination of what we already know about cancer, homelessness and access to screening. It then explores the views of screening teams themselves, as well as discussing lessons from other screening programmes and the needs of frontline practitioners. The paper then concludes with a series of best-practice tips and recommendations for change.

Background and context

The project is delivered by the Homeless Health Consortium, a partnership between Homeless Link, Groundswell and Pathway. The Homeless Health Consortium is part of the

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[1] Homeless Link and Groundswell (2022). *Bridging the Gap.* June 2022.

Health and Wellbeing Alliance (HWA), a joint programme funded and administered by Department for Health and Social Care (DHSC), NHS England (NHSE) and UKHSA. The DHSC-led Alliance programme is designed to facilitate collaboration and co-production between the voluntary and community sector and health system partners – DHSC, NHSE, UKHSA and the Office for Health Improvement and Disparities (OHID) – by bringing the voices and expertise of the sector, and the people and communities they represent, into national policy and delivery.

NHSE, OHID and UKHSA have all recognised inclusion health groups as populations to focus on over the coming years to reduce health inequalities. Inclusion health groups typically include people with experience of homelessness, people who are dependent on drugs or alcohol, vulnerable migrants, Gypsy, Roma and Traveller (GRT) communities, sex workers, people in contact with the justice system, and victims of modern slavery. Individuals may feature in a single group or may have intersecting experiences across multiple inclusion health characteristics.

For the NHS, the Office of Health Improvement and Disparities (OHID), and the Department of Health and Social Care (DHSC), measures to **reduce gaps in cancer screening** are a strategic priority. Both **reducing health inequalities among people experiencing homelessness** and **early cancer detection** are targeted under the Core20Plus5 framework.

This work feeds into the work of screening teams at OHID and aims to provide learning for their strategy teams, NHSE and homelessness providers. As part of the wider health system design to drive improvements in population health, Section 7A of the NHS Act 2006, as amended by the Health and Social Care Act 2012, outlines the specific responsibilities of the Secretary of State for DHSC that are delegated to NHS England for the commissioning of certain public health services. Screening is part of this agreement, and as such officials in OHID and DHSC monitor the overall performance of the NHS in delivering screening programmes successfully to all those who are entitled.

The Secretary of State has a duty to regard the need to reduce inequalities in England and ensure everyone obtains equal benefits from the health service. Monitoring for screening services therefore must regard the levels of inequality in their delivery. This guidance will help providers and commissioners to ensure that homeless people are less disadvantaged when being offered screening services, and that uptake can be monitored through the Section 7A Strategic Accountability Meetings.

The work brings together colleagues from across OHID, DHSC and NHSE as part of the wider drive to recover cancer screening rates post-COVID. While the project focuses specifically on people experiencing homelessness, it is expected that there will be transferable learning for those working across the health inclusion space. This is particularly expected for organisations working with those without a permanent address.

Methodology

This project was formulated around an in-depth literature review exploring the relationship between cancer screening and homelessness, exploring work from academic, medical and third-sector bodies to establish what is already known about the barriers and enablers to effective engagement. This primarily focused on research from within the UK, with international studies referenced when delivered in similar contexts or when presenting cross-cutting themes.

The study then sought to engage people working within cancer screening. This involved the delivery of a workshop to 30 individuals working in all areas of screening design and delivery across the three screenable cancers, varying from programme managers, clinicians, oncologists, and office staff. These workshops focused on a ‘vignette’ style case study, based on a fictional but realistic case. This workshop focused on the role of homelessness key workers and opportunities for joint work between teams, as well as exploring opportunities for flexibility within practice.

Alongside the primary research we also conducted a number of stakeholder interviews with people from various roles within NHSE and DHSC, discussing the current role of screening, what initiatives exist at current and the scope for innovation, learning and influencing. We also spoke with inclusion health specialists embedded within homelessness teams to establish what works at current and what programmes can be learned from in the delivery of cancer screening. Finally we also conducted research and interviews with clinicians involved in good practice and innovation nationally, establishing what is possible within current frameworks and where practice can be borrowed or broadened to improve delivery nationally.

Cancer and health inequality

Poverty and cancer: systemic inequality

There is a well-established link between socioeconomic deprivation, cancer rates and cancer mortality.[2][3] Wealth disparities consistently correlate with worse health – the more social deprivation a person faces, the higher their chances of dying early from preventable and treatable disease.

Across difference cancers, higher socioeconomic status is associated with 'significantly lower case fatality'[4] – cancers are more likely to be identified early and are therefore more likely to respond to treatment. Conversely, those from deprived socioeconomic backgrounds are statistically less likely to engage in routine screening and are more likely to present with advanced cancers.[5] Later diagnosis correlates with worse health outcomes, meaning that people from low-income backgrounds sadly face much higher levels of cancer mortality.[6][7]

The reasons for this are complex, and there is no one measurable factor that influences prognosis. Inequalities in health are driven by both controllable and uncontrollable circumstances: by the unavoidable circumstances of a person's physical environment or their experience growing up in poverty, through to more avoidable 'lifestyle' factors like smoking, diet and physical activity.[8] It is worthwhile noting that many so-called 'lifestyle' factors are themselves heavily influenced by environmental circumstances, and so the divide between what risks are within a person's control is more complex than often perceived.[9]

People from areas of higher deprivation are also significantly more likely to live with multiple health conditions, and this is again an indicator of worse outcomes when cancer is diagnosed.[10] Comorbid conditions can affect the choices of treatment available after diagnosis and can accelerate the progress of cancers, affect choices of treatment and ultimately act as a 'competing cause of death'.[11]

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[2] Ingleby, F. *et al.* (2022). An investigation of cancer survival inequalities associated with individual-level socio-economic status, area-level deprivation, and contextual effects, in a cancer patient cohort in England and Wales. *BMC Public Health.*

[3] Cancer Research UK (2020). Cancer in the UK 2020: Socio-economic deprivation.

[4] Lundqvist, A. *et al.* (2016). Socioeconomic inequalities in breast cancer incidence and mortality in Europe – a systemic review and meta-analysis. *Eur J Public Health.*

[5] Crosbie, P. Johnson, S and Shackley, D. (2023). Disadvantage and disease: Finding solutions to inequalities in cancer. *Manchester Cancer Research Centre.* Available at: https://www.mcrc.manchester.ac.uk/media/resources/on-cancer/disadvantage-and-disease-finding-solutions-to-inequalities-in-cancer/

[6] McPhail, S. *et al.* (2015). Stage at diagnosis and early mortality from cancer in England. *British Journal of Cancer.*

[7] Lundqvist, A. *et al.* (2016). Socioeconomic inequalities in breast cancer incidence and mortality in Europe – a systemic review and meta-analysis. *Eur J Public Health.*

[8] ibid

[9] Jusot, F. Tubeuf, S and Trannoy, A. (2010). *Effort or circumstances: does the correlation matter for inequality of opportunity in health?* IRDES.

[10] Frederiksen, B. *et al.* (2009). Do patient characteristics, disease, or treatment explain social inequality in survival from colorectal cancer? *Social Science and Medicine.*

[11] ibid

Even after controlling for various known risk factors, ‘unexplained’ inequalities in rates of cancer diagnosis and mortality remain for those in poverty.[12] This is compounded by the generally more advanced stages of cancer at diagnosis, where cancers are likely to be less treatable.[13] Deprivation connects a complex web of cancer risk factors to mean that cancers are harder to prevent and outcomes are worse at diagnosis.

Many of the drivers of cancer inequality happen at population level, driven by systemic inequality and lying beyond the reach of health services to deal with alone. However, cancer screening has been proven as an impactful way to reduce cancer mortality by increasing the likelihood that disease is identified and treated early, therefore maximising the likelihood of successful treatment.

For populations who are less likely to access screening, there is therefore meaningful impact in any work that improves access and uptake of programmes. Narrowing the gap in screening rates holds potential to reduce the rate of death from treatable cancers among excluded groups. It is this gap that this project seeks to examine.

Homelessness and health disparities

The evidence base on cancer and homelessness shows stark disparities as compared to the general population. This echoes the overall picture of health inequality among people experiencing homelessness in the UK.

We know that people experiencing homelessness have an average age of death much younger than the general population, standing at 45 for men and 43 for women.[14] One study attributes nearly one in three deaths while homelessness ‘to causes that are amenable to timely health care’.[15] People experiencing homelessness have worse health outcomes than even the most deprived citizens in wider population and often have worse access to routine care.[16] Effective preventative, diagnostic and treatment interventions hold scope to significantly improve the health outcomes of people experiencing homelessness.

Homelessness has a universally negative impact on health and wellbeing. Being homeless makes it difficult to engage in health-promoting behaviours such as physical activity and a healthy diet.[17] People experiencing homelessness face significant challenges when engaging with healthcare systems, meaning routine healthcare is often inaccessible. Individuals are less likely to successfully access primary care,[18] much more likely to rely on emergency healthcare[19] and are less likely to remain engaged in treatment for long-term

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[12] Lundqvist, A. *et al.* (2016). Socioeconomic inequalities in breast cancer incidence and mortality in Europe – a systemic review and meta-analysis. *Eur J Public Health.*

[13] ibid

[14] Breen, P. and Butt, A. (2022). Deaths of homeless people in England and Wales. *Office for National Statistics.* November 2022.

[15] Aldridge, R. *et al.* (2019). Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. *Wellcome Open Res.*

[16] ibid

[17] Hertzberg, D., Standing-Tattersall, C. and Boobis, S. (2025). The Unhealthy State of Homelessness 2025: Findings from the Homeless Health Needs Audit. *Homeless Link.*

[18] Gunner, E. *et al.* (2019). Provision and accessibility of primary healthcare services for people who are homeless: a qualitative study of patient perspectives in the UK. *British Journal of General Practice.*

[19] Hertzberg, D., Standing-Tattersall, C. and Boobis, S. (2025). The Unhealthy State of Homelessness 2025: Findings from the Homeless Health Needs Audit. *Homeless Link.*

health conditions.[20] These complex barriers to healthcare lead to worse health outcomes, including in cancer.

The barriers to accessing healthcare while experiencing homelessness are complex and pervasive at all levels of the system and can prevent people from engaging in routine screening and preventative care. People are less likely to be seen in primary and secondary elective care settings and more likely to seek support in emergency settings.[21] The barriers into healthcare are well evidenced, resulting from 'highly complex and fragmented health and social care systems'[22]; people struggle to make and maintain appointments, may miss communications due to out of date or omitted addresses or phone numbers, and may avoid medical settings because of previous traumatic or stigmatising experiences.[23]

Health exclusion for people experiencing homelessness goes beyond the reach of health systems alone, with many people unable to access the support and care they require to manage their health. People may be at higher risk of self-neglect due to a complex mix of health and social care factors and less likely to be in receipt of appropriate social support to manage their wellbeing.[24] While specialist outreach services work to engage a proportion of people in community settings such as day centres or accommodation providers, such services are often restricted to a small number of clinicians and limited in the care they can offer, meaning more complex conditions may continue to go undiagnosed.

Cancer and homelessness

Evidence shows that the 'burden of cancer and […] cancer related mortality' is high for people experiencing homelessness as compared to the rest of the population.[25] Figures around the burden of cancer death vary between studies. One study found cancers accounted for 19% of underlying causes of death for people experiencing homelessness.[26] The ONS official statistics on deaths while homeless puts deaths specifically attributable to cancers at 5%; however, when controlled for accidental death and suicide, this number rises to 11%.[27]

Critics have argued that less attention has been paid to rates of cancer death among people experiencing homelessness as assumptions about the population mean that more focus is placed on 'conditions such as suicide, drug overdose, accidents and violence; at the

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[20] Woodward, A. *et al.* (2023). Self-management of multiple long-term conditions: A systematic review of the barriers and facilitators amongst people experiencing socioeconomic deprivation. *PLoS One.*

[21] Field, H. *et al.* (2019). Secondary care usage and characteristics of hospital inpatients referred to a UK homeless health team: a retrospective service evaluation. *BMC Health Services Research.*

[22] Carmichael, C. *et al.* (2022). Exploring the application of the navigation model with people experiencing homelessness: a scoping review. *Journal of Social Distress and Homelessness.*

[23] National Institute for Health and Care Excellence. (2022). Integrated health and social care for people experiencing homelessness. Available at: https://www.nice.org.uk/guidance/ng214/resources/integrated-health-and-social-care-for-people-experiencing-homelessness-pdf-66143775200965

[24] Martineau, S. *et al.* (2019). Safeguarding, homelessness and rough sleeping: An analysis of Safeguarding Adults Reviews. *NIHR Policy Research Unit in Health and Social Care Workforce.*

[25] Schiffler, T. *et al.* (2022). Barriers to access cancer prevention services for the homeless population in four European countries. *Eur J Public Health.*

[26] Aldridge, R. *et al.* (2019). Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. *Wellcome Open Res.*

[27] Breen, P. and Butt, A. (2022). Deaths of homeless people in England and Wales. *Office for National Statistics.* November 2022.

expense of non-communicable disease, despite these contributing to more deaths'.[28] However, there is a body of evidence around factors influencing the rates and mortality of cancer among people experiencing homelessness including the barriers that prevent people accessing timely and appropriate care.

The impact of systemic barriers on cancer outcomes is significant. Early diagnosis is an indicator of better long-term outcomes in cancer care. The combined risks of 'unequal access and utilization of cancer screening services as well as advanced stages of cancer when diagnosed' mean outcomes for people experiencing homelessness are significantly worse.[29] Late diagnosis in acute healthcare settings such as emergency hospital departments[30] means treatment options are likely to be much more limited. Specialist hospital teams have reported people presenting with fungating tumours 'more commonly seen in developing countries',[31] at which point the chances or mortality are significantly higher.

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[28] Aldridge, R. *et al.* (2019). Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England. *Wellcome Open Res.*

[29] Gil-Salmeron, A. Guiterrez-Sciavon, C. and Katsas, K. (2020). Cancer care for the homeless population: A literature review. *The European Journal of Public Health.*

[30] Carmichael, C. and Smith, L. (2021). Synthesis report on health needs and barriers to access cancer care prevention for the homeless population at system, provider and individual levels. *Cancerless and Anglia Ruskin University.*

[31] Based on information shared by Pathway hospital teams.

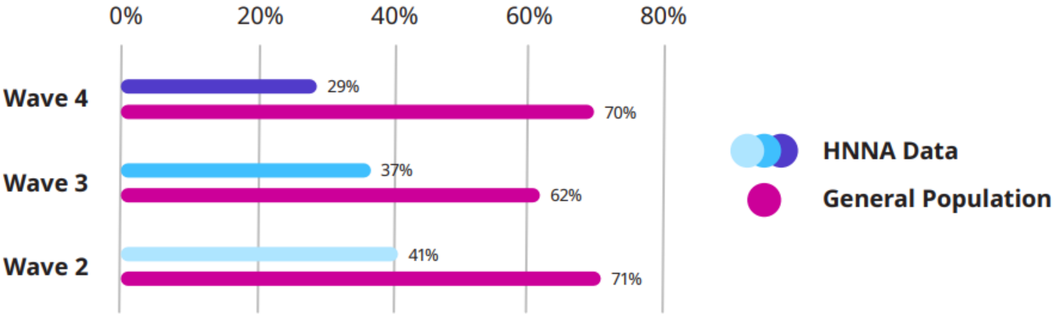
Screening uptake and homelessness

Cancer screening in the UK

Various cancer screening programmes exist in the UK and NHS breast, bowel and cervical screening is offered universally to all eligible persons. Routine screenings for cervical cancer are offered to anyone with a cervix, with screenings every three years for people aged 25 to 49 and every five years for people aged 50 to 64. Breast screenings are offered every three years to women aged between 50 and 71. Bowel screenings are currently offered every two years to anyone aged between 60 and 74, with the NHS Long Term Plan laying out a commitment to lower the screening age to 50 and improve the sensitivity of screening.

Screening programmes are estimated to save around 10,000 lives a year through prevention and early diagnosis. However, screening rates dropped significantly throughout the COVID-19 pandemic and lockdown, and rates have not yet recovered.

We know that screening uptake is lower among people experiencing homelessness, although the extent to which this is true varies between studies. Data from Homeless Link's Unhealthy State of Homelessness report shows that just 29% of eligible homeless women had attended a breast screening in the previous three years, in contrast to 70% of the general population.[32] Cervical screening rates were comparably reduced, with 38% of eligible people accessing screening in the previous three years as compared to 69% of the general population.[33]



Homeless Health Needs Audit, Wave 2, N=73; Wave 3, N=46; Wave 4, N=34

However, research from Groundswell[34] found only 21% of homeless women had never attended a cervical screening as compared to 25% of the general population. They hypothesised that this may be the result of 'proactive in-reach work often done by professionals in day centres' and the higher possibility that participants may have accessed specialist sex worker services which were more likely to offer screening on a drop in basis.

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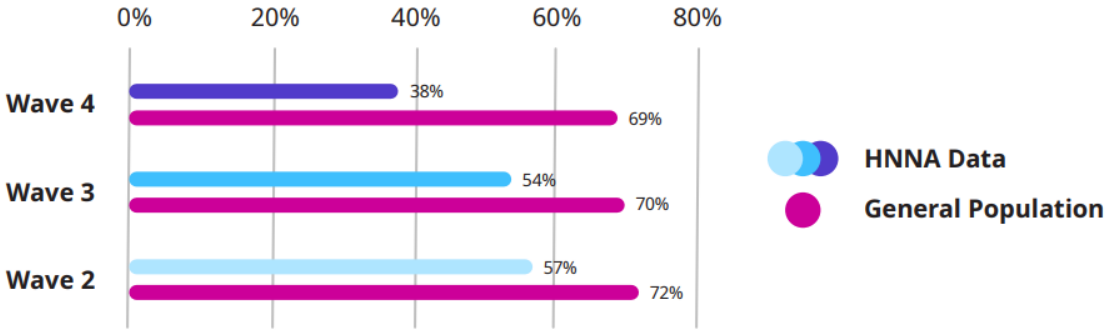
[32] Hertzberg, D., Standing-Tattersall, C. and Boobis, S. (2025). The Unhealthy State of Homelessness 2025: Findings from the Homeless Health Needs Audit. *Homeless Link.*

[33] Ibid.

[34] Groundswell. (2020). *Women, Homelessness and Health: A Peer Research Project.* Available at: https://groundswell.org.uk/wp-content/uploads/2020/02/Womens-Health-Research-Report.pdf



Homeless Health Needs Audit, Wave 3, N=122; Wave 4, N=131

Figure 2: Cervical screening uptake, Unhealthy State of Homelessness

It is valuable to note that there is no significant evidence outlining bowel screening rates for people experiencing homelessness in England. For those living in the most deprived areas of the UK, bowel screening rates show a similar disparity, with only 64% of people engaged in screening as compared to 75% of the general population.[35] It can be assumed that these figures would be replicated again among people experiencing homelessness, although little evidence exists to prove this.

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[35] King’s Fund (2024). *Illustrating the relationship between poverty and NHS services.* Web. Available at: < https://www.kingsfund.org.uk/insight-and-analysis/long-reads/relationship-poverty-nhs-services/ >

System barriers

There are a number of universal barriers to screening such as fear of the screening process and its potential results, difficulty securing an appointment, long waiting lists, practices failing to provide screening, or appointments being issued at difficult or inflexible times.[36][37] Evidence shows that socioeconomic status influences cancer screening uptake, with people from the most disadvantaged socioeconomic backgrounds much less likely to attend screenings.[38]

While improvements have been made to inclusion health outreach in recent years, tailored cancer prevention services are limited to the point of being 'effectively non-existent'.[39] Qualitative work with people with experience of homelessness shows very few recall invitations for cancer screening.[40] This means 'opportunities for the early diagnosis among [people experiencing homelessness] were often being missed'[41] - people are simply not invited. Without this, people are left unable to engage not because of a lack of willingness, but because of structural and service-level barriers.

Information systems and homelessness

Evidence shows us that assertive, targeted support is best practice when engaging people experiencing homelessness in healthcare. But when speaking to cancer screening clinicians, they repeatedly identified their computer systems as an insurmountable barrier to delivering targeted cancer screening. Screening invitations are sent to eligible patients across a GP surgery via post. GP databases do not routinely collect information about a patient's housing status, meaning there is no effective means at current for a screening team to target patients who experience homelessness.

Screening clinicians further identified the problematic nature of the postal-only invitation system for people experiencing homelessness. Access to appointments relies on paper notices sent via post, with no option for alternative reminders through telephone or email. These barriers mean that those without a fixed address may find it functionally impossible to attend a screening – they are simply not invited.'[42]

> *"Can we target people? Our systems don't allow us to identify them – so you may not know someone is homeless. Is it even appropriate to target people under data protection?"*

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[36] Jo's Cervical Cancer Trust. (2018). *Computer Says No: The growing issue of access to cervical cancer screening across the UK: The problems and how they can be overcome.*

[37] NHS England. (2022). *Breast screening: reducing inequalities.* 8 June 2022. Available at: https://www.gov.uk/government/publications/breast-screening-identifying-and-reducing-inequalities/breast-screening-reducing-inequalities

[38] Crosbie, P. Johnson, S and Shackley, D. (2023). Disadvantage and disease: Finding solutions to inequalities in cancer. *Manchester Cancer Research Centre.* Available at: https://www.mcrc.manchester.ac.uk/media/resources/on-cancer/disadvantage-and-disease-finding-solutions-to-inequalities-in-cancer/

[39] Schiffler, T. *et al.* (2022). Barriers to access cancer prevention services for the homeless population in four European countries. *Eur J Public Health.*

[40] ibid

[41] ibid

[42] Jo's Cervical Cancer Trust. (2018). *Computer Says No: The growing issue of access to cervical cancer screening across the UK: The problems and how they can be overcome.*

Practitioners reflected that populations with ‘a lot of people movement [can] prove challenging for our computer systems’ which ‘generally rely on address and post which for an NFA population is completely useless’. Due to the reliance on postal communications, practitioners highlighted how difficult it was to contact people if they changed address, with one provider reflecting: ‘If we’ve lost them, we’ve lost them – we just have to hope they pop up again’.

Clinicians from specialist homelessness practices did tell us of some positive variations in practice which allowed them to target invitations to screening where barriers may exist. However, these practices are not delivered at scale nationally and therefore reach just a fraction of people experiencing homelessness nationally, meaning the majority remain excluded in the design of current systems.

> *“Experiences of homelessness get hidden. It’s hard to target people or establish their experiences – flags on GP practice records for homelessness data can be pooled so you can attempt non-standard routes of contact, but this is case reliant.”*

Our conversations with screening clinicians reflected the systemic nature of health exclusion for people experiencing homelessness and suggested that people would remain excluded without a system-wide change to health data collection and information systems. Technology hampered the ability of teams to respond to the needs of populations who may not have regular addresses, including people experiencing homelessness, people in prisons and people from the GRT community. There is work ongoing within the NHS to update the information systems used by screening teams. It is imperative that any new systems be designed with consideration of the ability of screening teams to target people from excluded populations and improve their ability to utilise non-postal forms of contact such as text, phone or email. While this will not remove the risk of exclusion for people experiencing homelessness, it will vastly reduce the systemic exclusion of people without a permanent address.

Engagement risk and KPIs

People experiencing homelessness face known barriers to continual engagement with healthcare support. These barriers led the NICE committee on integrated care for people experiencing homelessness to advise that services working with people experiencing homelessness should recognise disengagement as part of the process of health inclusion, and work to actively support re-engagement wherever possible.

Multi-stage processes of screening and follow-up testing can carry a heightened risk of disengagement, as tests are spread across multiple appointments and may require more invasive procedures. A case study provided by St Mungos showed a woman who had attended an initial cervical smear, only to disengage after an abnormal result for fear of more intensive testing; ‘the client didn’t know what this meant or what the extent of the procedure would be, only that it sounded scary so she didn’t want to follow through’.

Experts highlighted the risk that this heightened chance of disengagement can create a perverse incentive not to work with people experiencing homelessness, as KPIs and stats for practices are often based on time-sensitive diagnosis standards. Effective work with people experiencing homelessness requires services to re-evaluate their timeframes and measures of success, and this is no different within cancer screening teams. Providers therefore require the freedom to adjust these measures depending on the populations they are working with. For practices to feel encouraged to assertively work with people experiencing homelessness, providers recommended that these standards be reviewed and additional flexibility given when working with high-risk groups.

> *"For bowel cancer […] if you have abnormal results, the hospital is held to standards – two weeks for an urgent referral, six weeks for a non-urgent referral. The clock ticks on this – there's a 28 day diagnosis standard, treatment should start within 28 days. If you can't find the patient, the hospital is held to that standard and the failure impacts your stats. Stats are published, you are criticised for them – it is hard to change attitudes [on screening homeless patients] when this is the case."*

Inflexible practice

The principles of effective work with people experiencing homelessness call for flexible support that can meet needs as they arise. Despite this, screening clinicians flagged that screening services can be rigid in their delivery. This faced widespread criticism from practitioners. The one-size-fits-all approach to screening was seen as inadequate by those administering it, but the flexibility required to meet the needs of people experiencing homelessness was not viewed as possible within current systems. This varied from the very practical to the financial.

On flexibility in practice, one specialist homelessness practitioner expressed their frustration:

"I can get my patients to do a stool sample here for me. I don't have any problems doing that, but I don't have the kits. They won't send them to me – it has to be for a named person. I haven't got the time to fill out 30 forms. Reception let me know if there's a bowel screening kit so I can explain it to a person – but that's only when I have extra time."

The design of services also makes flexibility in appointment times challenging. Specialists told us of targeted initiatives that were held back by the requirement for patients to be named in advance, meaning they were unable to offer opportunistic screening despite successful initiatives for other health conditions.

"Patients are not good at appointments. The appointment time is very restricting. We are a homeless GP surgery and appointments just don't work. I tried to get a walk in set up for mammogram screening. Screening teams weren't okay with that, because they didn't have a name. That's a barrier from the screening side of things. The TB van parks outside the homeless hostel and people can walk in, why can't we do the same?"

For people experiencing homelessness, there is widespread recognition of the value of services delivered in homelessness settings, which are known to increase engagement over time. Outreach health services are often perceived as the most successful: one inclusion health practitioner told us that "if you can do it [in the hostel] people will attend, but if you have to take people down the road, it won't happen – you lose them". The need for outreach services has seen a number of tailored outreach provisions developed with the aim to make screening more accessible.

However, recent years have seen these provisions shrink significantly. Accessible screening options such as cervical screening in sexual health clinics have been rolled back, with more services carried out in GP surgeries instead.[43] Similarly, a move towards home-based testing for sexually transmitted infections has seen patterns of use change in sexual health clinics, meaning chances to conduct opportunistic screens are also reduced. This is despite 'community-based screening strategies hav[ing] proven to be effective in increasing screening rates'.[44]

'We should be going out to them to screen them where they are eg going to a drop in centre rather than making them come to you. But I appreciate that can be hard depending on the equipment. But if there is someone the people trust telling them about the service, they will be willing to engage.'

Drop-in, community screening services overwhelmingly benefit people who are not registered or engaged with a GP, a cohort in which people experiencing homelessness are overrepresented. Reduced drop-in provision therefore has a disproportionately negative impact on this group, creating an additional barrier to engaging with routine screening where other programmes have not worked.[45]

Learning from: Tuberculosis treatment

Across different disease areas, the pioneering work of UCL's Find and Treat team has seen reduced rates of TB among people experiencing homelessness, drug and alcohol users, vulnerable migrants and people who have been in contact with the justice system. This is achieved by '**tak[ing] TB control into the community, find[ing] cases of active TB early and support[ing] patients to take a full course of treatment'** and is delivered by a mix of '**peer advocates, TB nurse specialists, social and outreach workers, radiographers and expert technicians'**.

The success of the programme has seen almost 10,000 people screened annually, and the programme has been evidenced as being highly cost effective and potentially cost saving. Learning from its assertive approach to delivery is highly applicable across alternative screening programmes and evidences the importance of specialist programmes in saving lives.

Whole systems investment

While there was a great deal of interest in making changes to cancer screening pathways for homeless populations among clinicians, there was also recognition of the culture change required to make those ambitions a reality.

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[43] Jo's Cervical Cancer Trust. (2018). *Computer Says No: The growing issue of access to cervical cancer screening across the UK: The problems and how they can be overcome.*

[44] Gil-Salmeron, A. Guiterrez-Sciavon, C. and Katsas, K. (2020). Cancer care for the homeless population: A literature review. *The European Journal of Public Health.*

[45] Jo's Cervical Cancer Trust. (2018). *Computer Says No: The growing issue of access to cervical cancer screening across the UK: The problems and how they can be overcome.*

"The main barrier is somebody higher up taking responsibility for taking the patient through the pathway. It's not the easiest, and it is a risk – it is someone saying they will screen or treat a person with no medical notes, it is finding them a bed and a room if they need monitoring. Funding for that is like gold dust."

This is, of course, not limited to cancer screening. Inconsistencies in care for people experiencing homelessness exist at all levels of the healthcare system, and wider challenges to funding and resourcing among NHS services can limit the ability of services to reduce healthcare inequalities.[46] Despite this, the general principles of the NICE guidelines encourage 'more effort and targeted approaches' to ensure that people experiencing homelessness have access to the same standards and quality of care as the general population.[47] This requires flexibility and an ability to challenge rigid systems and practices.

GPs were also encouraged to take a more active role in enabling screening, including taking 'any opportunity' to discuss it with patients from health exclusion groups and ensuring each practice had a lead on homelessness.

"Encouraging GPs to get people registered and eligible to screen, flag if they DNA, don't send letters, use any opportunity to talk about screening, ensure there is a lead within practices to follow up DNAs, is that lead up to date with their practice and training."

More broadly, there was a recognised need for a whole-systems approach to enabling engagement in cancer care and preventative screening. The barriers of being without a permanent home and engaging in screening were flagged as significant. Follow up tests can be invasive and may require access to sanitary equipment, cessation of substance use and the ability to receive results, all of which were recognised as significant challenges for many people experiencing homelessness.

Specialist inclusion health practitioners spoke of the impacts of receiving potentially life-changing diagnoses while experiencing homelessness, particularly when those diagnoses did not facilitate access to accommodation or changes in care. Diagnosis of cancer while homeless means trying to engage someone in an intensive and gruelling treatment pathway, which may be a huge load both practically and mentally while also navigating homelessness. Access to safe and hygienic accommodation is essential while moving through cancer treatment, and there was scepticism about efforts to increase screening if wider efforts to improve access to care and recovery accommodation were not also enabled.

"Bowel screening: not a case of "computer says no" but more about making sure people have a safe pathway of care, e.g. receiving and sending test kits, receiving results etc. Practical challenges, e.g. bowel prep before colonoscopy requires people to stay close to a toilet, adjust diet and avoid alcohol. This is okay if people are in a hostel and this can be mentioned to staff there but not easy for people on the street."

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[46] Jackson T., Nadicksbernd, JJ. O'Connell, D and Page, E. (2024). *Always at the bottom of the pile: The homeless and inclusion health barometer 2024.* Pathway.

[47] National Institute for Health and Care Excellence. (2022). Integrated health and social care for people experiencing homelessness. Available at: https://www.nice.org.uk/guidance/ng214/resources/integrated-health-and-social-care-for-people-experiencing-homelessness-pdf-66143775200965

Good practice spotlight

Wildflowers clinic, Peterborough

In Peterborough, health services and homelessness charities have collaborated to deliver the Wildflowers outreach clinic, which has been running since 2020. The clinic supports women who sell sex and are not engaged with primary care. Delivered in collaboration between a local GP and homelessness outreach charity, the project uses a dedicated clinical space to deliver cervical screening alongside other health and wellbeing support.

When the clinic launched, just 19% of women supported by the service had an up-to-date cervical screen. This has since increased to 93%. Some women supported by Wildflowers had not had a cervical screening in decades. The service offers support with a range of health needs alongside cervical screening, including sexual health, mental health, wound care and foot care.

The women Wildflowers work with often face severe exclusion and stigma from mainstream health and welfare services. Many had no service involvement when they began working with Wildflowers. The service lead described the success of the service as based on trust – with time spent building relationships with women and support with a range of holistic needs including housing, drug and alcohol support and engagement with the justice system.

Wildflowers has worked to effectively bridge support for women with abnormal screening results, taking an assertive approach to ensure that abnormal results result in further testing. With permission from women, support workers contact details can be used to share screening results and arrange follow-up testing. Direct relationships with the colposcopy unit mean that women can be given increased support during appointments including a support worker in attendance and a flag on results. This follows the model set by learning disability pathways.

Despite its success, the project continues to face significant challenges. Its funding is drawn from underspend elsewhere and is granted year-on-year, meaning a huge amount of uncertainty for the future. The relatively small number of women supported, and the severity by which their needs are unmet, mean that proving effectiveness through traditional KPIs is challenging. Workers identify the need to allow time for trust to be gained and successes to surface.

Staff merit the success of the project to engaged workers from within both healthcare and homelessness systems committed to working together. This has given additional scope for flexibility around appointment times, trauma-informed approaches and understanding of the needs of women. Primarily they merit success to consistency – being there, building trust, and working to meet the needs of women whenever feasibly possible. ‘If something needs doing, I just do it’.

Non-system barriers

Negative experiences, fear and anxiety

There are of course numerous barriers to cancer screening which lie beyond the reach of screening services alone. Cancer risk is often identified as a low priority for people with current experiences of homelessness, for whom engaging with follow-ups and potential treatment is near impossible. In the face of competing priorities, preventative examination “is really a luxury […] when you’re still carrying acute problems around with you”.[48]

Fear and anxiety, worries about pain during procedures, or concerns about receiving negative results can act as a significant barrier to engaging people with screening. Inclusion health specialists told us that ‘information spreads’ – that when someone has a negative experience, this has a ripple effect, as their peers may also avoid screening out of concern that the same will happen to them. Conversely, however, it was highlighted that this works in reverse – ‘good experiences will spread, but you have to be assertive and engaged and accept that this takes time’.

The anxiety around negative outcomes is well founded. There are significant barriers to accommodation which mean that even with a cancer diagnosis someone may not have access to safe, secure housing. The intensity of cancer treatment therefore means people may avoid screening and diagnostic testing out of concern about the treatment pathway. This was compared to Hepatitis C screening – previously, a diagnosis would mean 48 weeks of intensive, ‘lifechanging’ treatment meaning that very few people would agree to be tested. Only with the shift to shorter treatment blocks and simplified testing has engagement increased.

“For cancer screening – how do you tell people to prioritise it? A diagnosis is lifechanging. We need to communicate that the earlier you treat it, the better the chances of treatment. But some people aren’t in a place to be treated.”

The intimate nature of screening can worsen exacerbate existing concerns about stigma and judgment from medical professionals. Experiences of stigma are known to drive people experiencing homelessness away from medical settings, and providers highlighted the heightened risk of discrimination during screening: *”there are a lot of trust problems with healthcare professionals”.* Evidence shows the capacity to overcome these concerns is largely based on ‘a caring relationship, empathy […] extra effort to get to know the circumstances [people] were in”[49] – through outreach activities or joint working that assertively sought to engage people with experiences of homelessness.

Fear related to testing and sexual trauma can also be a concern, but evidence showed that this concern often stems more from the screening provider than people with experience of homelessness themselves. This perceived barrier can lead to overcautious approaches by providers. With cervical screening in particular, various sources reference sexual trauma as

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[48] Schiffler, T *et al.* (2023). ‘Access to cancer preventative care and program considerations for people experiencing homelessness across four European countries: an exploratory qualitative study’. The Lancet.

[49] Reilly, J., Ho, I. and Williamson, A (2022). ‘A systematic review of the effect of stigma on the health of people experiencing homelessness”. *Health and Social Care in the Community.*

a source of aversion to gynaecological healthcare.[50][51] While this is certainly true for some, other research suggests that the risk may be overstated. On the topic of fear, one study outlined that they 'did not find consistent evidence of its negative impact on breast and cervical screening participation'[52] among homeless women. They go on to say that 'this is not to say the women did not find these procedures difficult' but that 'they did however participate in screening' despite this.

Knowledge and education

Barriers to cancer screening are not limited solely to practice. Evidence shows a lack of knowledge around cancer, prevention and screening among people experiencing homelessness in general. Researchers have identified a 'generally […] very limited level of knowledge around cancer symptoms and cancer prevention' among homeless populations.[53]

Knowledge that early detection can mean better long term outcomes was 'understood by approximately half of the interviewees' of one study.[54] For others, cancer was described in black and white terms as something you either have or do not have: 'there were no discussions about types or stages of cancer'.[55] Another study found that 'almost all participants characterised their knowledge and understanding of cancer as very limited and generally based on the personal experiences of family or friends'.[56]

For people currently navigating homelessness, cancer was highlighted as a lower priority as people focus on their day-to-day survival. People identified other priorities like managing appointments and responding to addiction.[57] Similarly, population-wide prevention practices such as healthy eating programmes and smoking cessation are often seen as irrelevant and services are often not extended to people experiencing homelessness.[58] The focus on meeting short term needs means that 'living in the context of poverty makes it very difficult to maintain good nutrition, exercise and [maintain] a healthy lifestyle as recommended by care

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[50] Groundswell. (2020). *Women, Homelessness and Health: A Peer Research Project.* Available at: https://groundswell.org.uk/wp-content/uploads/2020/02/Womens-Health-Research-Report.pdf

[51] St Mungo's, Groundswell, Crisis and Homeless Link. (2021). *Women's Health Strategy: Call for Evidence Joint Submission from St Mungo's, Groundswell, Crisis and Homeless Link.*

[52] Moravac, C. (2018). Reflections of homeless women and women with mental health challenges on breast and cervical screening decisions: Power, trust and communication with health providers. *Frontier Public Health.*

[53] Carmichael, C. and Smith, L. (2021). Synthesis report on health needs and barriers to access cancer care prevention for the homeless population at system, provider and individual levels. *Cancerless and Anglia Ruskin University.*

[54] Moravac, C. (2018). Reflections of homeless women and women with mental health challenges on breast and cervical screening decisions: Power, trust and communication with health providers. *Frontier Public Health.*

[55] ibid

[56] Carmichael, C. and Smith, L. (2021). Synthesis report on health needs and barriers to access cancer care prevention for the homeless population at system, provider and individual levels. *Cancerless and Anglia Ruskin University.*

[57] Groundswell. (2020). *Women, Homelessness and Health: A Peer Research Project.* Available at: https://groundswell.org.uk/wp-content/uploads/2020/02/Womens-Health-Research-Report.pdf

[58] Hertzberg, D., Standing-Tattersall, C. and Boobis, S. (2025). The Unhealthy State of Homelessness 2025: Findings from the Homeless Health Needs Audit. *Homeless Link.*

providers, health promoters and cancer prevention agencies'.[59] Engaging in screening can by extension be perceived as less relevant or urgent for homeless populations, both by individuals themselves and the services that support them.

It is again worth emphasising that, while there is a small but diverse range of information exploring breast and cervical screening access, the pool of information exploring barriers to bowel screening for people experiencing homelessness in the UK is practically non-existent. Internationally, uptake has been identified as being very low with general barriers including 'procrastination, forgetting, fear of the test result, screening anxiety, disgust and low self-efficacy'[60] – combining with other barriers including a lack of private space to prepare for screening and a limited understanding of the risks associated with colorectal cancers.[61]

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[59] Moravac, C. (2018). Reflections of homeless women and women with mental health challenges on breast and cervical screening decisions: Power, trust and communication with health providers. *Frontier Public Health.*

[60] Kotzur, M *et al.* (2022). *What are the common barriers and helpful solutions to colorectal cancer screening? A cross-sectional survey to develop intervention content for a planning support tool.* BMJ Open.

[61] Asgary, R. *et al.* (2014). Colorectal cancer screening among the homeless population of New York City shelter-based clinics. *Am J Public Health.*

Solutions

Trust and utilising the frontline

“We have made links with some charities and spoken to link workers. They can be really helpful in terms of locating people. Those links are key when it comes to engaging the [homeless] population – being the liaison – addressing the bit about people being uncertain. Screening is a whole pathway – not a one off test. It needs a strategic plan.”

Frontline homelessness key workers form an essential part of the support system for people experiencing homelessness, particularly when engaging people with health and social care support. They play ‘a vital role in signposting people to relevant services, advocating on their behalf, and even enabling and encouraging people to engage in preventative healthcare’.[62]

The ability of key workers to link their clients in with healthcare initiatives falls to trust. The trusting relationship between key workers and the people they work with is fundamental to the success of homelessness support. Building healthcare into support planning and ensuring homelessness workers are equipped to hold conversations about health can have positive impacts on engagement across different healthcare areas, including screening.

But for frontline workers to confidently hold conversations about health, they must be equipped with the knowledge to do so, answer questions and settle anxieties. This includes knowledge of:

- What to expect from the screening process;
- What follow-up testing may entail;
- What happens after a positive result;
- What treatment for screenable cancers may look like.

Some screening teams have instituted specialised screening practitioners (SSPs) to accompany people through the bowel screening process, with scope for these individuals to play a ‘buddy’ role. Practitioners identified joint working with the VCSE as an opportunity to embed this further, with potential to identify screening leads within homelessness teams to work more closely with screening services, talk to clients and colleagues about screening and act as a point of contact to better enable joint working.

Some providers had already explored how relationships with VCSE support providers could improve disparities in screening. One provider spoke of working closely with a VCSE organisation which supported people from Gypsy, Roma and Traveller (GRT) communities, holding ‘casual conversations about health’ alongside other activities such as flower arranging, doing so for several weeks ‘before we introduced the idea of screening’. The ability to hold direct conversations in a trusted space was felt to have been critical to enabling positive engagement.

Homelessness providers also discussed the capacity for screening teams to learn from their work and the scope for screening practitioners to work within homelessness settings. Screening teams were invited to visit hostel spaces to ‘demystify’ them, ‘becoming familiar with what they are like […] learning the flow of a hostel and its residents’. With this, services could learn when best to target potential screening patients, adapting to the variable peak times that occur between different services and establishing when they were likely to have the most success engaging people directly.

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[62] Homeless Link and Groundswell (2022). *Bridging the Gap.* June 2022.

Good practice spotlight

North Central London Cancer Alliance

The NCL Health Needs Assessment identified a range of needs and healthcare access barriers for PEH including fear of stigma and discrimination, lack of identification or proof of permanent address, lack of awareness of the healthcare system and entitlements, trauma triggers, language and digital exclusion. Improving survival, focusing on early diagnosis and prevention and reducing health inequalities across the whole NCL population is two of the key strategic aims of the NCL CA.

An evaluation of the NCL programme, conducted by Homeless Link, can be found here.

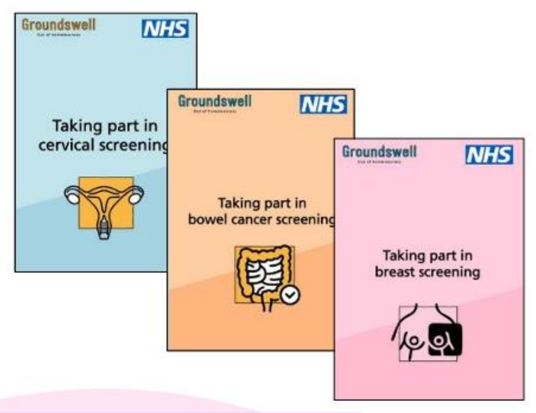
The project focused on raising awareness about the challenges people experiencing homelessness face in accessing cancer screening and in initiating systemic change to improve access and outcomes overall. Its key activities focused on strengthening collaborative work between health and homelessness providers, developing resources to explain and promote screening, training for staff in frequent contact with people experiencing homelessness, and identification and dissemination of reasonable adjustments.

Partners also ran a ‘your health first’ campaign outside a day centre promoting cancer screening, supporting health promotion and accompanying this with promotional material explaining cancer screening in simple stages.

The activity was successful in promoting conversations around cancer screening and creating small but impactful change to local systems, promoting trauma-informed care and improved practice when engaging people experiencing homelessness within screening centres.

As the programme was targeted at system-wide improvements, evidence of its tangible impacts such as improving screening uptake are limited. The project evidences the scope for improved system practice in cancer screening and the willingness of frontline staff and screening teams to improve care for populations experiencing health exclusion.

The project’s resources have been incorporated into a GP training module and are accessible here.



Flexible practice

Despite widespread challenges in screening access, the providers we spoke to were full of ideas to improve the experience of screening for people experiencing homelessness. These were based on their own experiences, what was possible within their clinics at current, and the flexes to practice that could improve experiences with little effort.

The assets provided by frontline workers and their ability to broker relationships between screening teams and people experiencing homelessness were a strong focus of the session. The unique role played by frontline practitioners was respected and their skills highlighted as a great source of knowledge and relationship-building. Frontline workers were identified as being able to help:

- Target screening to people experiencing homelessness locally;
- Identify people who may find screening inaccessible;
- Support people to feel calm and confident during appointments, and;
- Act as a point of contact for people regarding any follow up calls or support planning.

Flexes to practice: adjustments to request

In advance:

- Arrange an orientation visit so that you or the person you support knows what to expect.
- Ask to book a double appointment to make sure you're not rushed.
- Appointments at the beginning of the day are more likely to run on time.
- Ask whether there is capacity to support in the room – this may or may not be possible depending on the layout.
- There may be a separate waiting area for anxious patients.
- Let the radiographer know if a patient is feeling nervous.
- If someone backs out of screening on the day, a second appointment is always possible.
- Talk to your radiographer about communication needs and options for alternative contacts if follow up tests are required.

Transferable learning: Hepatitis C screening

“For screening, look at what worked with Hep C. A dedicated trust that focused on hostel populations, resourced staff to feel confident having conversations about Hep C, giving literature and knowledge. The programme focused on key workers and equipped people to answer questions.”

The national Hepatitis C screening programme has been rolled out in homelessness settings in England with high effectiveness. The programme has targeted homelessness providers including hostels, day centres, substance use services and street outreach.
Learning from this service (taken from *Evaluation of hepatitis C test and treat interventions targeted at homeless populations (outside London) in England during the COVID-19 pandemic report 2020,* Public Health England.

- Screenings take place **on site –** with staff testing in homelessness settings so they can meet people where they are.
- Staff have time to work **assertively** and **in person.**
- **Key workers** are treated as key community partners – spreading information about screening to their clients and promoting engagement with clinics.
- The success relies on **partnership working –** NHS, Hep C Trust, local authorities, homelessness providers and peer supports **all work together** to enable success.
- Pools resources with **other related services:** sexual health, TB screening, smoking cessation support, housing assessments.
- **Services may be resistant to engage at first –** so talk to them about their concerns and find workarounds if you can.
- Be flexible in **where testing can be administered –** adapting to the space you have available.
- **Specialised mobile testing vans** can help overcome barriers – fit for purpose and unmarked to avoid stigmatisation.
- Focusing on educating people can help **reduce stigma** associated with certain conditions or tests.
- Promotional materials for clinics should be **displayed prominently** and contain **specific details regarding dates and times.**
- When sharing screening results **conduct repeat visits to the clinic venue** and **liaise with key workers** to locate clients and share information.
- **Be willing to innovate!** Every setting and every client is different – test things out and find what works.

“It’s not just a poster on the wall. There are a million posters for everything – you need to get people talking about it and feeling curious. Then run a drop in at the hostel.”

System-wide solutions

“Sometimes you need people who have dedicated time to unblock barriers, but staff are so busy they simply don’t have time. Dedicated, specialised staff would really help.”

Despite the positive and creative suggestions made by staff, it is clear that there are systemic barriers that must shift if meaningful progress is to be made on equalising screening rates for people experiencing homelessness.

Contact

“There are post-appointment communication challenges. Is there another way to speak to a patient other than phone/post? We should flag these difficulties on a patient’s record.”

Consistent communication can prove a significant challenge to maintaining engagement with people experiencing homelessness. People may change address or phone number frequently and can face inadvertent exclusion from systems that rely on one form of contact. Flexibility within screening systems to register alternative forms of contact or maintain support through a named advocate or key worker would support wider inclusion.

Time

“We need time – to build a relationship, build confidence and trust, find out what they’re anxious about – it’s often not what’s on the surface.”

Trusting relationships are the hinge on which effective support for people experiencing homelessness relies on. While working alongside trusted workers can help smooth this process, the ability to conduct community engagement relies on time. But, as the NHS faces continuous cost challenges, outreach and community engagement activities have grown limited as services are expected to do more with less. Ensuring screening teams have capacity to conduct assertive engagement activities with high-risk groups can only be achieved by assuring those teams have the guaranteed hours and funding to put into this.

Education

“We need to get rid of the myths around screening – the whole point is about looking out for early signs so that cancer is treatable.”

One of the core problems of preventative healthcare initiatives is in helping people to understand its relevance in their lives. For people experiencing homelessness, who may have numerous competing priorities and where medical interventions are commonly sought in emergency settings, engagement with preventative care such as screening is low. Targeted Government programmes to promote and educate on screening, such as has happened in relation to TB, would be of worthwhile investment.

Innovation

“Self-testing – it’s happening in Australia, piloting in London, so people can test in their own home. It would be good to roll this out and may make a difference with at-risk communities.”

At current, cancer screening continues to rely on patients accessing support on-site – which can prove challenging for people who feel anxiety in medical settings. Breakthroughs in self-testing could be of enormous benefit to people experiencing homelessness, giving people the opportunity to conduct testing in their own time. Such approaches may also allow key workers to more easily integrate conversations around screening into their support planning.

Government should continue to invest in the testing and rollout of innovative approaches to screening and test their applicability for groups who are subject to health exclusion.

Good practice

There is also existing infrastructure for outreach screening targeting excluded groups. This can include the use of mobile breast screening units, which can be deployed to support women who are less likely to engage in hospital settings, including homeless women. There is international evidence of their successful use in homelessness settings,[63] although there is limited evidence of their use for this population in England.

There has been more success in cervical screening outreach programmes, which have been delivered in sexual health and community settings successfully for a long time. This includes drop-in screenings in homelessness services such as takes place in Blackpool[64] and the Cervical Screening Hub in Colchester.[65] Both examples use a more flexible approach than traditional healthcare settings, offering pre-screening chats to discuss the procedure and 'address any fear/feelings/embarrassment they may have about screening'. Similar approaches can be adapted from Nervous/Anxious clinics as found in Croydon, where patients are allowed multiple appointments of a longer length to overcome anxieties around cervical screening.[66] All examples require clinicians who are trained and skilled in working with the client group and in adopting trauma-informed approaches. This includes clear explanations of how procedures work, gentleness and reassurance throughout, and ensuring patients are given practical tips on how they can make the procedure more comfortable.

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[63] Moravac, C. (2018). Reflections of homeless women and women with mental health challenges on breast and cervical screening decisions: Power, trust and communication with health providers. *Frontier Public Health.*

[64] Healthwatch Blackpool. (2022). *Championing What Matters: Annual Report 2021-22.*

[65] Wilkinson, M. (2023). *Homeless Health Cervical Screening Hub in Colchester.* The Queen's Nursing Institute. Available at: https://qni.org.uk/resources/homeless-health-cervical-screening-hub-colchester/

[66] Croydon GP Collaborative. (2023). *Cervical Screening for Nervous and Anxious Patients.* Available at: https://www.cgpc.uk/cervical-screening. Accessed 18th July 2023.

Models of assertive outreach can also be borrowed from other healthcare areas. The NICE guidance on working with people experiencing [67]

Screening hub, Blackpool

Delivered as part of the Homeless Health Hub Nursing Service, nurses in Blackpool deliver a drop-in screening session on-site at a homelessness service. This involves breast and cervical screening delivered alongside nail-painting and 'pampering' sessions, hot showers and refreshments.

The team liaise with other agencies working in Blackpool to notify them of the upcoming sessions and maximise engagement, including engaging with hostels, housing teams and substance use services. The same service delivers a dedicated 'health bus' clinic open to people experiencing homelessness weekly.
"There are other professionals who tend to have more contact with homeless people, so it made sense to work in partnership with them so we could reach those missing out".

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[67] National Institute for Health and Care Excellence. (2022). Integrated health and social care for people experiencing homelessness. Available at: https://www.nice.org.uk/guidance/ng214/resources/integrated-health-and-social-care-for-people-experiencing-homelessness-pdf-66143775200965

focuses on reasonable adjustments that clinicians in any healthcare role can make to improve their clinical practice when working with excluded people.

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What We Do

Homeless Link is the national membership charity for frontline homelessness services. We work to improve services through research, guidance and learning, and campaign for policy change that will ensure everyone has a place to call home and the support they need to keep it.

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