

Transforming Hospital Care for Inclusion Health: Improving Treatment, Discharge and Community Links

One of a series of Pathway Policy Papers to inform the next decade of healthcare

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About the author

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Foreword

We are at a turning point in the long and proud history of our National Health Service. Described as 'broken' by the Secretary of State, there is a clear choice in how the Government restores when developing its 10-year Plan. This choice is between the continued, widespread exclusion of people facing severe deprivation from care, or rebuilding the NHS inclusively, slanting effort and resources towards those people in inclusion health groups, whose needs are among the most complex and severe in our country.

Pathway is publishing these policy papers to inform this choice. Drawing on the expertise of some of our Pathway Fellows and Faculty members, as well as our colleagues with lived experience, we offer to shine a light on what is possible and to offer thoughts and actionable ideas for change. We invite Ministers to take these ideas and the problems they are designed to solve into account when shaping the 10-year Plan.

The challenges described in the papers echo those seen every day by our Pathway hospital teams. Patients who could have received help earlier only receiving it at crisis point, wasting human potential and precious resources. The desperate challenges people face accessing help for combined mental health and substance use problem. The failure of our housing system to provide safe places to recover from illness and to stay well.

It is not like this everywhere, however, and it does not have to be like this forever. The papers point to evidence of what works in health and care services to meet the needs of people in inclusion health groups, as well as beacons of good practice around the country. Together, they show how choices could be made within the NHS to reverse the inverse care law, tilting time and resource towards those who need it most. Prevention is a strong theme throughout, showing how people's problems can and should be addressed before they spiral out of control.

The benefits of action go far beyond health - meeting people's health needs unlocks other gains, addressing underlying risks of homelessness in particular, enabling people to live well and for longer, as the Government wants to see us all do.

I am very grateful to our Pathway Fellows and other experts who have made time, often in the midst of busy clinical and frontline jobs, to share their thoughts and expertise in these papers. Britain led the world with the establishment of the NHS more than 70 years ago. As we write the next chapter of its history, let's make care and compassion for those who need them most central to its mission.

Alex Bax, CEO, Pathway

Summary

- The Government aims to move care out of hospital and into the community, but hospitals will continue to play a major role in providing care to people in inclusion health groups into the future. This is because of the high burden of disease faced by these groups, and past poor access to preventive and primary care.
- Hospitals should maximise the potential of every admission to provide comprehensive holistic care, to change the direction of someone's life, improve the help they receive, reduce the need for future re-admission, and prevent further deterioration of multiple health problems.
- Too often this is not what happens. Stigma and discrimination lead to poor care and high rates of self-discharge. Discharge planning is often not co-ordinated with housing and other services. The picture is of multiple repeat admissions and emergency attendances, missed opportunities to intervene, and the attendant high-cost burden of emergency, unscheduled care.
- Policy developments such as the Duty to Refer under the Homelessness Reduction Act, and the Discharge to Assess framework, have not brought about the hoped-for step change in this situation and need reform.
- The Government should ensure that all hospitals seeing more than 200 patients a year facing homelessness, commission a specialist, multi-disciplinary Pathway Team to oversee care co-ordination, and also implement a national mechanism to audit every self-discharge and every discharge to the street.

What is inclusion health?

Inclusion health is a growing field of research, activism, clinical practice, and care devoted to improving health and social outcomes for the most excluded groups in society. Although much early impetus focussed on improving health services for people experiencing homelessness, over the last 15 years the concept of inclusion health has expanded to cover a range of groups where extreme social and economic exclusion creates extreme health risks and health harms.

The degree of risk and harm observed in inclusion health groups falls far below even the depressing 'normal' range of health inequalities in British society. Disease prevalence rates can be up to 50 times higher than in the general population and mortality gaps between inclusion health groups and the average can be 30 or 40 years. Inclusion health groups can be defined by this observed extreme distance from the general population in terms of health status.

People in inclusion health groups include people experiencing homelessness, Gypsy, Roma and Traveller people, people engaged in sex work, vulnerable migrants and people in contact with the Criminal Justice System. There is a strong body of evidence of what works to improve health and care for these groups: NICE published guidance on homelessness in 2022 and NHS England produced a national inclusion health framework in 2023, but there is an 'implementation gap'. The good practice evidence is available but all too often that evidence is ignored or only followed spasmodically.

Introduction

Signalling the three shifts it wishes to see following the Darzi review, the Government has said its ambition is to move care out of hospitals and into the community, from analogue to digital, and from sickness to prevention¹. This will be harder to achieve for people in inclusion health groups, as their access to care in the community is often poor, leading to disproportionate and intensive use of hospital-based services. People experiencing homelessness attend emergency departments six times as often as housed people, are admitted four times as often, and stay on average twice as long².

This paper focusses on how to improve in-patient hospital care and discharge co-ordination for people experiencing homelessness and other inclusion health groups, and how maximising the benefit of a hospital admission can be good for the patient and for the entire system¹.

When admitted, these patients often report poor experiences of care. This includes direct failure to adequately respond to their needs, for example with opiate substitution therapy, and also unequal access to services like rehabilitation and intermediate care, which can mean that the admission is unduly prolonged. Such failures result in a range of negative outcomes including very high rates of self-discharge, discharge delays, or discharge to the street. The latter is a devastating outcome for a person's health, which itself should be seen as a 'never' event in safety terms. 74% of specialist staff in inclusion health also report negative attitudes towards their patients from other staff as one of the main barriers in their work.³

One in every six people experiencing homelessness takes their own discharge from hospital before their treatment is complete. They are at high risk of deterioration and re-admission, especially as their GP will not receive any information about the treatment episode. This both puts them at additional risk and misses an opportunity to prevent a further admission.⁴

At least 4,000 discharges from hospital back to the street occur every year, or 12 people every day, with the true total figure being possibly twice this number. Each one of these people has recently been ill enough to be admitted to hospital, is being discharged to a plainly unsuitable environment, and is therefore at high risk of being admitted again in a worsened health state⁵.

While providing better care for everyone outside of hospital is a laudable objective - and other papers in this series talk about how to achieve this - secondary (hospital) care will

¹ This paper does not specifically address improvements in A&E, but there is a range of good practice material and training for A&E staff on Pathway's [web site](#).

continue to be a major part of the way the NHS provides healthcare to people facing homelessness and other inclusion health groups for the foreseeable future.

Every emergency admission of a patient experiencing homelessness should be seen as an opportunity to change the way the person is living and to increase or re-plan the assistance and care they need, reducing the need for re-admission, and improving individual health outcomes in the future. Improving the quality-of-care homeless patients receive while in hospital, alongside the provision of high quality specialist step-down care, will improve these patients' health, and ultimately, reduce the overall burden on the NHS.

In parallel, efforts must be made to develop high quality community and primary care services, easily accessible to people in inclusion health groups, and to increase the supply of suitable accommodation readily accessible on discharge from hospital, helping us make the best use of secondary care resources at the right time, and for the right period of time.

What is the problem we are trying to solve?

Hospital staff often have a limited understanding of the multiple issues facing people in inclusion health groups, particularly links to Adverse Childhood Experiences and past trauma. Due to stigma and discrimination, people from these groups are often wrongly seen as being responsible for their own health problems and therefore less deserving of sympathy, resources and care.⁶

Poor quality care is compounded by poor understanding among staff of the clinical issues that disproportionately affect these groups, and inadequate provision for specialist management of alcohol and drug dependence and mental health problems increases the risk of self-discharge before completion of treatment.

Discharge planning for people with complex issues and homelessness is very variable, with some Trusts having few or no links with housing and community services. A default position of discharging patients back to homelessness often exists. Knowledge of existing guidance is poor, and the legal 'Duty to Refer' to local authority housing services under the Homelessness Reduction Act is not routinely followed.⁷ When a person becomes too unwell to be discharged the lack of community links and suitable discharge destinations leads to long delays.

If a person decides to discharge themselves, no follow up is arranged, and no discharge summary is sent to their GP, meaning management of their condition will be suboptimal. This

commonly leads to re-admission within a short period of time, and repeated cycles of expensive, incomplete episodes of emergency care.

This situation is further compounded by people not feeling able to present for help until their condition is very advanced and sometimes terminal. Patients who have had bad experiences in the past delay seeking help until their situation is critical. When they are ultimately admitted to hospital, treatment is more complicated, more expensive, takes longer and is less likely to be successful.

Systemic and policy issues lie behind these poor outcomes. There is a general lack of integration between Secondary Care Trusts and Primary Care and community services and there is often little joint working with other statutory services such as Local Authority Housing and homelessness services who would be able to provide additional support after discharge.⁸

Policy background

Recent years have seen a plentiful supply of national policy and guidance on hospital discharge. Largely aimed at reducing pressures on acute services, these have failed to bring the changes necessary to meet the needs of people facing homelessness because they are predicated on patients having stable housing, and fail to recognise the complexity of the situations inclusion health patients face.

The main policy development on hospital discharge - 'Discharge to Assess' (D2A) - was first introduced in 2016 and has been updated since. It aims to reduce the numbers of delayed discharges in hospital by arranging assessment of a patient's care needs to take place post-discharge, usually assumed to be back in their home, or in a temporary placement such as an intermediate care facility. The specialist homelessness intermediate care facilities needed to make this work do not exist in most areas. Patients are streamed onto different pathways depending on the complexity of their situation, with 0 being 'simple', and 3 being the highest level of complex need. The way in which this has been applied has been very variable for people experiencing homelessness. Some areas have deemed them all to be complex, and so on Pathway 2 or 3 and needing intermediate care or care home 'placement', while others have not taken the patient's homelessness into account and deemed all people facing homelessness to be Pathway 0 and discharge back to the street. To quote one member of staff: "if they came in homeless, they could go out homeless".⁹

In January 2024, MHCLG and DHSC published more specific guidance: 'Discharging People at Risk of or Experiencing Homelessness'. It gives examples of good practice and step-by-

step guides and tools that can be adopted for local use. In particular, it recommends that specialist housing officers should be embedded in local systems' Transfer of Care Hubs. It is not clear how much impact this guidance has had so far.¹⁰

Integrated services are the bedrock of effective care for people in inclusion health groups. The evidence for this was set out in NICE Guideline 214 'Integrated Health and Social Care for People Experiencing Homelessness' in March 2022. This gives evidence-based guidance on the best available ways to design, commission and deliver care to these groups, including the need for outreach and in-reach, multidisciplinary homelessness teams to work both within hospitals and the community, and joined-up care around the patients. There is a low level of awareness of and adherence to the guideline recommendations at present.¹¹

The 'Duty to Refer' legal duty was included in the 2017 Homelessness Reduction Act and attempts to bring about a degree of integration between hospitals and local authority housing services. It places a legal duty on public institutions, including hospitals, to inform local authorities when someone who is homeless or threatened with homelessness is using a public service. Apart from staff in specialist homelessness teams (like Pathway Teams) and some discharge hubs, the duty is not well known in secondary care settings and compliance with it is not monitored, inspected or enforced¹².

Finally, NHS England's 'National Framework for NHS Action on Inclusion Health' (October 2023), stresses how partnerships across different sectors, including health, housing, voluntary and community sectors, are vital in improving the health of people in inclusion health groups. The framework stresses the role of hospitals and Trusts in ensuring inclusion health groups can access the best possible care and long-term support by collaborating with the other sectors.

Taken together, all these policy documents provide a plethora of evidence-based, up-to-date guidance for secondary care services trying to plan for the safe discharge of people who are homeless in hospital. The fact that they are not used to guide practice more widely should be of widespread concern.

What is the evidence?

There is a substantial body of evidence-based guidance and good practice that demonstrates how hospital admissions should be used to meet the needs of people in inclusion health groups. The NICE Guideline points to the importance of using "hospital admissions as an opportunity to offer a comprehensive, holistic needs assessment, including

referral, if indicated". Multi-disciplinary teams, such as Pathway Teams, are critical to delivering this kind of care.

Recent evidence shows that of the patients supported by Pathway Teams in 2022-23, rough sleeping was reduced by 50% and sofa surfing by 35%¹³. This builds on an earlier randomised control trial showing reductions in street homelessness and improvements in quality of life for patients treated by Pathway Teams¹⁴.

Characteristics of this effective, evidence-based care include:

- **Multidisciplinary in-reach.** Multidisciplinary meetings should take place with housing, Adult Social Care, safeguarding and third sector input, in order to reduce risks for patients and improve collaborative working.¹⁵
- **Clear and consistent protocols for the management of alcohol and drug withdrawal syndromes,** supervised by in-reach specialist community teams.
- **Multidisciplinary planning of discharge** in conjunction with community services including housing, Adult Social Care and local specialist homelessness services from both the voluntary and statutory sectors.
- **Formal processes to track and review all discharges to the street and all self-discharges** among this patient group, recognising that these events will very often mean there are serious safeguarding issues that should be followed up.

Recommendations

The evidence is available, and guidance clear, on what needs to happen to improve the secondary care response to people from inclusion health groups, yet practice in this area remains variable and often poor. This stems from pressure in the system being focussed on discharge, and 'discharge to assess' being wrongly applied in these groups. The short-term thinking that the pressure brings meets with the lack of understanding of the person's needs, and the stigma experienced by people who are homeless, dependent on drugs or alcohol, or living with a mental illness. The patient becomes a 'problem' to be solved which is preventing more deserving people from getting the care they need. Even the published guidance can be dismissed as unrealistic on the ground, and therefore does not get followed.

Government policy in recent years has signalled that the areas worthy of NHS time, focus and resources have been the recovery of elective capacity and reduction of waiting lists, reducing the demands on emergency services, and maintaining the workforce, particularly in Primary Care.

Stronger indications are needed to alert Trusts to prioritise the needs of the people with the worst health outcomes. Until now it has been too easy for staff and managers to ignore these needs as someone else's problem or a low priority. Policies should be put in place to shift the focus of Trust leadership and staff, making inclusion health groups and their needs a top priority, to help raise the quality of hospital care, so that more of that care can ultimately take place closer to the community.

Short-term

1) Government should mandate self-assessment against current standards and guidance for all NHS Trusts

Trusts should be directed to undertake a self-assessment exercise against the best practice outlined in the DHSC guidance document regarding discharging people threatened with or experiencing homelessness, and produce a timetable for improvement.¹⁶

This should be accompanied by a mandatory audit of all discharges to the street over the previous year, and all self-discharges, on an ongoing basis, in order to look for patterns and create an improvement plan for publication in both areas.

2) Targets to prioritise improvement areas for inclusion health groups

In its new performance and accountability regime for the NHS, the Government should set targets to focus on the most important outcomes which aim to drive up the quality of hospital care, and ultimately help to shift care to the community.

One target should be to reduce the self-discharge rate for people experiencing homelessness to 4%, which is the same as the general population.

GP registration is particularly important for these groups, as follow-up and management of long-term conditions can be difficult. Trusts should prioritise this area, building links with Primary Care services, and set a target to ensure that 90% of patients are registered with an accessible GP on discharge.

3) The Government should drive greater senior hospital leadership and collaboration to improve outcomes for people in inclusion health groups

The Government should direct every Acute Trust to appoint a senior clinical board member to be the Inclusion Health Director, with responsibility for improving practice and outcomes regarding homeless and inclusion health. This director would have responsibility for ensuring that audits are completed, improvement plans are produced, and targets met. They would also ensure that collaborative working with community services, housing and voluntary groups is developed and given priority.

Medium Term

4) The Government should establish a hospital safe discharge programme, ensuring that no one is discharged to the street and that every hospital admission is an opportunity for prevention

Through commitments in the Spending Review, underpinned by strengthened accountability mechanisms, the Government should establish a national improvement programme to drive up the quality of hospital admissions and discharges for people facing homelessness and other inclusion health groups. Making the most of the window of opportunity provided by a hospital admission will be vital to ensuring that more care can move out of hospital through better connections with community-based services, and reducing readmissions.

Every Acute Trust with more than 200 patients facing homelessness each year should establish a Pathway Team; those with under 200 should appoint a homelessness lead nurse and embed a housing worker in the Transfer of Care Hub.

The programme should scale up specialist intermediate care for people facing homelessness to around 300 settings over a 10-year period, to meet need.

5) The Government and NHS England, working with the relevant Royal Colleges, should establish an inclusion health workforce improvement programme

The importance of improvement in the attitude, knowledge and skills of the workforce when caring for the inclusion health population in hospital cannot be overstated. The need for kindness and empathy is vital to a positive experience for all and good outcomes for health, but they are often missing.

Government policy should include the introduction of mandatory education for all staff regarding homelessness and inclusion health, including the links with Adverse Childhood Experiences and mental health issues, and the need for empathy and trauma informed approaches.

Long-term

6) Government Policy on Trust Inspection

The inspection regime for Secondary Care Trusts should be modified to make a greater priority of the improvement of the care of people in the inclusion health population and the planning of their discharge. Clear, evidence-based guidance is available and should be used as the basis for the new inspection regimen.

NICE Guideline 214 covers the areas necessary to demonstrate good practice and its recommendations for secondary care should be used as the basis for this new inspection protocol.

NHSE guidance on the discharge of people experiencing homelessness from hospital should be used to create the criteria for inspection on discharge procedures and the progress of Trusts towards integrated working with community partners.

Lived Experience Perspective

Lived Experience Programme Volunteer, Pathway

An admission to hospital has the potential to be life changing for someone facing homelessness. Treating a patient holistically and with empathy allows for interventions which not only address their immediate medical needs, but which also improve their quality of life. It presents the opportunity for a person to be discharged from hospital with accommodation in place, their health needs addressed, and a plan for follow up in the community.

And yet, in my personal experience of homelessness, and now my professional experience working in a hospital, I repeatedly see this opportunity go to waste. Negative attitudes towards patients caused by a lack of understanding amongst staff about people's interconnecting needs, experiences and backgrounds, allows stigma, unconscious bias and discrimination to continue unchecked.

When I was admitted to hospital, this lack of understanding and education also meant that staff were unaware of the policies that had my health and wellbeing in mind. Whilst there are procedures and policies in place, they are rarely used due to the stigma attached to those facing homelessness.

Together we must build an understanding of how stereotypes can get in the way of effective health treatment, empower practitioners to fulfil their legal duties, and create a culture change which normalises accountability.

There are countless examples of patients being discharged from hospital unsafely, largely down to a lack of communication between services. For example, I have seen many cases where a patient has self-discharged from a ward, and the community services which support them have not been informed. It comes as no surprise that these patients very often present at the Emergency Department once again, where the process will begin again. Therefore, there is a need for stronger care coordination, which is built on a foundation of communication between secondary care and community services and multidisciplinary working to support patients.

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