INCLUSION PAYS

Preventing Crisis. Reducing Cost. Improving Flow.

A practical guide for commissioners and system partners.

Refugee and Asylum Seeker Service

When health services reach people before crisis, the system works better - and costs less.

Inclusion Health isn't just about fairness; it's also about using NHS resources where they deliver the greatest value.

Our Inclusion Pays series sets out the financial and operational case for investing in groups too often excluded from timely, coordinated care — including refugees and asylum seekers, people experiencing homelessness, Gypsy Roma Traveller communities and veterans. Through targeted outreach, prevention and partnership, our model delivers these clear system benefits:

- Fewer people entering urgent and emergency pathways
- Shorter time spent in hospital and faster, safer discharge
- Lower overall cost through community-led, primary care intervention
- Improved access, experience and outcomes for Inclusion Health groups

This is Inclusion Health as it should be delivered: practical, data-driven and proven to reduce pressure across urgent, acute and community services - while improving access and outcomes for people who would otherwise reach care too late.

We would like to thank NHS Surrey and Sussex Integrated Care Board for their ongoing support of the Inclusion Health Refugee and Asylum Seeker Service.

We're keen to share our experience and work alongside partners to strengthen Inclusion Health across systems. Please get in touch to continue the conversation.

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About us

Born out of crisis response, built for long-term sustainability.

Developed in response to an urgent system gap, our service has become an award-winning, scalable model of coordinated, data-driven and compassionate care for people arriving in the UK without access to healthcare.

As a GP federation, Alliance for Better Care unites 77 practices across Surrey and Sussex, connecting primary care with community and voluntary partners to reach people excluded from traditional health systems.

Managing a fluctuating population of over 3,000 patients.

Our model is a proven, scalable approach that delivers on the NHS long-term plan, tackling inequalities, supporting discharge and turning early intervention into measurable system value.

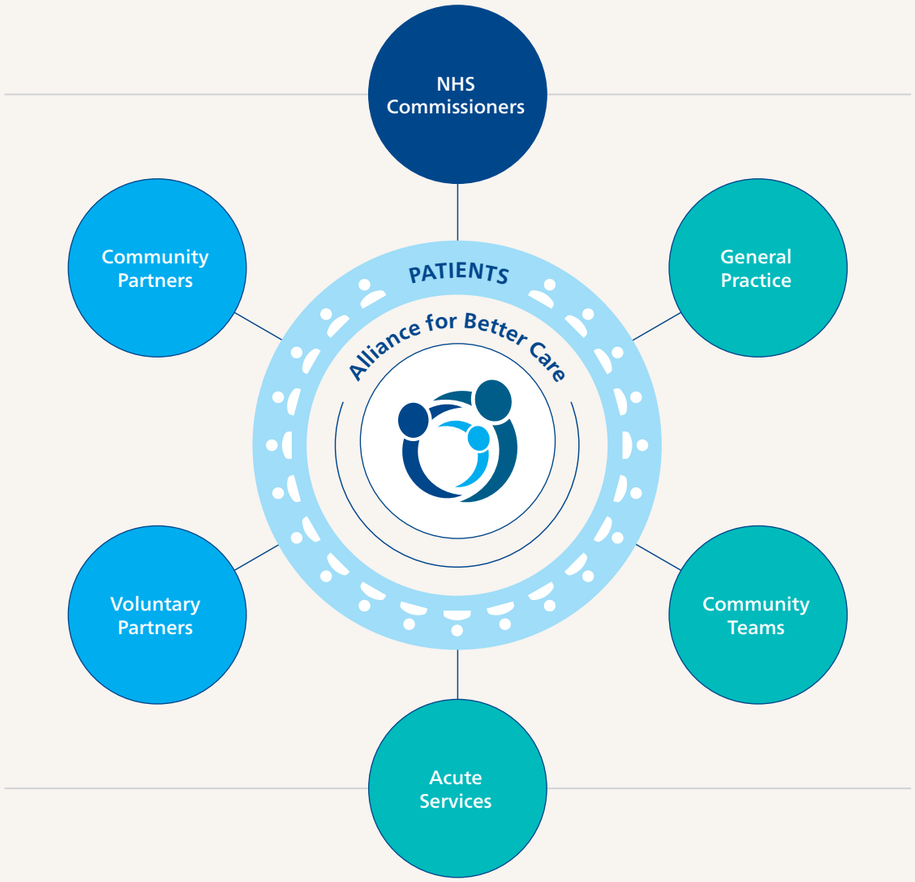
We work at the point where clinical risk, social vulnerability and system fragility intersect. The impact of this model is clear and measurable. It includes:

- Preventing avoidable urgent care attendance and A&E admissions
- Improving hospital flow through coordinated discharge
- Supporting people with complex long-term conditions on arrival
- Reducing public health risks through early detection and screening
- Strengthening safeguarding for people at risk of exploitation or harm
- Increasing access and reducing demand through digital inclusion

Why we're the specialist partner of choice

We are proud to be a trusted, proven partner in Inclusion Health — delivering measurable system value and compassionate care for those most at risk of exclusion.

We work at the centre of a connected ecosystem — linking NHS Commissioners, primary care, community teams and acute services with voluntary and community partners. Every pathway is co-designed around the needs of patients who face the greatest barriers to accessing care.



Specialist clinical expertise

Skilled in managing complex Inclusion Health needs, providing continuity of care additional to core GMS work.

Highly trained, trauma-informed workforce

Experienced in providing safe, compassionate care in non-clinical settings such as hotels, temporary accommodation, hostels and community hubs.

Rapid, flexible deployment model

Ready to respond to emerging population needs and system pressures.

Data-led delivery

Using real-time data to track access, outcomes and efficiency, ensuring resources are used effectively and transparently.

Proven impact on system flow

Demonstrable reductions in A&E attendances, delayed discharges, DNAs, re-admissions and unregistered patients.

Excellent patient experience

Consistent feedback showing improved wellbeing, safety and trust among our most vulnerable communities.

Integrated partnership network

35+ organisations across voluntary, NHS and local authority sectors working together to address both health and social determinants.

National recognition for innovation

Highly commended at the HSJ Partnership Awards and featured in NHS England case studies as a model of good practice in Inclusion Health.

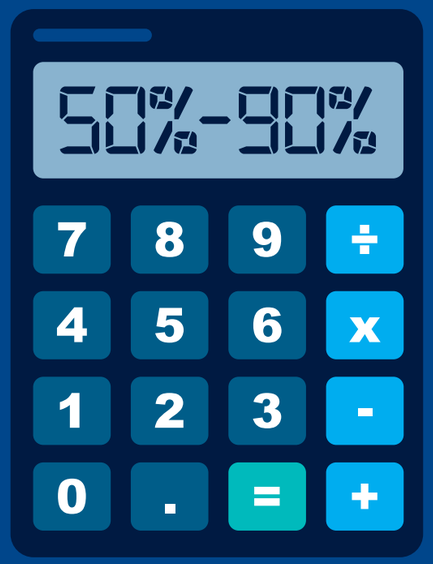
Health Inequality is expensive

Commissioning this model delivers a return of up to £13 for every £1 invested by preventing escalation into urgent and acute care.

By modelling avoided hospital admissions, reduced urgent-care demand and earlier, coordinated support, this analysis shows exactly what the NHS saves when community-led intervention replaces crisis. It quantifies avoided cost, released capacity and the measurable system value delivered by ABC's Inclusion Health model.

Return of up to £13 for every £1.00 invested

System savings:



Burns Management

This scenario reflects a realistic pathway where burns are managed through emergency and outpatient services when early, community-based intervention is not in place.

In the absence of timely assessment and follow-up, care defaults to higher-cost hospital settings for conditions that could be safely managed in the community.

70%

of system savings with ABC
£564.00 per patient

Return on investment:
£2.28 saved per £1 invested.

Patient presentation: Burns sustained during transit, commonly linked to fuel exposure on boats, with pain, blistering and risk of infection.

Without ABC
Hospital-led pathway

£811.00

£ £ £ £ £ £ £ £ £ £

Patient presents to A&E due to lack of early access to community-based assessment, wound care and follow-up. Language barriers and unfamiliarity with the health system limit understanding of self-care and when to seek help.

- 1 × A&E attendance
- 1 × first hospital outpatient appointment
- 2 × follow-up hospital outpatient appointments
- 3 × GP appointments for ongoing wound review, concerns and repeat dressings

(Excludes dressings and pain relief)

With ABC
Community-based, primary care-led pathway

£247.17

£ £ £ £ £ £ £ £ £ £

- 7 nurse-led contacts (assessment, dressing changes, monitoring)
- 30 minutes per contact

Scabies

This scenario reflects a realistic pathway where scabies is not identified or treated early, leading to repeat presentations, escalation into urgent care and increased risk of transmission within households or communal accommodation.

Delayed intervention drives avoidable pressure on emergency services and wider public-health risk.

92%

of system savings with ABC
£849.39 per patient

Return on investment:
£13.03 saved per £1 invested.

Patient presentation: Severe itching, secondary infection and safeguarding concerns.

Without ABC
Hospital-led pathway

£920.00

Patient does not understand treatment protocol – limited access to laundry and clothes, risking reinfection and spreading to family members.

- **x3 A&E presentations**
  Ongoing symptoms for initial patients plus two family members.

(excludes medication, outbreak management and staff absence)

With ABC
Community-based, primary care-led pathway

£70.61

- **x1 hour HCP appointment**
  Diagnosis and treatment issued, with education, including liaison with hotel staff regarding laundry and voluntary sector and community partners regarding adequate supply of clothing.
- **Follow up HCP appointment**
  Ensuring effective treatment and no further spread.

(excludes prescription and medication)

Termination of Pregnancy

This scenario reflects a realistic pathway where lack of early access, language support or system navigation results in delayed presentation and escalation into urgent or acute care.

Through early identification, navigation and follow-up, our service enables access to medical termination up to four weeks earlier, supporting timely decision-making and avoiding escalation to more complex, higher-cost interventions.

53%

of system savings with ABC
£855.76 per patient + 4 weeks

Return on investment:
£2.12 saved per £1 invested.

Patient presentation: Unplanned pregnancy in a woman experiencing distress and uncertainty, with delayed access to information, language support and timely referral.

Without ABC
Hospital-led pathway

£1,619

- **1 × Double GP appointment**
  (confirmation of pregnancy and referral)
- **1 × BPAS clinic appointment**
  (counselling and decision-making)
- **1 × Surgical termination**
  (up to 14 weeks)
- **1 × GP appointment**
  (for emotional distress)
- **Talking Therapies**
  assessment and treatment

With ABC
Community-based, primary care-led pathway

£763.24

- **1 × Nurse consultation on arrival**
  (pregnancy test, options discussion and referral)
- **1 × BPAS clinic appointment**
  (counselling and decision-making)
- **1 × Medical treatment appointment**
  (within appropriate gestation window)
- **2 × 30-minute nurse follow-up contacts**
  (medication support, symptom monitoring and recovery support)

Our model isn't just compassionate, it's cost-effective

By reaching people early, working across agencies and coordinating care in community settings, we:

- prevent avoidable admissions,
- reduce time spent in hospital pathways, and
- support faster, safer discharge.

The result is better outcomes for people - and lower cost for the system.

6,695 patients seen and 11,134 patient contacts*

*over a 12 month period.

Measurable impact across primary care, prevention, urgent care and flow

These outcomes demonstrate delivery against the NHS Long-Term Plan — improving primary care access, reducing demand on urgent and emergency care, and strengthening hospital flow through proactive, community-based intervention.

NHS Priority	What We Deliver	Our Impact
From sickness to prevention		
• Reduce inequalities	• Targeted, trauma-informed outreach	• Fluctuating population of over 3,000 people supported
• Prevention first	• Integrated screening, vaccination, health checks	• Outbreaks prevented, early diagnoses increased
• System value (prevention)	• Early intervention	• Reduced crisis demand and pressure on urgent care
From hospital to community		
• Shift care from hospital to community	• GP-led clinics in clinical settings	• Avoided admissions, reduced A&E demand and facilitated early and safe discharge
• Partnership working	• Collaboration with 35+ partners	• Joined-up, co-designed pathways
From analogue to digital		
• Digital innovation	• Dashboards, triage and self-referral tools	• Faster access and data-driven decisions

Inclusion pays in practice

Measurable system value, delivered now. Over the past 12 months, our Inclusion Health model has reached people before crisis, protected NHS resources and strengthened care across primary, urgent and community services.

1. Urgent and emergency care avoidance

Diverting crisis presentations and protecting hospital capacity.

95%	of patients treated within the service did not require onward urgent care
3	Emergency Department (ED) re-attendances for the same presentation over 12 months
92%	of burns cases managed without needing any discussion or referral to specialist burns unit
493	burns contacts, 13% of these were Paediatric
104	safeguarding escalations managed through coordinated community response

2. Primary and community care access

Improving continuity and reducing unregistered patients.

100%	of patients supported to register with a GP practice
6,695	patients seen and 11,134 contacts
133	direct referrals from patient transport provider

3. Hospital discharge and flow

Reducing delays and supporting safe, coordinated discharge.

42	discharges supported, with medication, GP registration and safety net follow-up in place
2 days	average discharge delay reduced by two days, freeing up acute capacity for others

4. Public health and screening

Preventing outbreaks and reducing the cost of late-stage disease.

100%	of new arrivals screened for communicable diseases and offered vaccination
95%	Diphtheria vaccination uptake achieved in one hotel population
11	active TB diagnoses identified early — preventing late-stage presentation and outbreak
27	blood borne virus and STI diagnoses detected and treated
17	new HIV diagnoses identified via clear pathways between ABC and sexual health

5. Maternity and women's health

Early identification, continuity and safeguarding for women and families.

392	pregnancy-related consultations (acute, routine, referrals)
67	referrals direct from hospital midwives for prescriptions, reviews and expedited registration
46	women with FGM identified and supported

6. Mental health and personalised care

Preventing crisis escalation and improving wellbeing.

60%	of mental-health consultations involved suicidal ideation
70%	managed by our service, with 30% referred to GP for medication monitoring
329	patients received 1:1 personalised care support
94%	of patients reported improved wellbeing

Inclusion in practice: real people, real impact, real system value

Our case studies offer a window into the everyday realities faced by people seeking refuge and asylum — and into the role that coordinated, trauma-informed Inclusion Health services play in preventing crisis, protecting public health and strengthening NHS capacity.

Behind each case is a person or family navigating unfamiliar systems, often with limited English, complex trauma histories, disrupted care pathways or long-term conditions that can deteriorate quickly without early intervention. These stories highlight the type of need that is often invisible in mainstream services — but highly visible in its consequences when people fall through the gaps.

"Thank you so much for this lifeline."

Patient, Refugee and Asylum Seeker Service.

View our case studies at:
allianceforbettercare.org/inclusion-our-impact

We don't just talk about lived experience, we build with it.

Co-designed with communities

Our model is shaped by the people it serves. People with lived experience help design and improve services so they reflect real lives, not assumptions.

Peer volunteers

We have established trusted support from within the community and have recruited and trained peer volunteers who have helped people engage earlier, navigate services and feel safe asking for help.

Culturally informed navigation that unlocks access

Our health advocates provide practical, culturally informed support — reducing miscommunication, preventing escalation and enabling people to navigate NHS services with confidence.

Personalised care team

Continuity that supports recovery. Our team builds trusted relationships, focuses on what matters to each person, and helps them access the support they need to move forward.

Trauma-informed

Our care is designed for safety, dignity and control. Specialist training helps to avoid re-traumatisation and deliver care that feels safe and empowering.

Case Study

Mother and newborn with Tuberculosis (TB)

System outcome: improved flow and public health protection

Improving hospital discharge and flow | Reducing health inequalities | Integrated care across settings

A 39-year-old asylum-seeking mother from West Africa was placed in a hotel in the Gatwick area with her nine-month-old baby following a complex journey. During her stay, she became unwell with respiratory symptoms and was initially treated by our team. When her condition failed to improve, she was referred to A&E, where scans raised concerns about TB.

When we first met her, she was anxious and exhausted. She had already been admitted and discharged once, then deteriorated again, leading to readmission. She was worried about her baby, frightened about returning to the hotel, and struggling to understand what was happening or what would come next.

Coordinated discharge and public health action

ABC's response:

- attended multiple MDT meetings with acute clinicians, health visitors and social services
- coordinated a safe discharge plan with local hospital, balancing clinical safety with the need to free hospital capacity
- visited the hotel immediately on discharge to assess both mother and baby
- provided daily, hands-on support to administer the baby's precautionary TB medication
- worked alongside the TB team, who attended the hotel with our nurses
- coordinated practical support with the hotel, including meals during isolation and reassurance about safety

Critical for safety and continuity

This approach enabled a safe discharge, maintained medication adherence and reduced pressure on hospital beds. Just as importantly, it reassured a vulnerable mother at a moment of acute anxiety, preventing reattendance and protecting both public health and hospital flow.

Case Study

Trafficked survivor – complex burns

System outcome: avoiding urgent care, supported discharge and recovery

Urgent and emergency care avoidance | Hospital discharge and flow | Mental health and personalised care

A young Vietnamese woman who had been trafficked to the UK sustained severe burns during a boat crossing when fuel mixed with salt water, causing deep tissue injuries. She spent several weeks in intensive care and was later transferred to a specialist burns unit for ongoing scar management.

When we first met her, she was isolated in hotel accommodation, in significant pain, with no personal belongings and struggling emotionally following her journey and hospital admission. She required ongoing dressing changes, pain management, trauma-informed support and coordination across multiple services.

Coordinated discharge and public health action

ABC's response:

- provided regular onsite burn dressing changes and coordinated scar management with the specialist burns team
- conducted pregnancy and sexual health screening due to safeguarding concerns
- assisted with pain management and medication adherence
- supplied clothing and basic essentials to restore dignity and comfort
- offered trauma-informed emotional support to build trust and confidence
- supported independence by accompanying her to services and connecting her with peer support groups

Critical for safety and continuity

This coordinated, trauma-informed approach supported the patient's safe recovery after hospital discharge, promoting both physical and psychological healing while reducing the risk of crisis, non-attendance, and readmission. By providing community-based dressing changes, ongoing support, and connection to specialist services, the patient has begun rebuilding her independence, engaging with her care plan, attending support groups, and managing her health more confidently.

Methodology

Data assurance

Figures are based on routinely coded clinical activity drawn from ABC's clinical systems, safeguarding reports and Inclusion Health dashboards. Outcome measures include validated clinical records and assessment tools, including the NHS-accredited MyCAW wellbeing tool used by the Personalised Care Team. All data is presented in line with standard clinical governance. Volumes vary due to population movement.

National benchmarking

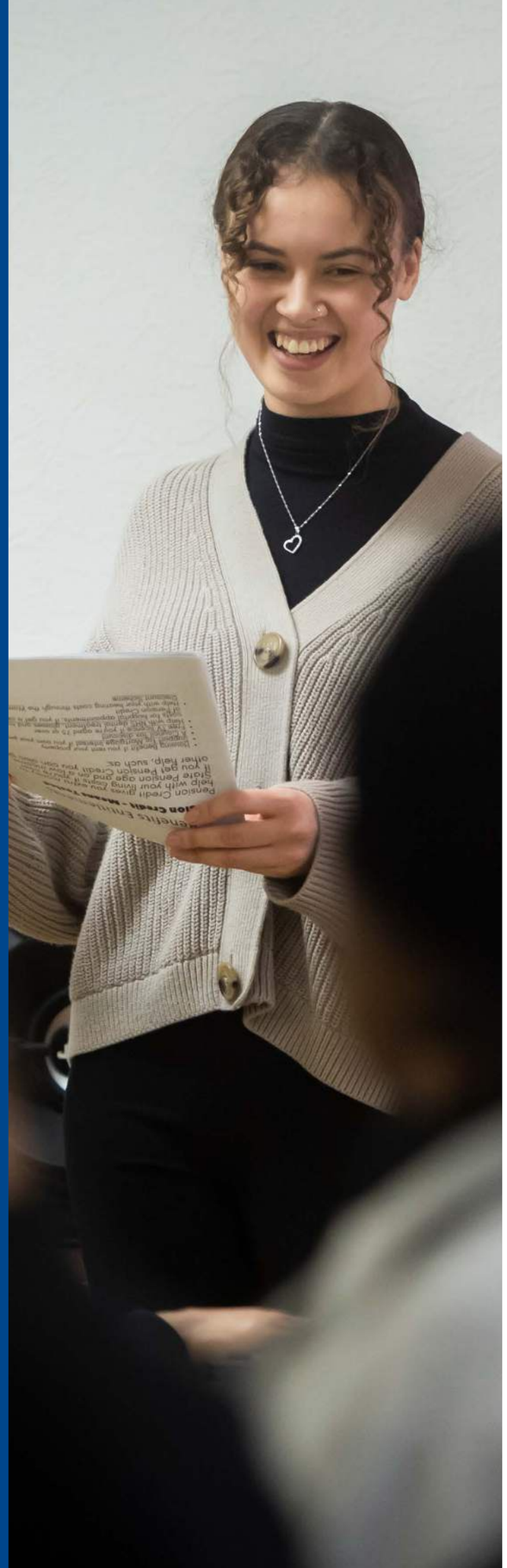
Where cost comparisons are presented, ABC's activity has been benchmarked against national NHS reference costs, using the NHS England National Cost Collection (NCC) – National Schedule 2024/25. This provides standardised unit costs for urgent, acute, community and outpatient care and enables consistent comparison between community-led and hospital-led pathways.

Return on investment (ROI)

ROI analysis compares real ABC-delivered pathways with likely hospital-led alternatives where early intervention is not in place. Each example reflects conservative assumptions and focuses on direct healthcare costs only.

Across the pathways analysed, early, community-led intervention consistently reduces escalation, repeat attendance and time spent in urgent and acute care. Returns vary by pathway depending on how conditions typically escalate when access is delayed.

Cost comparisons are illustrative and based on national reference costs; individual pathways and local tariffs may vary.



Thank you!

Our work is only possible because of the commitment and collaboration of the many NHS teams, voluntary organisations, not-for-profit groups and community partners who support us to create lasting change within a stronger, more inclusive health system.

A full list of our partners available at: allianceforbettercare.org/our-partners

- Department for Health and Social Care
- NHS England
- NHS Surrey and Sussex Integrated Care Board
- Africa Community in Surrey and Sussex
- Crawley Community Action
- Crawley Community Transport
- Crawley Game Changers
- Crawley Open House
- Crawley Borough Council
- Crawley Wellbeing
- Day Lewis Group
- East Sussex Community Voice (ESCV)
- FreeShop Crawley
- Goodsam
- Happy Baby Community
- Health innovation Kent Surrey Sussex
- Helen Bamber Foundation
- Home-start
- Horley Community Centre
- Love Your Neighbour, Crawley
- Menshare Listening Group
- Mole Valley District Council
- Mole Valley Ramblers
- Pathway
- Reigate and Banstead Borough Council
- Refugees Welcome Crawley
- Renewed Hope
- RHS Wakehurst
- Stripey Stork
- Surrey Community Action
- Surrey County Council
- Surrey Outdoor Activity Centre
- Sussex Aid for Refugees
- Sussex County Council
- Sussex Health Inclusion Network
- University of Sussex
- West Sussex County Council
- West Sussex Mind

Inclusion Health is a smart public investment.

This report shows exactly what the NHS saves when early connection replaces crisis — and invites commissioners to explore how this proven model could be applied in their own systems.

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Alliance for Better Care CIC

allianceforbettercare.org/refugee-and-asylum-seeker-service

Thank you to NHS Surrey and Sussex Integrated Care Board for their ongoing support of the Inclusion Health Refugee and Asylum Seeker Service.

Scan for an online version of this report or visit: qrco.de/ABCInclusionPays

Scan to find out more about our Refugee and Asylum Seeker Service or visit: allianceforbettercare.org/refugee-and-asylum-seeker-service

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