

# Integrated care for homeless people in hospital: an acid test for the NHS?

If the NHS can work well for homeless people, then it will certainly work well for the rest of us. These are challenging times, lengthening queues out of accident and emergency departments are a 'false localizing sign' – they are simply the visible result of failure to move patients through the hospital system and discharge them promptly (King's Fund, 2013), and this is partly the result of inadequate community services to provide for a safe discharge and to prevent the next admission.

The increasing costs of hospital care reduce the opportunities to invest in community services and the downward spiral continues. But NHS funding constraints over the coming years mean that continuing as we are is not an option. Radical approaches to providing integrated care closer to home will require NHS trusts to develop partnerships with their local communities. The care of frail elderly patients has naturally received a great deal of attention, multi-morbidity combined with social care needs demands a coordinated response if people are not to repeatedly end up back in hospital, the most expensive part of the system. But how can care closer to home be achieved for a patient who has no home?

## Morbidity in the homeless

Long-term homelessness is characterized by tri-morbidity, the combination of physical ill health with mental ill health and substance misuse, often complicated by lack of social support and poverty. Homelessness is an independent risk factor for mortality after a hospital admission. A study in Glasgow (Morrison, 2009) compared patients admitted to hospital with drug-related problems and found that homeless patients were seven times more likely to die in the next 5 years than housed patients with the same condition. Despite poor outcomes the secondary care costs for homeless people (DH Office of the Chief Analyst,

2010) are eight times those for housed people. We have got to be able to do better than this.

With a growing realization of the importance of integrated care have come new statutory duties under the Health and Social Care Act 2012. The NHS is now required to 'have regard to the need to reduce health inequalities' in both access and outcomes, while the vision of Public Health England is to 'improve the health of the poorest fastest'. So what approaches are available to tackle these problems in the hospital setting?

The first step is to ask the question: 'do you have somewhere suitable to go when you leave hospital?' Having identified that a patient is homeless or insecurely housed the next step depends on the services available locally. The options for best practice are outlined in a report commissioned by the Department of Health (Homeless Link and St Mungo's, 2012). These vary from an agreed protocol with the local authority, to a housing support worker in the hospital and a clinically-led care coordination service such as that pioneered by Pathway ([www.pathway.org.uk/](http://www.pathway.org.uk/)) – a new charity dedicated to improving the quality of health care for homeless people and other excluded groups.

## The Pathway approach

The best evidence for cost effectiveness supports the Pathway approach (Hewett et al, 2012). This approach has been proven

at several hospitals, including University College London Hospital, Royal Free, Royal London and Brighton and Sussex University Hospital, with services under development for King's Health Partners, Manchester Royal Infirmary and Bradford Royal Infirmary.

Essentially, this innovation provides individual care coordination supported by a multi-agency team, in much the same way as diabetes teams and palliative care teams. One or more full-time nurses coordinate care on a daily basis, supported by regular ward rounds led by a GP with a special interest in homeless health. A weekly multiagency meeting brings together housing workers with social services, drugs and alcohol teams, liaison psychiatry and voluntary sector street outreach and hostel workers to develop individual care plans. Some teams benefit from Care Navigators – people with an experience of homelessness – who can provide additional mentoring and advocacy. This focused care coordination is intended to improve the quality of care, but has also been shown to reduce the average duration of stay for homeless patients by 30% (Hewett et al, 2012).

The next point of focus will be 'medical respite'. This is intermediate care for homeless people, which provides an opportunity for convalescence and continued medical support, while multiagency work is underway to find a suitable long-term placement. Added impetus has been

## KEY POINTS

- Homelessness is a health-care issue.
- The Health and Social Care Act 2012 placed a statutory duty on the NHS to 'have regard to health inequalities' with particular attention to access, outcomes and integration.
- Identify these patients early, follow a protocol if you have one in your hospital, press for a protocol if you don't.
- The Pathway approach supports clinically-led care coordination.
- Medical respite – intermediate care for homeless people leaving hospital – will be the next area for development.

given to this concept by the recent announcement of a £10 million grant from the Department of Health to support improved services for homeless people leaving hospital.

### Conclusions

Making visible the invisible health inequality of the homeless offers an in-built smoke alarm for the safety and quality of patient care across our communities. In the wake of the Francis Report and the emergent revelations around the Care Quality Commission, an acid test for the regulator might be how carefully it interrogates for

the quality of care of our poorest and most abandoned patients. [BJHM](#)

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