

# People who are homeless



## A DIFFERENT ENDING: ADDRESSING INEQUALITIES IN END OF LIFE CARE

People who are homeless have a life expectancy that is significantly lower than the rest of the population; the average age of death of a homeless person is just 47 years old.<sup>1</sup> Discrimination is common, and people who are homeless are vulnerable and may feel excluded from society. As a result, they often have complex relationships with health and end of life care services.

### Lack of awareness

People who are homeless are usually not identified as approaching the end of life early enough, even though early identification is more important for this group. It takes a long time for people who are homeless to develop a trusting and nurturing relationship with services, so people need to be identified early to allow planning to happen and to have the opportunity to reconnect with family if possible.

Lack of awareness of the number of homeless people locally, and even lack of acknowledgement of their existence, is part of the problem. As a result, the needs of people who are homeless are often overlooked by commissioners, services and health and care staff. In one local area, the commissioner had stopped funding a primary care service for homeless people, leaving a clear gap in access to healthcare. In another area, healthcare professionals and commissioners we spoke to were not aware that there were homeless people in the local area, even though the area had a statutory homelessness rate of twice the national average.

### THE POSITIVE IMPACT OF SUPPORT AT THE END OF LIFE

One man became homeless after his relationship broke down and he was living in a hostel. He was addicted to alcohol and drugs, and although he undertook several detox programmes he was not able to stop his addictions.

He developed hepatitis and his liver began to deteriorate, and he was considered for a liver transplant, but as he was unable to stop his addiction he could not proceed. The medical team made him aware that unless he stopped drinking he was likely to die within a year, but he found it hard to accept, and only really engaged with services within the last three months of life.

The palliative care team were hugely supportive alongside his GP, providing pain management and emotional support. They also offered the hostel team practical advice and support. The palliative care team was also invaluable in supporting repeated hospital admissions in the final weeks of his life, making his time in hospital in the last weeks of his life less distressing.

The man had been estranged from his family for several years, and in his final months he was able to reconnect with his sister after a long period of no contact. However, he was not able to return to the hostel; his health deteriorated quickly and he died in hospital.

### National Council for Palliative Care story

<sup>1</sup> Crisis, **Homelessness: a silent killer**, 2011

We did, however, also find a small number of examples where the needs of homeless people were clearly identified and people were receiving good end of life care. We heard about services directly engaging with groups who receive poor healthcare generally. This had led to services being better at identifying the last phase of life as part of improved healthcare overall.

## Poor physical healthcare

Poor physical healthcare in general is a significant problem for people who are homeless. Organisations we spoke to told us that homeless people have very complex health needs, often including substance misuse, poor mental health, physical conditions and illnesses such as HIV, AIDS and hepatitis. Death is usually not planned for, and most homeless people with support needs end up in hostels, which find it difficult to meet their needs.

In some areas, primary care services are commissioned for homeless people, which support the provision of good end of life care as well as improved healthcare. For example, Inclusion Healthcare in Leicester provides outstanding primary medical services, including end of life care, to homeless people, as outlined in our good practice case studies publication.

## Unequal access to care

Although there is an expectation that people with a high level of need should move out of a hostel and into another setting, there are often no suitable services to care for them. Lack of specialist provision for homeless people can lead to them being cared for in hostels, where staff are not equipped to deal with high levels of health and care needs.<sup>2</sup> Organisations we spoke to told us that people who are homeless find it difficult to access care homes, and inpatient hospice provision is usually not accessible because of their additional needs, including addiction and substance misuse.

We found some examples in our fieldwork where services such as hospices had been able to meet the needs of homeless people. This was usually because they took an individual approach to personalised care, which enabled them to meet the person's individual needs well. St Mungo's and Marie Curie have developed a resource pack to support services involved in caring for people who are homeless at the end of life.<sup>3</sup>

2 Shulman C, Hudson B et al, research in progress

3 Kennedy P, Sarafi C and Greenish W, **Homelessness and End of Life Care**, 2013

## THE IMPORTANCE OF EARLY IDENTIFICATION

We were told about one man who died at 41 having been identified by an end of life care service for homeless people after he was admitted to hospital with symptoms of alcohol related liver disease. The service asked the medical team whether they felt he was likely to be in the end stages of liver disease, and needing palliative care.

The medical team felt that there were signs of deterioration but decided that he was not in need of palliative care, and discharge from hospital was planned. The service was in close contact with his mother who came down from the North of England to visit him in hospital, although she was not able to visit often due to the cost.

The service felt that if it had been identified earlier that he was dying, much more could have been done to support his mother to spend time with him in the last two weeks of his life. However after they expressed their concerns to her, she was able to make an additional visit, before he died the next day in the acute medical unit of the hospital.

### National Council for Palliative Care story

### **SUPPORTING PEOPLE TO GET THE RIGHT CARE**

A person who was homeless who had a life limiting illness walked in off the streets into the healthcare centre. Once trust had been established, staff working at the centre supported this person to register with a GP and find a place to live at a local hostel. When this person was in their last weeks of life, staff from the centre supported the local hostel to train their staff to manage, store and administer controlled medicines. The person receiving care was supported in the planning and delivery of their care and support. This person had become estranged from their family, and their wish to be reunited was also supported and facilitated.

#### **Local area fieldwork findings**

### **CQC ENCOURAGES:**

- Commissioners and providers to recognise the end of life care needs of people who are homeless, and to take action to understand and meet the needs of homeless people in their local area.
- Commissioners and providers to support early identification of people who are homeless who may be approaching the end of life, as part of improved healthcare for homeless people.

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#### GOOD PRACTICE CASE STUDIES

#### PEOPLE'S EXPERIENCE BRIEFINGS:

- People with conditions other than cancer
- Older people
- People with dementia
- People from Black and minority ethnic (BME) groups
- Lesbian, gay, bisexual or transgender people
- People with a learning disability
- People with a mental health condition
- People who are in secure or detained settings
- Gypsies and Travellers

