GP led care coordination for homeless patients in secondary care: focussing on improving the patient experience can also save money.

**Context**

University College London Hospital. A 900 bed, acute hospital trust in North West London. The client group were all homeless patients admitted as an emergency to medical or surgical wards in the hospital.

**Problem**

Frequent and repeated admissions of homeless patients with complex needs, perceived by staff to be disruptive and associated with poor outcomes.

**Assessment of problem and analysis of its causes**

A GP and nurse team was invited to carry out a needs assessment informed by a literature review. They interviewed patients and staff and analysed the hospital database. The needs assessment showed that homeless patients attended A&E six times more often than the housed population, were admitted four times as often and stayed three times as long with total costs eight times that of housed people. This was associated with an average age of death for homeless people of 40 – 44 years. Homeless patients gave negative feedback about their experiences and some staff revealed negative attitudes to homeless patients. The key characteristic of homeless patients with complex needs was tri-morbidity, the combination of physical ill health with mental ill health and drug or alcohol abuse. So patients and staff were unhappy, costs were high and outcomes were very poor. A pilot intervention was proposed combining a hospital nurse with a community GP and a person with an experience of homelessness to provide regular ward rounds, visiting each homeless patient on every ward.

**Intervention**

A Homeless Health (nurse) Practitioner (HHP) was seconded full time to the hospital discharge liaison team. She accepted referrals and visited all homeless patients within a day of admission. A community nurse attended the hospital for four half-day sessions to lead ward rounds and the process was supported by a Care Navigator – a person with an experience of homelessness who joined the ward round and supported the GP, nurse and patients with mentoring and support. A weekly multi-agency care planning meeting involved hospital teams, mental health teams and community housing, social care, drug and alcohol and voluntary sector workers in coordinating and planning for discharge support of homeless patients.

**Strategy for change**

The needs assessment process involved consulting with community and hospital staff working with homeless people, and recruited their support and involvement. As the service was implemented staff were informed through line management cascades and by posters on the wards, but mainly by personal approaches and daily visits to all clinical areas. As continuous improvement data has been gathered this has been fed back to staff teams via the hospital newsletter and presentations to various clinical groups.

**Measurement of improvement**

A database has been maintained for all referrals to the team, showing time elapsed from admission to referral, duration of admissions and number of repeat admissions. Feedback from staff, patients and colleagues was gathered. Very positive feedback from patients and staff was gathered, accompanied by a 30% drop in bed days occupied by homeless patients, equivalent to a reduction of 1000 bed days for this hospital. Allowing for the costs of the intervention, this quality improvement was highly cost effective. Longer term follow is now suggesting a reduction in re-admission rates.

**Effects of changes**

Patient experience transformed. Staff much more positive about working with this patient group, community agencies commented on improved and positive relationships and better care coordination. Initial resistance to change experienced, from consultant staff concerned about a GP on the wards and from A&E staff concerned about missing waiting time targets.

**Lessons learnt**

Now that the model has been clearly demonstrated to be of benefit we are introducing it into other acute hospital trusts. We have learned to present the positive experience for patients and staff alongside the cost benefits. The approach is launched at stake holder events and followed up by a detailed local needs assessment and networking process.

**Message for others**

Collaborative care between a community GP, hospital nurse and a person with an experience of homelessness can transform the experience of unscheduled care for homeless people, and reduce costs.