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Care of vulnerable patients and those likely to experience Health Inequalities in the Emergency Department

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Introduction

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. The ED provides universal access to care regardless of ethnicity, socioeconomic background, and underlying health status serving as a 24/7 access point and safety net to the most deprived and vulnerable in our population. The GIRFT report of 2019/20 demonstrated that there were more than twice as many ED attendances for the 10% of the population who live in the most deprived areas compared with the 10% who live in the least deprived areas (1).

"Inclusion Health" populations are those that experience the extremes of deprivation and health inequalities. These groups include the homeless, sex workers, vulnerable migrants (undocumented migrants, refugees and asylum seekers) or Gypsies and Travellers. This section will focus on these inclusion health populations.

It is estimated that approximately 300,000 people are experiencing homelessness in England (2017) (2). Among homeless people, the mean age at death was 45.9 years for males and 43.4 years for females in 2019 (3). Asylum seekers and refugees made up approximately 21% of immigrants to the UK in 2022 (4) and there are approximately 800,000 undocumented migrants (5) – many of whom will be homeless and not admit to their status for fear of data sharing with the home office. Inclusion health populations are significantly less likely to be registered with a GP meaning preventable healthcare needs are not treated in a timely fashion, in addition to making ED attendance more likely - homeless people in England are 60 times more likely to visit the emergency department in a year than the general population (2).

Attending an Emergency Department represents an opportunity to address health inequalities through a holistic assessment of a person's health needs and drawing in support of wider partners to help prevent the more adverse outcomes from disease or injury, and further reduce the need for unplanned care. The full document can be found on the RCEM clinical guideline page 'Homelessness and Inclusion Health' [6].

Chronic homelessness is an associated marker for tri-morbidity, complex health needs and premature death. Tri-morbidity is the combination of physical ill health needs with mental health needs and drug and alcohol misuse [2]. Drug- and alcohol-related causes contribute to the most frequent reasons for attendance and admissions of persons experiencing homelessness in the ED and inpatient respectively. There is a need for prevention measures to reduce the prevalence of drug and alcohol, injury and poisoning-related admissions to the ED, enhanced service provision at the community level, and multisector collaborations [1].

Standards

1. Emergency Department staff must fulfil their statutory duty to identify those patients who are homeless or at risk of being made homeless.

2. Emergency Departments must obtain and record up to date contact details for all patients who are homeless or at risk of homelessness.

Recommendations

1. The Emergency Department should provide information regarding hostels, local hubs, street outreach teams where these services exist for any patient who is homeless or at risk of homelessness.

2. All patients who are homeless or at risk of being homeless should have an opportunity to discuss issues related to alcohol or drug misuse and that the emergency department has written advice regarding local services.

3. A homelessness staff information pack should be available and reviewed annually, with details of homeless services, local street outreach, day centres, alcohol, drug and specialist targeted health services, and information on out of hours services.

4. All emergency departments should have processes in place to ensure staff are aware of how to arrange emergency accommodation for homeless patients both in and out of hours and staff should be aware of the SWEP.

5. When discharging a patient who is homeless or at risk of homelessness, staff should consider the impact and feasibility of the discharge plan (including follow up, medications, isolation) in the light of homelessness, and document this consideration. e.g. Homeless people who inject drugs (PWID) attending with suspected DVT will be unlikely to return for USS next day.

6. All Emergency Departments should have processes in place to ensure staff know who to inform when a homeless patient or a patient at risk of homelessness is admitted through the department into the main hospital.

7. The ED should have processes in place to identify those groups at high risk of health inequality (health inclusion groups), which may be associated with Homelessness

8. The ED has access to an Inclusion Health team.

9. The Trust or Health Board has a Homelessness Officer who liaises directly with the emergency department.

10. An alcohol and drug assessment, brief advice and referral is available according to NICE guidance.

11. The ED has access to regular educational updates on inclusion health (i.e. specific health conditions, impact of psychological trauma, cultural competence, services available to vulnerable groups, legislation) so that staff are aware of the services available to patients in the inclusion health categories, and how to access them.

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