Background

‘At diagnosis I did not understand what would happen next’

‘I was told I would be supported but never told who and no one ever called me’

Patients experiencing homelessness (PEH) includes anyone without safe, secure, or legally accessible accommodation, including those displaced by domestic abuse

Cancer is now estimated to affect one in two people at some point during their lifetime. Evidence indicates that people experiencing homelessness are disproportionately affected, with studies suggesting that the incidence of cancer may be up to twice as high compared with the general population

Acute Oncology (AO) is a specialist 24/7 advisory service for patients experiencing complications secondary to their cancer or treatment. All patients following a cancer diagnosis should have access to an AO telephone triage service

Due to many factors including poor health literacy, delayed diagnosis, location changes and being lost to follow up these patients unfortunately experience inequitable access to these services resulting in poor outcomes

There is little current data into access to AO for patients experiencing homelessness. These patients are also unrepresented in the NCPES. Annecdotally those working in AO would be unsure how to support these patients suggesting that current access provisions are poor

Contributing factors

‘I don’t recall being made aware of the Acute Oncology service when I was diagnosed’

‘To this day I am still unsure exactly what Acute Oncology is’

System



- Current process of accessing AOS not designed to the needs of PEH.
- Not all HCP / members of MDT who care for PEH are involved in this process
- Support once treatment commenced often lacking or not clear to the patient

Process



- Multiple members of MDT often involved
- Difficult building a rapport / trust – leading to unwillingness to engage
- Many may fear process requires too much effort to call
- Unsure what AOS is and if aware unsure when to call
- If unwell only option is to present to ED

Measurement



- No consistent data collection on PEH and access to AO TT services
- No feedback received from this group including from the NCPES
- No tags on EPR to easily identify these patients as vulnerable

Patient factors



- Numeracy and literacy skills
- Poor understanding of when to call
- Little insight into diagnosis and treatment plan
- Fear of judgement/stigma
- Compliance with advice/safety netting

Access



- Access to a phone including credit
- Financial restraints
- Transportation
- Frequent address/location changes
- Patients often lost to FU
- Little opportunity to refer to another local service

Identification and proactive engagement

- Housing screening / status at cancer entry points
- Create homeless / vulnerable housing tag on EPR
- Care coordinator / key-worker
- Partner with local homeless services

‘Having moved so many times I feel low and alone’

Integrated and flexible access pathways

- Flexible triage / assessment pathway
- Tailor written / verbal information
- Strengthen communication with primary and community services

Staff awareness, training and coordination

- Person centred MDT’s
- Cross-system protocols
- Monitor access and outcomes
- Training on health inclusion

‘I want to have my own place where I feel safe and looked after’

Engagement with lived experience partner



Informal interview with patient with lived experience of both cancer and homelessness. Unstructured with questions prompted in line with primary and secondary drivers:

- AOS attendance at 1st clinic appointment would be useful to meet the team and establish rapport before care later required
- Tailored written information / vidoes pre commencement of tratment would be useful to help with education on what to expect and when to call to report symptoms
- Open to liasing with AOS via TEL and would welcome invitations for F2F review
- Due to issues with phone credit, would be open to receiving calls from the AOS team at regular intervals post SACT to check for treatment toxicities and if F2F review required
- Creation of vulnerable housing tag would help avoid having to explain vulnerabilities every time contact is made and wouldhelp remove feeling of judgement when calling
- Happy when appropriate for AOS to make contact with other agencies involved in care including GP, palliative and other community care services

Next steps and future aspirations

- Utilise project findings to support development of a supportive care MDT and clinic
- Integrate findings into SOP on support specifically for those experiencing housing vulnerabilities
- Development of vulnerable housing tag on EPR which can be used to identify these patients before point of entry
- Share learning with colleagues and encourage conversations on how we can utilise these findings in everyday practice
- Explore possibilities of an AOS free phone number

