COVID-19 homelessness project

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Redeployment: Covid-19 Homeless project operational manager

TCST Personalised Care Senior Implementation lead

Healthy London Partnership

Supported by and delivering for:

- Background on homelessness and health

- Homelessness response and COVID-19

- Brief overview of No Recourse to Public Funds' (NRPF)

- Reflection and learning

Background to homelessness and health in London

Office of National Statistics: 2018

726 deaths in UK (Street and emergency shelters)

Mean age:

45 for men (88%)
43 for women (12%)

40% related to drug poisoning

19% related to cancer

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2018
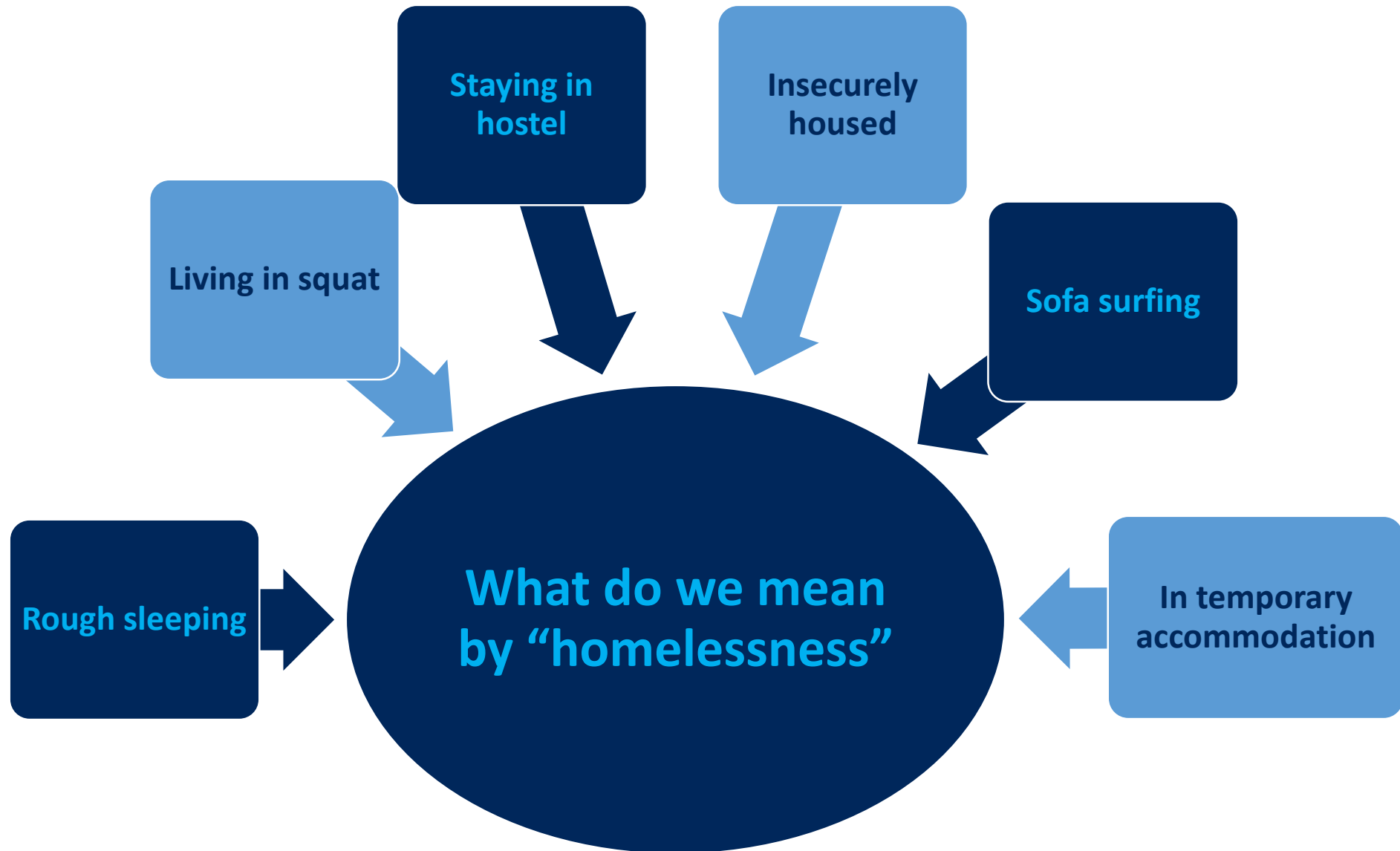

Homeless deaths rose by a record 22% last year, says ONS report

Charities demand action after estimated 726 homeless people die in England and Wales

▲ Jon Sparkes from Crisis said homeless people 'should not be dying unnoticed and unaccounted for'. Photograph: Yui Mok/PA
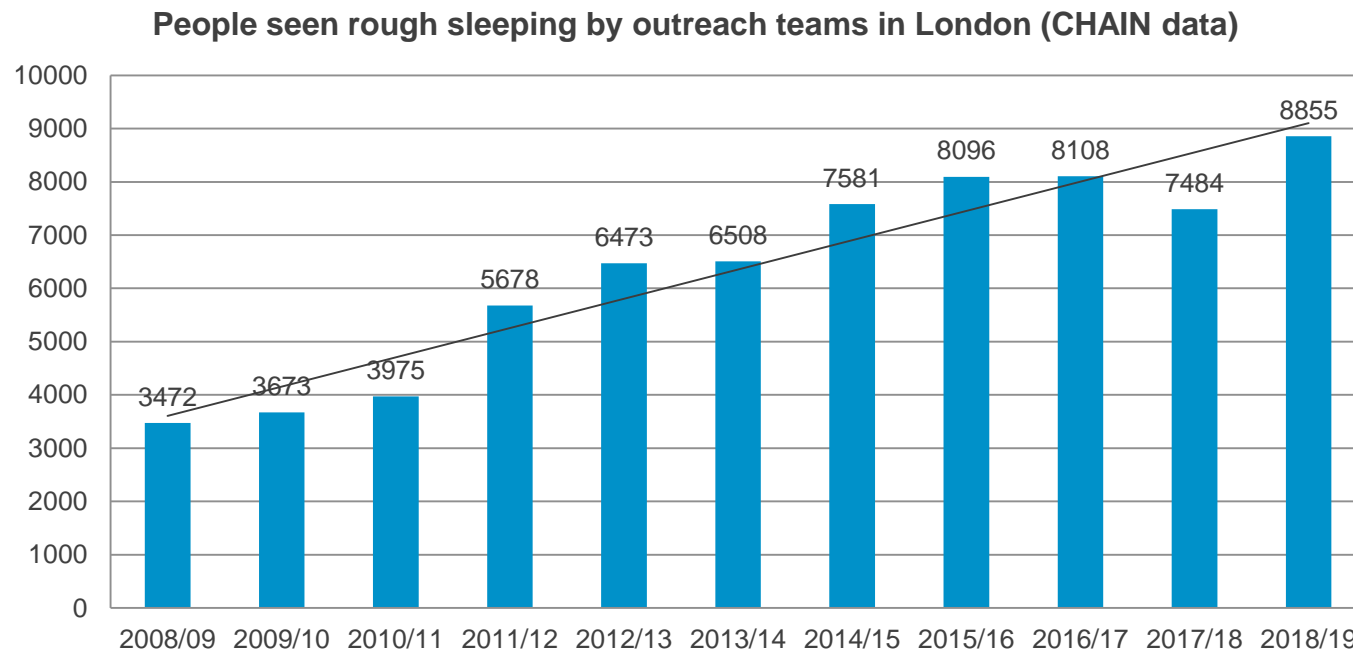
Homelessness is increasing

Rough sleeping
Year on year increase in people seen rough sleeping in London
24% increase in new rough sleepers
49% UK nationals
60% just seen once

Homeless hostels
9,186 bed spaces for single people who are homeless pan London in 2015-2016 (a 26% decrease from 2011-2012)

People seen rough sleeping by outreach teams in London (CHAIN data)

Year	People
2008/09	3472
2009/10	3673
2010/11	3975
2011/12	5678
2012/13	6473
2013/14	6508
2014/15	7581
2015/16	8096
2016/17	8108
2017/18	7484
2018/19	8855

Temporary accommodation e.g. B&Bs
54,280 households in temporary accommodation in London in 2016-2017

Hidden homelessness
Unknown

Data from CHAIN annual report, Homeless link and Ministry of communities and local governments

Underlying causes of homelessness

Many routes to homelessness – Structural causes and Individual vulnerabilities

Welfare

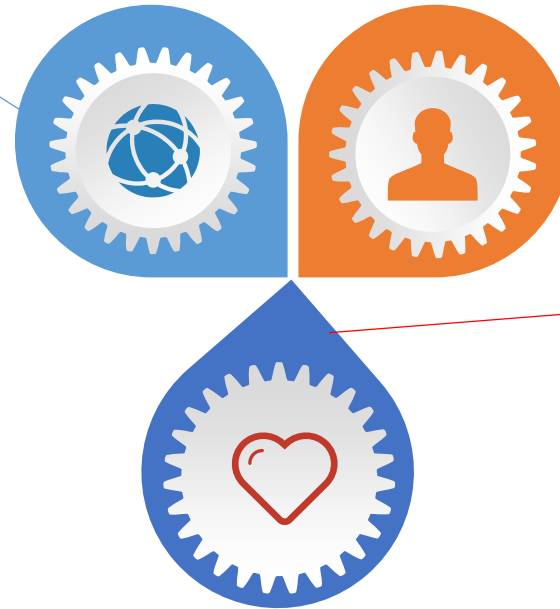Drug or alcohol problems

Experienced Neglect or abuse

Mental health problems

Inequality

Parent with addiction

Domestic violence

Adverse child events*

Income policies

Leaving care

Acquired brain injury

Poverty

Parent with mental ill-health

Parent incarcerated

Housing supply / affordability

Parental separation

Criminal justice

Relationship breakdown

Unemployment / employment rights

Immigration NRPF

http://www.cdc.gov/ace/about.htm*

Complex needs and Tri-morbidity

Substance Misuse

> 60% history of substance misuse

Mental Health

70% reach criteria for personality disorder
53% dual diagnosis
15 X more prevalence psychosis

Physical Health

>80% at least 1 health problem,
20% > 3 health problems

Hepatitis C - 50 x higher
TB - 34 x higher
Heart disease - 6x higher
Stroke - 5x higher
Epilepsy - 12x higher
COPD - 15x higher

High rates of multimorbidity and early onset frailty

St Mungos (2010), Homelessness, it makes you sick, Homeless Link Research (n = 700)
Suzanne Fitzpatrick et al (2010) Census survey multiple exclusion homelessness in the UK (n= 1268)
Story, A. (2013) Slopes and cliffs: comparative morbidity of housed and homeless people. The Lancet. Nov 29. Volume 382. Special issue. S1-S105
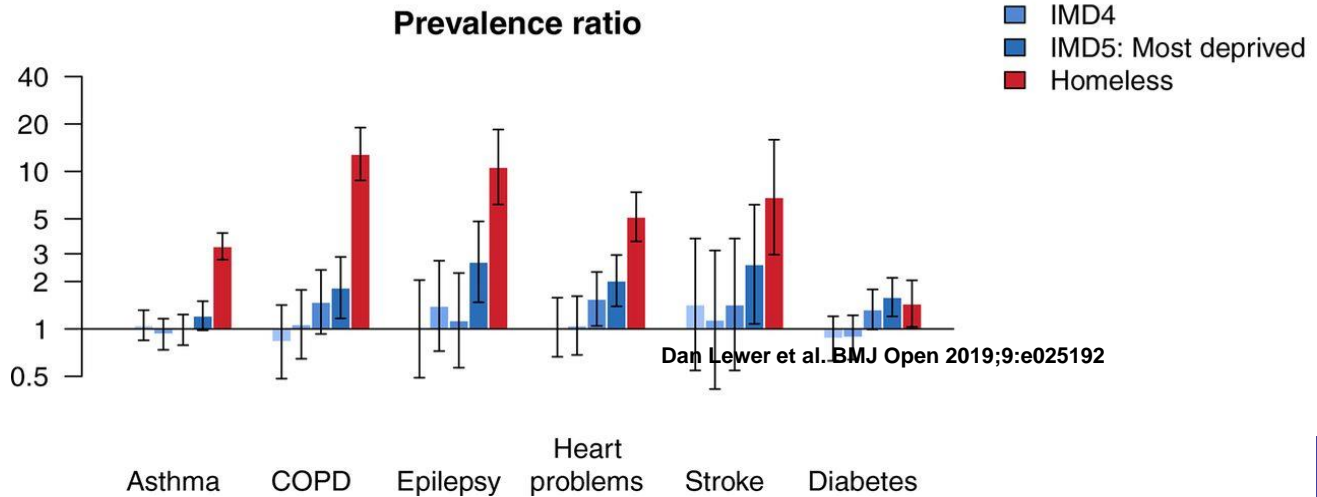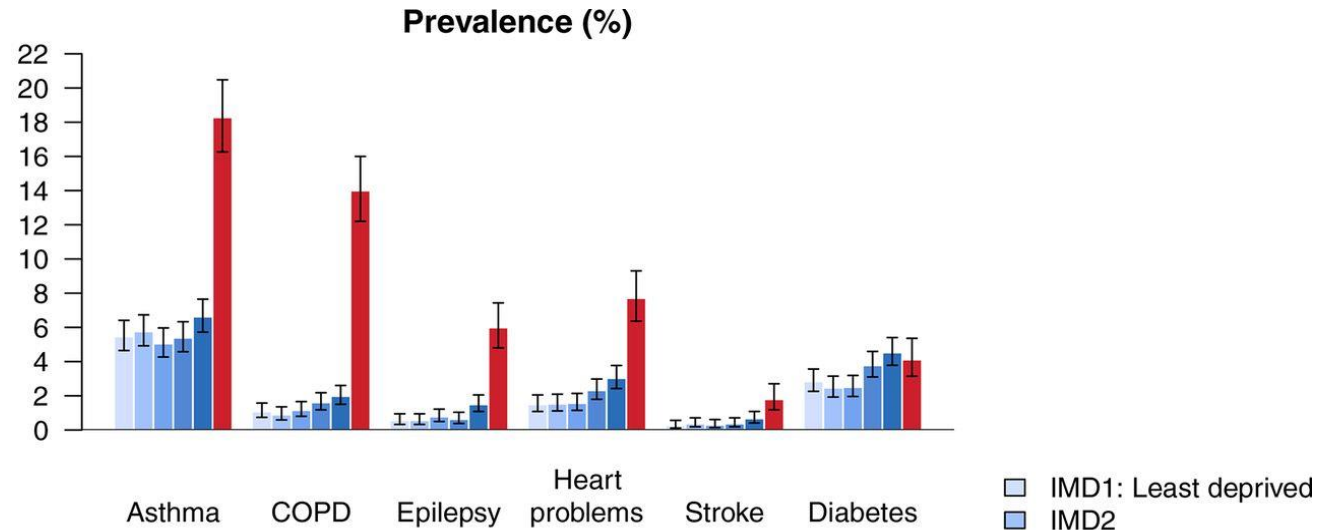
Prevalence of long-term conditions (top panel) and prevalence ratios (bottom panel), with 95% CIs.

IMD: index of multiple deprivation.

Dan Lewer et al. BMJ Open 2019;9:e025192

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Support networks for people experiencing homelessness

- Many had few and limited contact with family members

- 28% consider themselves to have no close friends

- More than half spent most of their time alone (with only 25% finding this unacceptable)

Bonner & Luscombe, 2008. The seeds of exclusion
(N=438 from Salvation army, Belfast)

Complex needs and Access to Health Care Inverse Care Law

Barriers to accessing health care services can include:

- Health not a priority

- Fear & distrust, feel unwelcome

- Difficulty registering with GP

- Inflexibility in appointments – discharged for non-attendance

- Fear of withdrawing

Impact of these barriers:

- People seek treatment when problems reach advanced stage

- High A&E attendance

- High rate of self discharge

- High rate of unsafe discharge

- Revolving Door

COVID-19

Covid-19 and homelessness

Recommendations, due to vulnerability and need to social distance:

Aim to reduce shared spaces and support people into accommodation where they can self isolate by:

- *closure of winter night shelters*

- *rough sleepers into accommodation*

- *support discharges from hospital*

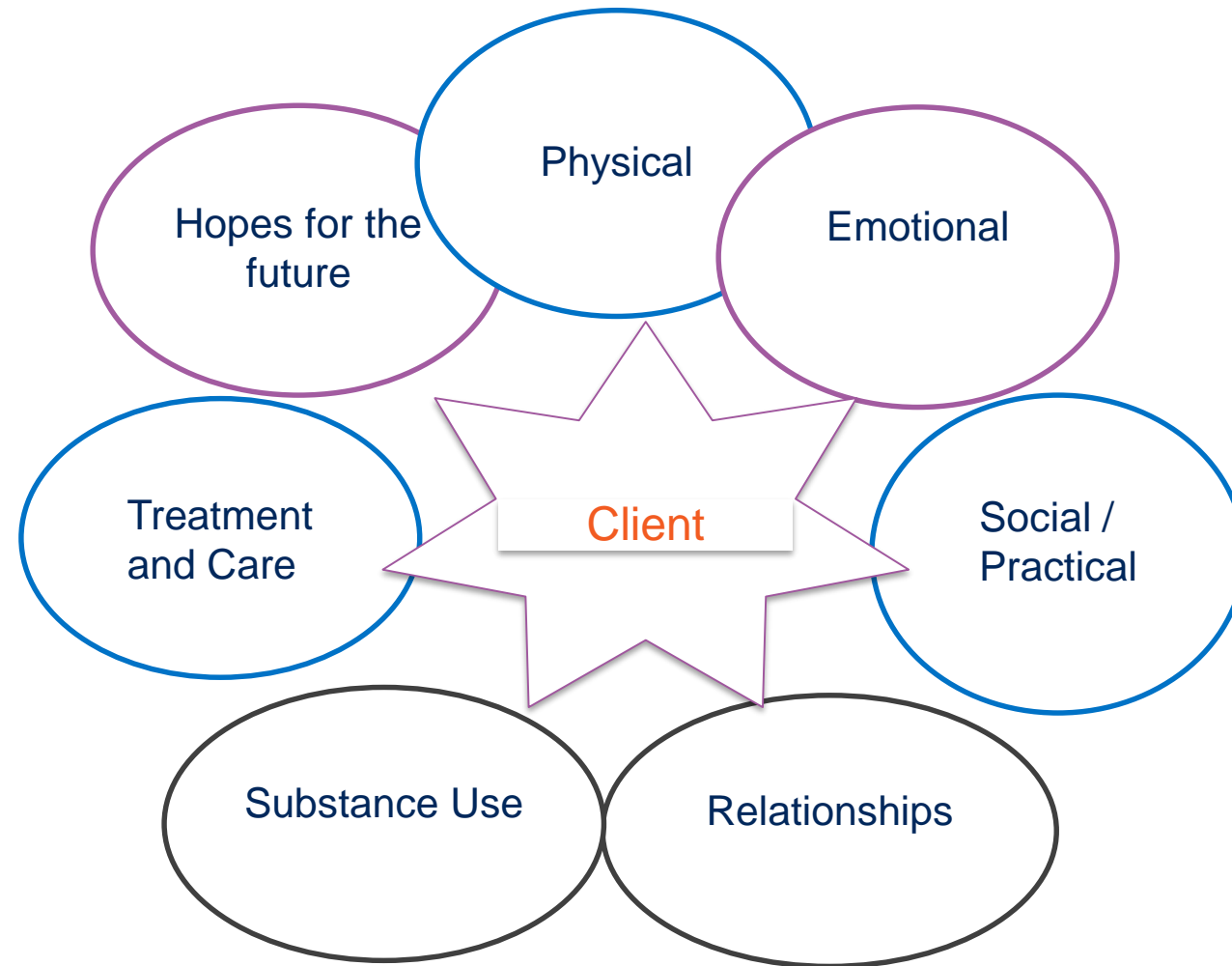Establishment of COVID facilities in hotels

Support hostels to enable social distancing, identification, testing and self-isolation of people who are symptomatic

Opportunity

- Government commitment that no-one returns to street

- Large numbers of people in hotels and other temporary accommodation

- Some have (limited) health support in-reaching

- Many more people linked into substance misuse services and many received support around smoking cessation

- Given time for people to reflect / opportunity for change

- Drive to get people registered with GP's – cascaded and agreed through STP's & CCG's

Person centred care – support and concerns mapping

- Place client in centre
- Work alongside them and start from where they are
- Locate important issues to address
- Colour lines according to priority
- www.homelesspalliativecare.com

Legend:
- —— High Priority
- —— Low Priority
- —— Difficult

Physical

Emotional

Hopes for the future

Treatment and Care

Client

Social / Practical

Substance Use

Relationships
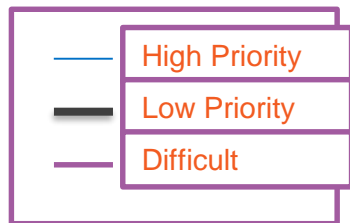
COVID-19 First Phase Emergency Response – Catalogue of Actions

Response	
Emergency Structure	• London COVID-19 Homeless Health Delivery Group reporting to the Out of Hospital Cell
Testing and Contact Tracing	• Daily surveillance tracker in hostels and hotels • Find and Treat outreach team testing in accommodation settings and undertaking contact tracing
Shield and Cohort Separating Covid/non-Covid, vulnerable (shield)/low support	• Separation of Covid +ve cases by transfer to the COVID CARE hotel at City Airport • COVID CARE beds for transfer of Covid +ve cases from street outreach, A&E and hospital discharge • Mildmay step-down beds from hospital for Covid +ve or symptomatic patients • COVID PROTECT hotels for non-Covid vulnerable/shielding with complex needs
Services & Equipment	• Hotel PPE & telemedicine – mobile phones, blood pressure cuffs, pulse oximeters, thermometers • Hotel initial triage for settle-in / primary care registration / continuity of care • Third sector providers welfare support and daily symptom checking • A pan-London drug and alcohol service for hotels prescribing substitute therapies / e-cigarette and substitute therapies for smokers made available by donation
Health Needs Assessment & Screening	• UCLH COVID19 Homeless Rapid Integrated Screening Protocol (CHRISP) Tool to assess for ongoing shield/housing requirements, vulnerability and ongoing health and care needs to inform move on plans. • Screening offer for HIV, HepC, HepB (latent TB screening offer tbc)
Guidelines, protocols and training	• Guidelines, tools and training for clinical pathways, infection control, needs assessment, service standards, for accommodation settings : https://www.healthylondon.org/resource/homeless-health-during-covid-19/

Healthy London Partnership > Our work > Resources > Homeless health during COVID-19

Homeless health during COVID-19

The Homeless Health Operations Centre is staffed by the Healthy London Partnership, supporting the London COVID-19 Homeless Health Response Cell, as a multi-agency approach to managing the health needs and minimising the transmission of COVID-19 within the homeless population in London. This is set out in our operating manual.

We have brought together a range of information and guidance which we hope are helpful to partners and providers. These have been created quickly from various sources and we have endeavoured to credit information wherever possible.

Case studies

A podcast and a written case study on 'Homeless health in London – the response to Covid-19', covering the period March to early June 2020 have been created. For the podcast, click here and the written case study, click here.

General guidance

NHS England and Improvement COVID-19 Clinical homeless sector plan: triage – assess – cohort – care

NHS England and Improvement COVID-19 Homeless Health staffing approaches and Homeless Health oversight implementation

NHS England Mental Health and Primary Care guidance

Latest Public Health England guidance.

On this page:

- Case studies
- General guidance
- Guidance for commissioners
- Moving on from hotels
- Information for hotels
- Information for hostels
- Referrals for testing and COVID CARE
- Information for primary and community care
- Drug and alcohol guidance
- Mental health guidance
- Palliative and End of life care

For more information contact:
hlp.homelesshealthcovid19team@nhs.net

COVID-19 First Phase Emergency Response - Impact

UCL modelling indicated that more than one-third of the hostel and street homeless population could get Covid-19. This could have led to 4,000 hospital admissions and 364 deaths by August.

With an average age of death for people who are homeless of 44, high levels of complex co-morbidities make them particularly vulnerable. They face barriers to self-isolating and following effective handwashing and infection control

0.3% of the population of New York are homeless and yet current data shows 2% of Covid related deaths in New York were attributed to the homeless population

London has saved lives, flattened the first surge and prevented acute demand

There is no homeless specific data on deaths in London available. London has managed to avoid the far larger and deadly outbreaks seen in US cities, such as New York and San Francisco. **In San Francisco for example night-shelters have had 66% of residents test positive.** London moved people from multioccupancy settings and streets to hotels as well as moving Covid +ve to a seperate COVID CARE hotel. Testing by UCL's outreach team mid-April at the peak of the first surge indicated that **only 3-5% of rough sleepers in London were Covid +ve.**

That position can be maintained if accommodation solutions, testing and separation of COVID +ve cases continues

Integrated Health & Care and Housing

Now

Joint Ambition

No return to rough sleeping

Continued protection from Covid 19

All residents of Covid Hotels (GLA and non-GLA) offered a support plan covering housing, training, employment support and holistic health and care support

STEP 1 - Prior to Move On

Needs assessment | **Risk stratification**
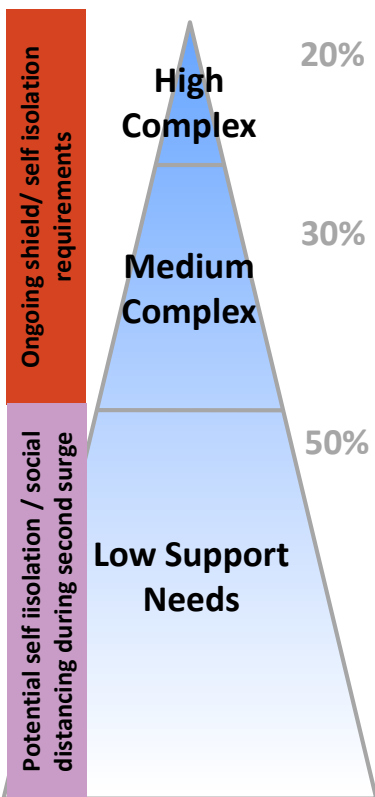
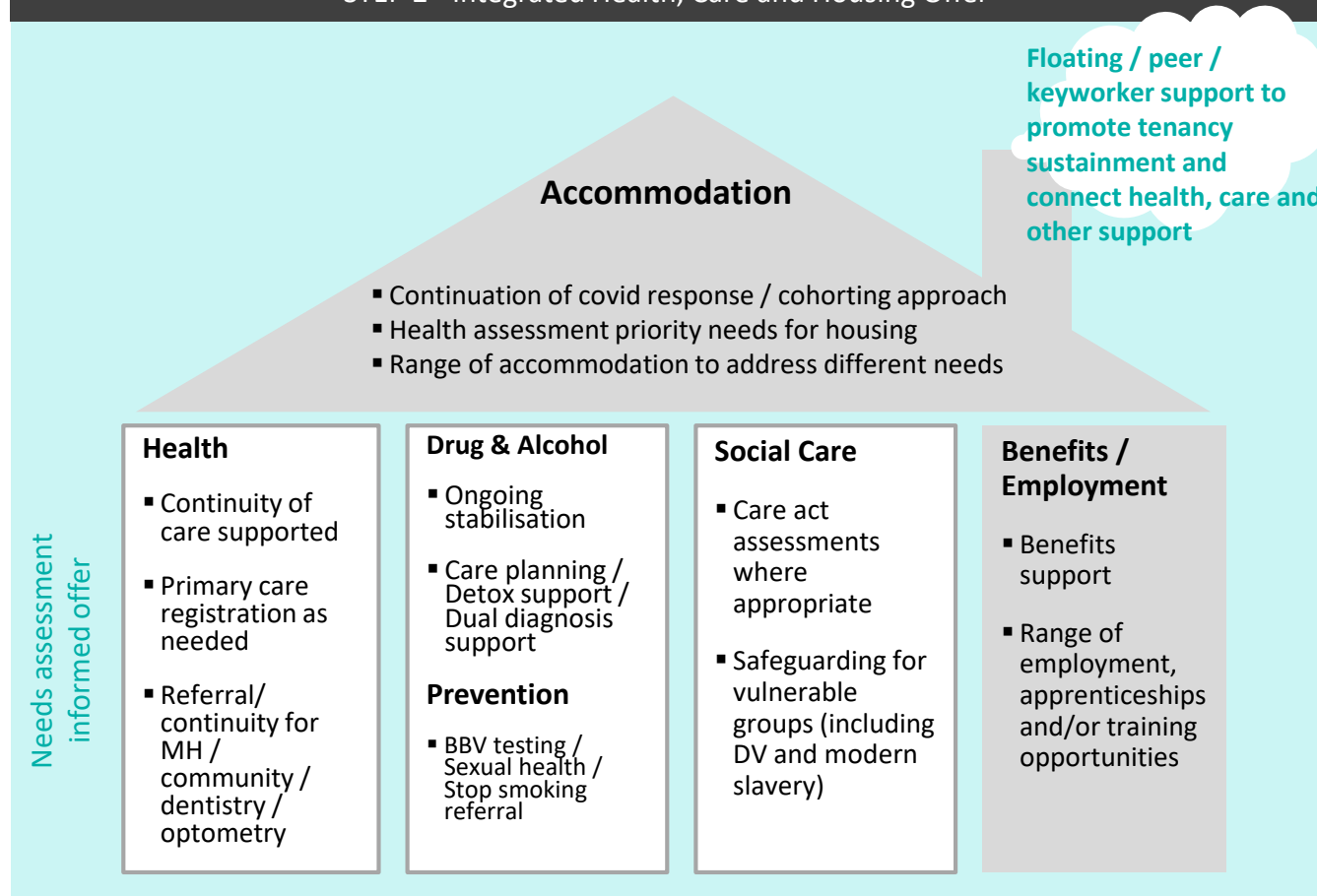**PERSONAL GOALS**

CHAIN Census

- Immigration Status
- Housing needs
- Employment
- Benefits

CHRISP Tool

- Health needs
  - Mental health
  - Primary Care – multi-morbidity, cognitive
  - BBV & TB screening
- Drug & Alcohol support needs
- Social care needs
  - Mobility/learning difficulties

Ongoing shield/ self isolation requirements

Potential self isolation / social distancing during second surge

- High Complex — 20%
- Medium Complex — 30%
- Low Support Needs — 50%

STEP 2 - Integrated Health, Care and Housing Offer

Floating / peer / keyworker support to promote tenancy sustainment and connect health, care and other support

Accommodation

- Continuation of covid response / cohorting approach
- Health assessment priority needs for housing
- Range of accommodation to address different needs

Needs assessment informed offer

Health
- Continuity of care supported
- Primary care registration as needed
- Referral/ continuity for MH / community / dentistry / optometry

Drug & Alcohol
- Ongoing stabilisation
- Care planning / Detox support / Dual diagnosis support

Prevention
- BBV testing / Sexual health / Stop smoking referral

Social Care
- Care act assessments where appropriate
- Safeguarding for vulnerable groups (including DV and modern slavery)

Benefits / Employment
- Benefits support
- Range of employment, apprenticeships and/or training opportunities

Shield — Integrated Health and Care Offer

Social distance — GP registration and floating key worker

Care home or hospice for people with higher care and support needs

Headlines extrapolated based on small sample

Finding	Applied to pan London provision (1366 people)	Applied to other temporary accommodation (2589 people)	Indicative total in temporary accommodation in London
24% NRPFs	328	621	949
36% work ready	492	932	1424
23% not registered with a GP	314	595	910
18% currently (or have previously) had input from mental health teams?*	246	466	712
10% require shielding	137	258	395
13% will need 24/7 on site support	178	335	513
33.2% of people report depression and anxiety and the same number dental problems	454	860	1313
12.4% of people drink alcohol daily	169	321	490
8.7% problems with stairs or walking	119	225	344
3.4% problems washing or dressing	46	88	134

*These figures do not represent unmet need and are likely to be higher.

Initial findings as of week ending 12th June – CHRISP data
provided by UCL and CHAIN by St Mungo's

Homelessness - people with No Recourse to Public Funds (NRPF)

Includes undocumented migrants, visa overstayers, refused asylum seekers and some EU citizens

If people who are NRPF have care and support needs: Adult social services are required to undertake a **needs or human rights assessment**

Meeting these needs may require the local authority to provide accommodation

Support around NRPF:

NRPF Network:

http://www.**nrpfnetwork.org.uk**/information/Pages/Social-Services.aspx

Reflections and learning

What were you doing during Covid?

- Supporting the London Covid homeless health project.

- Operational lead and key point of contact. E.g. PPE, clinical triaging, chair weekly ops meeting.

- Coordinating and commissioning services in primary care, mental health and drug and alcohol services.

- Develop and implement plans for next step including health needs assessment, move on plans and hotel closure plans.

- **What did you learn from the experience?**

- Operational experience in emergency planning and managing challenging situations.

- Setting up services for people with very complex health and social care needs.

- Ways of working with wide range of stakeholders e.g. LA and charities.

How has the redeployment benefited TCST?

- Built professional relationships with wider stakeholders including local authority, charities and the NHS

- Understand the challenge of one of the most vulnerable group in society and what health provision they required.

- Understand how ICS relationships are developing.

- How personalised care are developed in other settings.

Thank you!