# COVID-19 Homeless Health Hotels – Primary Care Service Standards

**Author: Jemma Gilbert, Director of Transformation / Incident Director Homeless COVID-19**
**Clinical Lead: Dr Adrian MacLachlan, Lewisham GP / GP Specialist Homeless Health**

## 1.0 Introduction

This paper sets out primary care service standards for the London COVID-19 homeless hotels. For sign-off by the London COVID 19 Clinical Advisory Group.

## 2.0 Background

Local government and the GLA have been responding to an MHCLG directive to 'bring everyone in' housing rough sleepers in temporary accommodation since late March. National guidance developed by UCLH clinical leads with PHE input has been adopted to provide an overview of the health model that is required on sites. STPs and CCGs have been coordinating health input to sites.

## 3.0 Safety concerns prompting the need for additional standards

A 'two-weeks on' review of the model in place identified gaps in triage assessment and primary care connection in some boroughs that increases risks with regards to a lack of care continuity for this vulnerable population.

- Lack of knowledge of current clinical status of a high proportion of hotel residents/rough sleepers.
- Missed opportunity in some hotels of completing an initial triage assessment with connections made back to primary care
- This has resulted in lack of knowledge of underlying health conditions and current medication requirements, leaving clients at risk of running out of essential medications, acute health deterioration, and frontline charity sector staff unaware and therefore at risk.
- Unidentified (very possibly unmanaged) health needs will be across the whole range of chronic disease categories, as well as significant substance misuse and mental health problems.

Whilst STPs have facilitated local primary and community care input, onsite charity/welfare workers are struggling to make contact with the primary care teams / 111 and OOHs services which puts the residents they are caring for and themselves at higher risk with a number of sites designated unsafe by Pathway clinicians.

## 4.0 Primary Care Service Standards

Primary care service standards are required for the London COVID-19 homeless hotels to ensure that there is a common expectation about primary care input requirements on sites:

- Essential initial triage assessment of residents on every site to identify immediate needs
- Primary care registration of all residents (existing registrations to be maintained for 70% of residents, estimate 20-30% unregistered (e.g. equivalent to 30-45 new local registrations for a hotel of 150 residents)
- Access to GP OOHs, community nursing and mental health services with in-reach to hotels as required
- Having a named GP clinical lead for each hotel site for local clinical accountability

The standards are based on the national direction that all are eligible for primary care access and registration but recognises that this is an unprecedented ask of local primary care services in the following ways:

- The concentration of people experiencing rough sleeping on a hotel site which would usually be dispersed
- The 'out of area' nature of many of the hotel residents who were transported across London according to hotel availability and/or triage and the importance of continuity of care
- The quantity of new registrations at a stretched time for primary care
- The complexity of health needs found in people experiencing rough sleeping
- The need for additional primary care workforce support to enact this effectively
- The temporary nature of this arrangement
- Dispersed specialist workforce
- Importance of nursing
- Different needs in the Care and Protect sites

This group have some of the worst health outcomes is the population, with an average age of death of 44.

There is a long history of a range of services to support the homeless population in London, with specialist practices, mainstream practices offering local enhanced services, specialist teams which have evolved across London. We have had a London Homeless Health Programme within HLP and Homeless Health is a priority within the London Vision. https://www.healthylondon.org/our-work/homeless-health/

This provision of accommodation at hotels provides a time-limited opportunity to improve the health of this group whilst they are in hotels and potentially beyond by ensuring equal access to GP registration.

The proposed Primary Care Service Standards were developed by a small expert group of specialist homeless health GPs, STP leads, Londonwide Local Medical Committees (LLMC) members, CCG commissioners and Pathways team GPs.

### 4.1 List of Minimum Service Standards

1. All hotel residents should receive an 'Initial Triage Assessment' of immediate primary care, mental health and drug and alcohol needs. The 'Initial Triage Assessment' determines if the new hotel guest is registered, what medications they are on and how many days supply remaining, if they have existing links to substance misuse and mental health teams. (see attached triage process)

2. Where residents are already registered and/or under care from existing community and mental health teams the relevant connections will be made for continuity of care. Once contacted the registered practice should alter the designated pharmacy to one near the hotel.

3. Where residents are not registered or registration is undetermined they will be allocated a local registration with a nominated local link practice/PCN for homeless hotel provision. This to enable access to community systems including electronic prescribing / Spine / EPR access /account with Language Line for example.

4. Where possible phone access should be made available in hotels. With phone access the current practice will deliver most of the care through video and phone consultations. Prescriptions can be sent through EPS. During lockdown, the vast majority of LTC care and covid care will be carried out remotely.

5. There will still be a need for face to face consultations in some instances. This may need to be carried out at the hotel site if the patient needs to shield, or in an assessment centre/local surgery if they are not the highest risk. During lockdown, face to face consultations only take place if an examination is likely to change diagnosis and/or mx for a condition that may cause mortality or clinically significant morbidity.

6. Patients registered in a different borough would need to have access to a surgery local to the hotel for necessary face to face consultations and any essential interventions.

7. Through registration, the full hotel population will gain access to the GP OOHs services as well as community and mental health provision. Any requirements for site visits/in-reach provision should be facilitated through the service provider local to the hotel NOT necessarily the registering practice which for some will be out of area.

8. The local arrangements for face to face consultations with suspected covid cases will need to be extended to the out of area registered GP. For example, some boroughs have a covid centre (hot hub) that local GPs can book into. Where hotel residents have access to sats monitoring then the need for face to face interactions for covid is predominantly because the patient may have another diagnosis that must not be missed. In adults, the demand for this service is likely to be very low.

9. In order for the registered patient to be able to provide covid triage and monitoring remotely, the patient would need to have access to a pulse oximeter and gloves – ideally clear and there must be infection control measures for the equipment.

10. Should the patient's registered practice have to temporarily close because of staff illness – a risk to all practices - then local contingency planning arrangements will need to be made for provision of primary care services to the site.

11. A single alcohol and drug provider (Change Grow Live https://www.changegrowlive.org/ ) has been procured pan-London by the GLA to provide support to all hotel residents. They provide a single point of contact for guidance and out of hours clinical support for substance misuse related emergencies for all GLA hotels.

12. Localities will require a lead contact point for the homeless person's acute discharge pathway described separately, and potentially the community clinical input to the daily discharge MDT.

13. Ideally, specialist GPs for homeless health in London will be able to provide additional advice to local GPs where needed.

## 5.0 Caseload estimate

This model applies to all homeless hotels some of which in London have been procured by the GLA and/or MHCLG and some of which have been local authority procured.

To provide an indicative picture of demand. On 8th April 1099 rooms were available in the pan-London MHCLG/GLA sites, of which 991 (90%) are occupied. The indicative unregistered population for these sites is 276 people across London, an average of 69 patients in the four STP areas where there are hotels. Local boroughs should notify CCG and STP leads of any additional sites stood-up in their locality.

| | Capacity 8 April | Rooms occupied last night 8 April | Indicative unregistered (full capacity x 0.30) |
|---|---|---|---|
| **Hotels** | | | |
| **SWLondon** | | | |
| Wandsworth | 145 | 127 | 36 |
| Croydon | 102 | 79 | 26 |
| **NWLondon** | | | |
| Ealing | 81 | 81 | 20 |
| Westminster x 2 | 55 | 46 | 14 |
| H&F | 125 | 124 | 31 |
| H&F | 19 | 18 | 5 |
| Brent | 14 | 7 | 4 |
| **SELondon** | | | |
| Lambeth | 141 | 117 | 35 |
| Southwark | 31 | 28 | 8 |
| **NELondon** | | | |
| Tower Hamlets | 138 | 129 | 35 |
| City | 200 | 196 | 50 |
| Redbridge | 48 | 39 | 12 |

## 6.0 Equipment requirements

Equipment required for each site to support remote symptom checking and monitoring includes:

- Thermodots x10 number of residents
- Infrared thermometers x2 per site
- Pulse Oximeter on each site
- Blood pressure cuff on each site
- Gloves

Additional equipment requirements for sites can be found here

Local arrangements should be made to supply PPE where required and in accordance with PHE guidance.

## 7.0 Funding and contracting

The proposed primary care service standards are intended to complement local arrangements, providing a set of minimum expectations. There is no one size fits all with regards to how STPs deliver this service. CCGs have arranged these services in different ways. Some through existing specialist homeless health services, some through PCNs. Some are contracting work through new enhanced service arrangements others guaranteeing funding for additional locum or site visit activity where the workforce cannot be redeployed locally. COVID funding routes for reimbursement will be utilised by STPs in order to secure the necessary services.

## 8.0 Exit plan

It is not yet clear at what point hotel sites will be closed, but they are currently commissioned until mid/late June. An exit plan strategy is currently being developed working closely with the London Accommodation Sub-Group. The below exit plan is indicative only and a final plan will be developed with local authorities in London, housing leads, rough sleeping leads and DASS to agree a joint approach.

Longer term a programme of work is being developed in response to the London Vision to ensure equal access to healthcare for this group in London for implementation in 21/22. This also supports the ambitions for homeless health set out in the NHS Long Term Plan. There may be an opportunity to transition to that more quickly given the learning through this COVID period. This will be discussed as part of the exit strategy development.

Opportunities under consideration as part of a future model include a PCN contract with APMS enhanced service offer for inclusion health that can be locally tailored to local needs including where needed for rough sleepers.

The more short-term goal is to find permanent registration for all residents in this temporary Covid accommodation, recognising that it is more appropriate and beneficial to manage their needs in community settings and that many interactions with acute care are preventable. We know from a recent large scale NIHR study that compared to those living in the poorest part of the country they have nearly four times the rate of A&E visits, and are 3.8 times more likely to have an emergency readmission and 3.8 times more likely to have an A&E visit within a year.

Additional extended triage is recommended to support the exit strategy from hotels including mobility, cognitive issues i.e. learning difficulties, dementia, care needs, palliative care. This information may already exist for residents already registered. For residents that are newly registered, arrangements may need to be put in place for each STP area.

It is anticipated that the hotel population will at some stage be more widely dispersed. Residents with a temporary registration will have their right to registration GP access cards. On check out they will be engaged in a conversation about choice of location, ongoing primary care registration where possible determining their likely destination. It is anticipated that this would be the St Mungo's / Thamesreach support or other equivalent teams on site. An offer can be made to facilitate a practice introduction for ongoing registration at that point. This would be done in conjunction with accommodation providers where new arrangements have been made to offer ongoing housing and health teams will comply with the Duty to Refer for Housing in this instance.

**ANNEX 1 - DRAFT SAMPLE Each STP/CCG will have local arrangements for meeting the primary care service standards. This sample specification was developed with the Pathway's team to support CCGs/STPs to engage providers in delivering the triage requirements.**

This service specification has been developed to describe what is required to support an initial triage assessment for all residents.

Local STPs/CCGs will commission this activity directly. Triage will need to be conducted on site by a clinical team. In some instances, this has been commissioned through a GP federation or an out of hours service, or a specialist homeless practice. In the early set-up of hotels Pathway clinicians have provided interim cover and have as a result developed protocols in how to conduct triage effectively and support local non-clinical staff on the frontline to deliver enhanced infection control measures. They can consult, offer training and support in the delivery of triage through their inclusion health clinical leads, where available (contact alex.bax@pathway.org.uk)

**Triage service specification**

- All hotel residents receive an 'Initial Triage Assessment' of immediate primary care, mental health and drug and alcohol needs that is clinically-led.

- The 'Initial Triage Assessment' will determine if the new hotel guest is registered with a GP already, what medications they are on and how many days supply remaining, if they have existing links to substance misuse and mental health teams in all parts of London. It will also identify any other immediate health needs e.g. wound dressings, mental health support

- Triage information should be shared with the registering practice and where there is need for ongoing observation of residents on the hotel site this responsibility should be conveyed to the resident, the frontline staff in the hotel and too the registering practice. Where additional face to face consultations are necessary this should be put in place in line with the primary care service standards.

- It is essential that key appropriate information captured from the clinically-led triage by a specialist in homeless health is transferred to a registering general practice to be captured on their system as part of a patient record.

- The registering practice is responsible post-triage for ongoing health surveillance and may require support from the frontline workers to arrange to speak to residents on site. It will be important for the triage team to engage these frontline workers and registering practices at the outset to establish these roles on a sound footing. Once the initial triage assessment has been completed. Residents can continue to contact their primary care and other health teams directly via the usual routes. The hotel staff/charity workers on site will continue to facilitate ongoing requests for clinical input on behalf of the resident, liaising with their existing practice.

- Ongoing identification of covid symptomatic patients needs to occur daily at each hotel site. The effectiveness of this and appropriate escalation, is crucial to preventing spread of infection within hotel sites. Processes have been agreed for this with the LCRC/GLA with daily reporting mechanisms in place. Frontline workers should be advised on when to alert and contact NHS services for advice and information.

- Frontline teams (charity/welfare support staff) on site have been given guidance for daily checking new symptoms and escalating any changes through appropriate channels. They have guidance and protocol on supporting effective self-isolation and on infection control measures that can preventing viral transmission. A protocol for access to Covid CARE is also being issued so that symptomatic residents can be considered for transfer to Covid CARE. The triage team can reinforce these protocols whilst on site to ensure staff and residents are taken the necessary safety precautions.

**ANNEX 2 - DRAFT SAMPLE Each STP/CCG will have local arrangements for meeting the primary care service standards. This sample contract was developed by one CCG in London and can be adapted if additional payments for service are required. It is attached to support more rapid deployment in other areas as necessary.**

**Service Level Agreement for the Provision of General Practitioner Service to Homeless residents of RBKC/QPP rehoused during the COVID-19 crisis in local hotels and other types of accommodation**

**Duration: 1st April 2020 – 30th June 2020 (for review)**

**Parties**

The Commissioner: **West London CCG**

The Provider **:** **TBC**

## 1. CONDITIONS OF AGREEMENT

### 1.1 Parties to the Agreement

This Agreement is made on the first day of April 2020 between:

(1) WLCCG

(2) TBC

### 1.2 Background

This Agreement is made by the Commissioner with the Provider to secure the provision, by the Provider, of a General Practitioner ("the Service") to homeless residents housed in locals hotels and other types of accommodation during the COVID-19 crisis. Details of level of service provision are contained in the Service Specification.

### 1.3 Duration of Agreement

The Provider shall commence delivery of the Service on the 1st April 2020 ("the Service Commencement Date"). This Agreement shall expire on the 30th June 2020 ("the Expiry Date"), unless it is terminated earlier in accordance with clause 1.11 or extended by up to 1 year in accordance with clause 1.8.

### 1.4 Price and Payment Arrangements

The price of services that are provided under this agreement are detailed in the Financial & Activity Summary, Schedule A. The Commissioner (WLCCG) shall make monthly instalments in advance to the Provider of the total annual amount detailed in Schedule A.

### 1.5 Representatives

Each Trust will nominate representatives for the Service provided under this Agreement.

The contact points for this agreement are:

For the Commissioner -

**Jane Wheeler XXXXX**

For the Provider -

**TBC**

**Should the nominated representatives, or contact details, change during the term of this Agreement, the affected party shall notify the other party at the earliest opportunity.**

**1.6 Monitoring and Review of the Service**

The Parties agree to meet on a regular basis, not exceeding quarterly intervals, to review and monitor performance under this Agreement and discuss any matters they consider necessary in relation to the Service.

Once approved, in order for payment to continue, WLCCG must be satisfied that the service has been carried out as approved, subject to minor variations and/or changes in circumstances not likely to significantly alter the service provided. Any plans for major changes should be notified and approved in advance. The provider does not have permission to sub contract the service without WLCCG approval.

**1.7 Variations to the Agreement**

Both parties acknowledge that circumstances may change during the course of this agreement, which could affect the services covered. A proposal by either party to add to, modify or remove part of the service will be subject to one month in advance for the change unless both parties agree to a shorter period. Any proposed changes to the agreed service specification will be negotiated and jointly agreed between both parties before being implemented.

**1.8 Extension of the Agreement**

The Commissioner may in its discretion propose to the Provider that this Agreement should be extended in whole or in part by a period of 3 months commencing on the day after the Expiry Date, by issuing to the Provider, not later than 1 month prior to the Expiry Date, an extension request notice.

Within 10 Operational Days of the Provider's receipt of the extension request notice set out above, the Commissioner and the Provider shall meet to discuss and agree whether to proceed with the extension, and if the Commissioner and the Provider agree to proceed with the extension, this Agreement shall not expire on the Expiry Date but on the final day of the extension.

**1.9 Resolution of Disputes**

Any dispute between the two parties should be resolved by the liaison points detailed in clause 1.5, and the parties will use their best endeavours to achieve this. Any disputes that are not resolved in this way will be referred to the Parties respective Managing Directors (or comparable position) for resolution.

**1.10 Indemnity and Liability**

Without prejudice to its liability for breach of any of its obligations under this Agreement, the Commissioner shall be liable to the Provider for, and shall indemnify and keep the Provider indemnified against, and the Provider shall be liable to the Commissioner for, and shall indemnify and keep the Commissioner indemnified against, any loss, damages, costs, expenses, claims or proceedings whatsoever in respect of:

1.10.1 Any loss of or damage to property (whether real or personal);
1.10.2 Any injury to any person, including injury resulting in death; and
1.10.3 Any Losses of the indemnified Party,

that result from or arise out of the indemnifying Party's negligence or breach of contract in connection with the performance of this Agreement or the provision of the Services (including, in the case of the Provider (without limitation), its use of Equipment or other materials or products, and the actions or omissions of the Staff or sub-contractors in the provision of the Services), except insofar as such loss, damage or injury has been caused by any act or omission by, or on the part of, or in accordance with the instructions of the indemnified Party, its employees or agents.

The Provider shall maintain in force (and/or procure that its sub-contractors and Non Employed Consultants shall maintain in force) at its own cost appropriate indemnity/insurance arrangements in respect of employers' liability, clinical negligence where the provision or non-provision of the Services may result in a clinical negligence claim, public liability and professional negligence.

**1.11 Termination**

The Commissioner shall be entitled to terminate this Agreement forthwith by notice in writing, (subject to the outcomes of performance management process as detailed in Schedule 4) if the Organisation commits any material breach of any of its obligations hereunder and in the case of a breach capable of being remedied, fails to remedy such breach within 7 (seven) calendar days of written notice by the other party requiring it to do so.

Either Party shall be entitled to terminate this Agreement without reason having first given the other Party a minimum of 1 calendar month written notice.

In the event that the Commissioner's funding in relation to the Service is reduced or removed, the Commissioner reserves the right to reduce the amount specified in Schedule A accordingly or to terminate the Agreement with 1 months' notice, by giving the Provider notice in writing.

**1.12 Force Majeure**

Where a Party is (or claims to be) affected by an event or circumstance beyond the reasonable control of the Party, including without limitation war, civil war, armed conflict or terrorism, strikes or lock outs, riot, fire, flood or earthquake, which directly causes that Party to be

unable to comply with all or a material part of its obligations under this Agreement ("an Event of Force Majeure"), it shall take all reasonable steps to mitigate the consequences of it, resume performance of its obligations as soon as practicable and use all reasonable efforts to remedy its failure to perform.

The Party claiming relief shall serve initial written notice on the other Party immediately it becomes aware of the Event of Force Majeure. This initial notice shall give sufficient details to identify the particular event. The Party claiming relief shall then serve a detailed written notice within a further 5 Operational Days. This detailed notice shall contain all relevant available information relating to the failure to perform as is available, including the effect of the Event of Force Majeure, the mitigating action being taken and an estimate of the period of time required to overcome it and resume full delivery of Services.

Should the Party claiming relief be unable to resume the Service after a period of 30 calendar days, the other Party shall have the right to terminate this Agreement with immediate effect.

**1.13 Severability**

If any part of this Agreement is declared invalid or otherwise unenforceable, it shall be severed from this Agreement and this shall not affect the validity and/or enforceability of the remaining provisions.

**1.14 Assignment and Sub-Contracting**

The Parties shall not assign, delegate, sub-contract, transfer, charge or otherwise dispose of all or any of its rights or obligations under this Agreement without the prior written consent of the other Party which shall not be unreasonably withheld.

**1.15 Governing Law and Jurisdiction**

This Agreement shall be considered as a contract made in England and shall be subject to the laws of England.

**2. SERVICE SPECIFICATION**

**2.1 Background**

.

In response to the COVID-19 pandemic across London a plan has been agreed to support homeless people who are at risk due to frequent underlying health needs, and for whom self-isolation is difficult. This support hinges on moving people to hotels and other types of accommodation'. Whilst some people will have a GP they are registered with, being located in the hotels or other type of accommodation' will mean they cannot access normal GP services and these specification describes the support needed, prior to and during their residency in the hotels.

**2.1 Service Provided**

The service outline:

Ensure the provision of general medical services to homeless residents of RBKC/QPP who are temporarily housed in local hotels or other types of accommodation including:

- Providing Qualified GP Support
- Providing medical advice
- Responsibility for prescribing medication according to patient needs
- Appropriate referral to an acute /specialist provider
- Thorough assessment of residents' clinical, psychological and socials needs

The practitioner will take a clinical lead role for the site, liaising and coordinating other staff as required to ensure care delivered at the correct level.

Patients will be registered temporarily with the XXXXX practice

To provide daily attendance at the hotel or other type of accommodation including: (Mon-Fri). There will be approximately 10 hours of clinical visits per week that also includes clinical advice/triage via the telephone remotely (particulars stipulated later in the SLA).

Clinical time may vary dependent upon size of the hotel or other type of accommodation e.g. larger building (60 - 100 units) ~10hrs but smaller building (30 – 60 units) ~5hrs (to be agreed once service starts).

To have robust lines of communication with the homeless health team, other professionals involved in programme and other relevant healthcare professionals to ensure an integrated approach for the provision of medical care for all residents.

Emergency out-of-hours cover is provided by the local GP Out of Hours provider (in West London CCG this is LCW).

**Daily role:**

- Response to urgent medical need
- Response to concerns over self-reported symptoms
- Response to concerns noted by on-site homeless support team
- Unavoidable medical intervention such as leg dressings, infections (non COVID)
- Management of alcohol withdrawal and supporting self-detoxes/reduction in use
- Management of opiate withdrawal
- Management of opiate substitution prescribing and issues around moving of scripting locally
- Management of acute mental health issues and liaison with services
- Responding to issues around safeguarding and care act assessments / social care for patients who previously had care needs
- Managing issues around patients long-term conditions including diabetes / cancer / heart disease etc

**Information collation and recording:**
Referral information to be provided by Triage service:

- Health teams need to know WHO is coming in and need the first contact health triage service to have gathered the following information:
    a. Demographics incl need for interpreter

   b. Mobile number (VITAL for keeping medical contact remotely). Referrers to issue patient with a phone if needed
   c. Vulnerability factor (eligibility criteria for PROTECT)
   d. GP details
   e. Next of kin (if possible)
   f. Evidence of a NEGATIVE COVID symptom screen or test.
   g. No known contact with anyone that is COVID19 positive

**At induction to the venue:**

- Medical history as above
- Information about hygiene measures, hand washing, sanitising surfaces
- Information about symptoms and who to inform

**Further information gathered once in** hotels or other type of accommodation**:**

- List of medical problems
- Regular medications
   a. How much medication do they have?
   b. When will they need next script?
- Addictions needs
   a. Name of current or recent substance misuse team - particular attention to if injecting and any needs around needle/syringe provision
- Mental health needs
   a. Name of current or recent mental health team and medication including who administers
- Other services currently linked with including Social Care, Probation or other support
- Do they smoke/vape? How much etc? Access to tobacco/e-liquid/NRT– discussion around smoking policy of hotel or other type of accommodation

**Practicalities:**

- Check patient's details on NHS spine
- Patients well linked to own GP to remain under their care remotely
   a. Patient or Staff to contact GP to confirm (1) medical history, (2) request GP summary emailed and (3) transfer prescription to pharmacy nearest the venue (4) request a prescription issue if patient running low
- Patients without GP registration to register with local specialist practice as a temporary patient or immediate and necessary. Where this is impossible, to liaise with local practice for consideration of temp reg.
- Patients known to drug treatment services (DTS) to remain under their care at arm's length
   a. Contact DTS to organise local pharmacy for scripting
- Patients not known to a DTS to be managed by primary care team with support /referral local DTS as needed (see DTS information on local services and links)
- Patients currently under CMHT – to liaise re provision of remote support where needed.
- Patients with acute mental health concerns - support likely needs to come from local teams e.g. Joint Homelessness Team/HTT

**Liaison**

- Liaison with MH trusts within the local borough in the event of people needing Joint Homeless Team input and, or CMHT/HTT input
- Discharge to the hotels and other types of accommodation for those with high levels of mental health needs should only be used if there is no possibility of accommodation within boroughs
- Liaison local substance misuse services to provide advice and possibly take on patients not currently linked to a service
- Liaison with social care services locally as needed
- Brokering relationship with local pharmacist – particularly around OST
- Brokering relationship with local GP surgery (ideally specialist homeless practice where this exists but if not a local surgery) and requesting registration forms to be sent for completion.

**Governance and safety**

- Clinical notes for patients to be kept in locked cabinet in medical room
- Medical room to be equipped to with supplies as per previous lists
- Naloxone available onsite
- PPE to be available to staff as needed in line with latest national guidance
- Patients who need medical review to be screened for COVID symptoms before any face to face medical intervention.
- Patients reporting suspected COVID symptoms to have a remote consultation followed by a brief face to face assessment in required PPE in line with latest national guidance.
- Need for locked box/locked access to controlled drugs if dispensing onsite considered
- On-site homeless service support team to hold any alcohol needed to prevent withdrawals

IN WITNESS this Agreement has been entered into by the parties on the date first above written.

Signed for and on behalf of :
**WLCCG**

Signed: ……..

Date:……

Signed for and on behalf of :
**PRACTICE TBC**

Signed: ……..

Date:……

**2.2 Statutory Requirements**

The post holder will comply with any General Practitioner statutory regulations and provide evidence:

- To participate in a minimum of 5 day CPD per year and provide evidence

Confirmation that GPs visiting the home have:

- Current GMC and NPL registration
- Current MPS (medical defence) cover
- Up to date clinical appraisal (including dates)
- Confirmation GPs meet the requirement for CPD (overall)
- DBS check within last 3 month or proof on update service
- Right to work in the UK check

Infection Control training:

- Infection Control must be undertaken on an annual basis and evidence provided

**2.3 Performance Targets and Outcomes**

Ten hours GP time per week (daily visits). To conduct medical assessments, including medication reviews for all newly admitted residents and residents who have specific medical needs as referred by other professionals within the homeless health system.

**2.4 Clinical Governance**

Professional clinical supervision is provided by: PRACTICE TBC

Clinical outcome targets, performance times and quality standards to be set and monitored by both parties.

Participate in any investigation/Root Cause Awareness (RCA)

**3 Costs**

Agreed as £110 per hour for GP input.

**Schedule A**

**Activity and Financial Summary**

| Service | Details | Price per week | Price per month |
|---|---|---|---|
| GP Service and Admin | | £1,145 | £4580 |
| **Total:** | | **£1,145** | **£4580** |

Funding to be agreed on a monthly basis

**Schedule B**

**Requirements from** hotel or other type of accommodation **sites**

**Essential requirements of** hotel or other type of accommodation **site to support medical and clinical provision**

- Lifts
- Rooms of a good size for medical equipment
- Wide corridors for putting on and taking of medical equipment
- Access via ambulance
- Generally - laminate/wipeable surfaces where possible
- Infection control:
    - Regular cleaning especially of hard surfaces
    - Including bedding change every week
    - Deep clean arrangements
    - All communal areas cleaned daily

Practical considerations for the site

- Screening of staff for any risks that result in them needing to self-isolate
- Posters in hotel or other type of accommodation to remind people to wash hands/avoid touching surfaces/social distancing keep a 2m away from others
- Hand gel available for staff use only
- Clinell wipes available for high risk areas
- Cards given to patients describing what symptoms to look out for and how/when to inform staff if they feel unwell
- Nicotine replacement/electronic cigarette needs consideration ? stock available onsite
- Provision of cleaners
- Information about use of masks