COVID-19 HOMELESS HEALTH RESPONSE

Clinical staffing support

The current situation is fast moving and evolving on a regular basis. Always refer to the single source of advice and keep up to date with the latest guidance on COVID-19 (coronavirus) via the NHS (www.nhs.uk/conditions/coronavirus-covid-19/) and government websites (www.gov.uk/coronavirus) and follow the advice.

Purpose of this document

This document is intended for health leads at NHS England and Improvement regional footprints, and STP/ICS leads[1], working with local government to reduce the impact of COVID-19 on people facing homelessness. Background to the Homeless Health COVID-19 response can be found in the letter sent to local authorities on plans to protect rough sleepers during the pandemic[2].

This document sets out potential approaches to staffing as part of a health-led multi-agency response across the NHS, local government, and the voluntary, community and social enterprise sector (VCSE).

It draws on work in London to support this population and will be revised as necessary based on operational learning. Colleagues should check they are using the most up-to-date version available.

When developing a local staffing response, it is important to note that the approaches outlined in this document are not prescriptive. There is considerable variation in the size and layout of 'Care', 'Protect' and low risk facilities for rough sleepers and homeless people. Local authority, health and voluntary sector partners will need to consider local conditions and adapt the approaches outlined in this document.

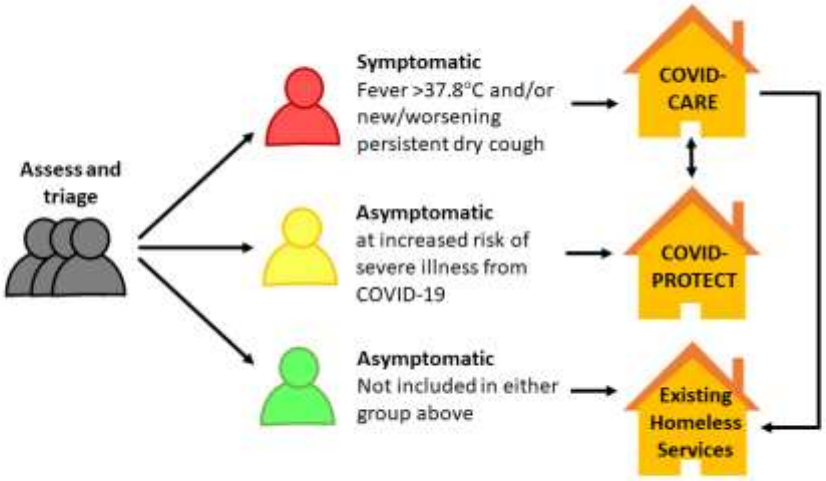
[1] Sustainability and Transformation Partnerships/Integrated Care Systems

[2] https://www.gov.uk/government/publications/letter-from-minister-hall-to-local-authorities

The COVID-19 homeless health response

The homeless health response is based on a process of assessment and triage into three separate groups before people are moved into accommodation.

Clinical triage to determine accommodation



Roles and responsibilities in managing staffing

Local authorities

Local authorities have been asked by the Ministry of Housing, Communities and Local Government (MHCLG) to move people out of accommodation with shared bathroom facilities and communal areas / and off the streets - “Everyone In”.

They are responsible for securing accommodation e.g. ensuite hotel rooms or self-contained units, and for leading on staffing relating to site management, including cleaning, reception, management, catering, and security.

Local authority public health teams are also responsible for commissioning drug and alcohol treatment services, including for the COVID-19 homeless sites.

Note: across London, additional pan-London drug and alcohol support is being procured to support the needs of people in the COVID-CARE and COVID-PROTECT accommodation. Other regions may develop a similar model.

NHS

The NHS, coordinated via NHS England/Improvement regional teams, is supporting the health elements of the response. Health partners are responsible for:

- identifying clinical staff support to the sites

- deployment, support and supervision of the clinical staff
- oversight and support for non-clinical staff undertaking triage
- supporting primary care registration of residents. (see Annex A for more information on patient registration)
- assessment, review, planning and treatment of residents' health needs and symptom management
- prescribing medication
- mental health
- liaison and arrangements for hospital discharge/step down
- escalation to local NHS capacity for intensive life support

Voluntary, community and social enterprise sector

The voluntary sector plays an important role in any multi-agency approach. VCSE services provide:

- Practical support to deliver appropriate and trauma-informed care and support for people experiencing rough sleeping, along with statutory partners
- Specialist services including inclusion health, specialist substance misuse services, mental health services, homelessness outreach, specialist accommodation, employment and training – commissioned by both NHS and local government
- Volunteer and peer support, with access to existing volunteers and peer supporters/experts by experience who understand homelessness issues and are experienced in supporting people.

The precise role of the VCSE is for local determination and will be influenced by local relationships, capacity of the sector and commissioning arrangements. It is recognised that much of the voluntary sector is under extreme financial pressure at the moment and is often mobilising effort at its own risk and unfunded.

The London hotels each have significant VCSE-provided staffing, including a manager, key workers and other staff. Hotels are working in partnership with VCSE organisations with extensive experience of running building-based services for the homeless client group. The staff provided by the VCSE sector are paid staff and not volunteers.

Staff deployment to COVID-CARE

It is recognised that COVID-CARE facilities are being rapidly deployed on an emergency basis and that they will be supporting a highly complex client group that may pose additional infection control challenges. It is therefore recommended that:

- COVID-CARE should be staffed by people who do not have chronic illness

- expert advice from older or co-morbid staff should be provided by telephone or video link.

COVID-CARE facilities should have access to 24-hour medical care – with GPs giving telephone advice including out of hours on call, and nursing and health care assistant support on site

This team should be supported by specialist clinicians providing advice as necessary on drug and alcohol dependence, mental health, acute medicine, infectious disease, palliative care and close liaison with local A&E services for decisions on transfer to secondary care.

NICE guidance on for referral into critical care should be followed Overview | COVID-19 rapid guideline: critical care | Guidance

NHS staff should work alongside experienced homeless sector workers, experts by experience/peers and ancillary workers who are redeployed from existing local homeless organisations and allied support services.

While it is recognised that other regions are working with different levels of need, the proposed clinical staffing model for the COVID-CARE facility in London is given below to share learning.

- 24-hour nursing cover of six nurses on three 8-hours shifts as a minimum
- 1 full time admin
- Volunteers and/or Health Care Assistant to support the nurses
- GP time as required (0.5 WTE) to conduct virtual 'ward' review daily, prescribe and make referral decisions
- Team to be able to use local on call clinical arrangements
- Appropriate access to drug and alcohol support either through local service or emergency provision
- Link to mental health teams able to provide assessment and treatment to the facility, virtually or face to face
- Data management and reporting

This staffing list is proposed for a facility accommodating about 50 people; therefore, staffing ratios need to be reviewed and scaled to support varying local need.

Depending on the staff provided by the accommodation that has been secured, there will be a need for a wider range of non-clinical staff roles including cleaning, reception, managers, catering and security.

Volunteers and peer supporters/experts by experience can potentially support with:

- Welcome to new arrivals
- Meal preparation and delivery
- Cleaning and laundry
- One-to-one support for self-isolating residents to check on wellbeing

- Transport within the facility
- Printing distraction and wellbeing packs

Staff deployment for COVID-PROTECT

COVID-PROTECT facilities should provide 24-hour support with visiting (daily) medical teams and medical telephone advice as required. This should be provided by local primary care or inclusion health specialists.

As in COVID-CARE, COVID-PROTECT facilities will require experienced workers, experts by experience/peers and ancillary workers who are redeployed from existing local homeless and allied support services.

The non-clinical staff team should be supported by floating clinical support, including mental health and addiction and chronic disease management.

The proposed clinical staffing model for the 148-bed COVID-PROTECT facility in London is:

- 2 nurses for one day time shift
- Volunteers and Health Care Assistants
- GP cover (4 sessions of GP time), likely to be by phone
- GP on call needed
- 1 full-time admin
- Appropriate access to drug and alcohol support either through local service or emergency provision
- Peer supporters/experts by experience
- Link to mental health teams
- Data management and reporting

Depending on the staff provided by the facility there will be a need for a wider range of non-clinical staff roles including cleaning, reception, managers, catering and security.

Volunteers and peer supporters/experts by experience can potentially support with:

- Welcome to new arrivals
- Meal preparation and delivery
- Cleaning and laundry
- One-to-one support for self-isolating residents to check on wellbeing
- Transport within the facility
- Printing of distraction and wellbeing packs

Mental health staffing support

People experiencing rough sleeping and homeless experience high levels of chronic illness including mental health issues, combined with high levels of drug and alcohol dependence. Clinical staff supporting facilities are the first point of contact for mental health support and escalation issues. As sites are set up, arrangements need to be established for clinical staff to draw on the support of community mental health teams, taking into account:

- Existing mental health diagnoses of residents
- Escalation procedures if there is risk to individuals or other residents because of mental health issues
- Support for non-clinical staff and volunteers/peer supporters in hotels to understand and respond to mental health needs of residents.
- A mental health checklist has been developed nationally to support staff to respond appropriately to mental health needs

Drug and alcohol support

Close working with PHE regional leads for drugs and alcohol and local authority-commissioned services is essential to mobilise drug and alcohol treatment staff to deliver drug and alcohol support. Many of those being accommodated may not be known to services and will represent an additional demand on commissioned provision.

Regional staffing

The following central clinical and operational support functions are developing in London, although this is rapidly changing as different needs emerge. Again it is recognised that other regions are supporting varying levels of need.

- Clinicians from existing inclusion health teams working flexibly to fill gaps in care across the region as new hotels are opened
- Nurse practitioner to develop triage
- Support to liaise with hospital discharge teams and manage flow
- Potential for regional or sub-regional commissioned drug and alcohol support for each of hotel sites. In London this has been commissioned by the GLA
- Project management and administrative support for clinical tracking and record-keeping, and to support wider governance
- IT and data management resource
- Supplies management including food provision operations, handled via a central supply depot

Identifying staff to support facilities

Clinical staff support to COVID homeless facilities should be coordinated at NHS England/Improvement regional level and connected to wider clinical workforce planning and deployment through the relevant regional COVID command cell.

NHS E/I regional leads will mobilise support via STP/ICSs and/or Strategic Co-ordination Groups (including public health colleagues) to support the health needs of newly accommodated rough sleepers.

In London region this is being managed through a Homeless Health COVID-19 STP Leads Group. This group's purpose is to oversee the STP planning, requirement setting and development of a pan-London model of care for implementation across temporary accommodation sites for London's homeless population. This includes oversight and direction to the service planning process including clinical workforce resourcing and allocation.

Current models implemented (e.g. in Westminster) have used existing specialist GPs, nurses and community health workers who already have a detailed knowledge of the client group and strong links with local homeless sector providers, drug and alcohol services and community mental services.

If NHS regions are not aware of inclusion health specialist or primary care capacity in their area, they can seek advice via the national team managing Homeless Health COVID-19 work (see contacts at end.)

Clinical support for sites can be delivered by phone from clinicians who are having to self-isolate, for example daily reviews with nurses, speaking to individual residents for assessment and monitoring purposes, support for decisions on escalation.

Clinical supervision, risk management and escalation

The clinical leader identified for the COVID homeless workstream in each NHS England and Improvement region should coordinate approaches to clinical risk management and escalation. Once clinical staff have been mobilised to support the Care and Protect facilities, support structures for those staff should be developed including supervision.

Approaches should be agreed if individual cases need escalation either based on their physical health relating to COVID-19 or if someone's mental health deteriorates and they are deemed to be at risk to their self or others.

Staff training needs

The training needs mentioned here are not intended to be comprehensive bit it is noted that infection control training/awareness is important for all, especially for non-specialist members of staff, such as those employed directly by the hotel, and for volunteers and peer supporters.

The national Homeless Health COVID-19 team is sourcing an e-learning package for staff in COVID homeless facilities on mental health first aid. More details will be made available in due course.

Contact for queries

Queries relating to this document should be addressed to england.covid-homeless@nhs.net

ANNEX A

Extracts from NHS England and Improvement update for primary care, of which the full text is available here:

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/gp-preparedness-update-letter-27-march-2020-.pdf

Patient registration General

We would like to clarify the application requirements regarding new patient registrations. The regulations require that “an application for inclusion in a contractor's list of patients must be made by delivering to the contractor's practice premises a medical card or an application signed (in either case) by the applicant or a person authorised by the applicant to sign on the applicant's behalf”. We would like to confirm that in the current situation, delivery may be by any means, including by post and digital options. A signed, scanned application or picture of a signed application emailed to the practice is acceptable. Equally, where a practice has online registration options, a supporting signed letter from the patient, posted or emailed to the practice, is acceptable to complete the registration. Practices must, however, ensure that where online registration solutions are used, all GMS1 fields are collected and relevant information entered into the clinical system during registration. This will ensure Primary Care Support England can process the registration.

Registration of patients, including those with no fixed address, asylum seekers and refugees

Practices should continue to register new patients, including those with no fixed address, asylum seekers and refugees. **Practices should agree how they can most effectively connect and support locations that are accommodating people who are homeless.** More detailed guidance on registering patients is being developed. We would like to remind GP practices that the absence of photo identification or a fixed address is not a reason to refuse a patient registration.

Homeless patients should be registered either at a c/o address where one is available (eg a shelter/ support service) or the GP practice address. We can assure practices using the GP practice address as a c/o does not place responsibility on the practice to repatriate correspondence (eg hospital letters). Homeless patients should be encouraged to keep in contact with the practice at regular intervals where they have ongoing health and care (primary and secondary) requirements.