Reducing the impact of COVID-19 on people facing homelessness

Operational guidance for oversight and implementation of the health response

Reference to other guidance

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.

Contents

1. Introduction

1.1 Purpose of this document

This document is intended for health leads at NHS England and Improvement regional footprints, and STP/ICS[1] leads, 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 Homeless Health Checklist in Annex 1 and the letter sent to local authorities on plans to protect rough sleepers during the pandemic.[2]

It provides practical suggestions on how to collaboratively plan and deliver as part of a health-led multi-agency response across the NHS, local government, and the voluntary, community and social enterprise sector (VCSE). This includes the identification and support of the governance and structures required to connect this work to the wider COVID-19 emergency response which is controlled through regional Incident Control Centres.

The London region approach has been annexed as an example of a potential approach that can be adapted/drawn upon. However, it is recognised that other regions operate with different context and structures to London. The national NHS E/I Homeless Health COVID-19 team is available to advise colleagues on specific local circumstances (see contact and resources section at end.)

1.2 Checklist of key points

- Support multi-agency working by connecting the health response to COVID-19 accommodation sites through the local authority-led Local Resilience Forums
- 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
- Connect COVID-19 homeless health work to overall Incident Control and Command structures in NHS England and Improvement regional teams, specifically: -
    - Mobilising primary care to support newly established sites
    - Managing discharge from hospitals and mental health care
    - Reducing avoidable admissions and A&E attendance
    - Supporting prison release
    - Flagging issues relating to personal protective equipment (PPE)
    - Connections with drug and alcohol services and support

[1] Sustainability and Transformation Partnerships/Integrated Care Systems

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

    - Outbreak / infection reporting and management with Public Health England (PHE) local centres
- Develop clear processes with partners for reporting, risk management and escalation
- Build on partnership working with the homeless (VCSE) sector which has experience and skills in supporting needs of people experiencing rough sleeping.

2. Overview of Governance Structure

2.1 Governance structure

The success of the Homeless Health COVID-19 response depends on multi-agency working between the NHS, local government and the VCSE and will benefit from clear leadership and good governance.

NHS England and Improvement regions are putting in place governance structures for the homeless health COVID-19 emergency response. This does not override any formal incident structures already in use by partners and functions in a strictly complementary/supplementary manner.

Governance and structures for partnership working will vary depending on how local government is organised in different areas. Connection is required to:

- STPs/ICSs to provide a health response to newly housed rough sleepers
- NHS COVID-19 cells or workstreams supporting a range of issues: hospital discharge, 111/urgent and emergency care, primary care, mental health, prescribing, workforce and accommodation, PPE and supplies, finance, data collection and reporting, communications, prison release – with overall reporting of Homeless Health work through the designated regional cell.
- Local Resilience Forums (LRFs), Strategic Co-ordination Groups and local authority hubs to support those in our communities who are at the highest risk of severe illness.
- Local authority functions of housing, adult social care, and public health commissioned services such as drug and alcohol agencies.

2.2 Planning, coordination and implementation of the homeless health response

NHS E/I leads have been identified in each region of England to lead the Homeless Health COVID-19 work. They should identify a lead in each STP/ICS to respond to the specifications for COVID-CARE and COVID-PROTECT sites, identifying the required health and care input with local primary care providers, mental health trusts and adult social care. They should work in partnership with their counterparts in Public Health England to ensure that the local authority public health functions are accounted for in the regional approach.

At NHS E/I regional level it is recommended that the Homeless Health COVID-19 work is reported through an existing appropriate cell and that governance arrangements are set up to plan and implement this work. Exact structures will vary depending on local government partnerships.

The overall purpose is to minimise the transmission of COVID-19 and reduce mortality through early identification of clinical deterioration, providing supportive care and rapid escalation to NHS critical care facilities if needed.

The following planning and management functions need to be delivered:

- Implementation of the COVID-19 homeless health response, ensuring a sustainable and robust approach is in place for each element of the implementation, across the region
- Oversight and direction to the health service planning process; ensuring a methodical approach is taken to programme scope, approach, key priorities, schedule/timeframes, project governance, risks and outcomes
- Liaising with local government and appropriate local voluntary sector partners, including substance misuse services, for early notice of sites being set up and how health services can be provided to them
- Development of the model of care, including referral pathways and discharge planning.

At an operational level the following functions need to be covered with reporting and escalation through governance structures.

- Operational management including holding secure records of everyone accommodated, risk assessments for all sites
- Escalation of issues and risks as they occur in real time
- Brokering communication between accommodation sites and each STP/ICS/local authority area to coordinate responses, deliver regional enablers and progress key areas such as workforce, equipment and supplies, digital support
- VCSE mobilisation and support
- Maintaining regular reporting/sit-reps and actioning requests received.

These operational-level activities may be coordinated on an NHS E/I regional footprint level (as in London) or at a local authority footprint, depending on local geographies and structures. However, it is essential that there is oversight and reporting into regional level COVID-19 command and control structures for planning, support and escalation.

2.3 Other key issues for regional level coordination

2.3.1 Primary care

It is a priority for regional leads to support primary care cover for accommodation sites. The aim is to support registration, triage and assessment, remote support and care continuity at sites. It will need to take into account the complex care needs of people experiencing rough sleeping and the fact that many of those being

accommodated may have no previous primary care registration [3].Solutions being adopted include working with homeless and inclusion health practices or enhanced practices, and agreeing a local Primary Care Network or general practice to be designated responsible for each new accommodation site. This will include responsibility for connecting residents with their registering practice as well as supporting those that have no registration.

It is recognised that primary care teams' capacity is an issue and, in some areas, digital support for telemedicine is being utilised to help resolve this challenge, in addition to provision of mobile phones for residents.

2.3.2 A&E discharge and accommodation status

Regional level coordination should also take into account the COVID-19 Hospital Discharge Service Requirements published on 19 March, including specific information on homelessness.

2.3.3 Mental health and substance misuse

People experiencing rough sleeping and homelessness have high levels of chronic illness including mental health issues, often combined with substance misuse. COVID Care and Protect facilities will be supporting people who have experienced trauma and have serious mental health issues.

It is therefore a priority for NHS E/I regional leads of this work to connect to COVID Command mental health workstreams so that support and advice is available from mental health services to site management teams in relation to treatment, risk, and escalation. Close working with PHE regional leads for drugs and alcohol and local authority-commissioned drug and alcohol services is also essential, noting that many of those being accommodated may not be known to services and will represent an additional demand on commissioned provision.

2.3.4 Exit strategy

Whilst people experiencing rough sleeping are accommodated, there is an opportunity to address longer term housing needs and requirements for health and care support. This includes ensuring that all those experiencing rough sleeping are registered with primary care and have care plans for mental health and substance use in place. It is recognised that there are challenges to achieving this in the context of current pressures on the NHS and wider public services. An exit strategy should

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

be developed jointly with local rough sleeping leads and housing cells to examine all opportunities for transitioning people in to sustainable solutions and ending homelessness.

2.3.5 Social Care

Individuals with the highest needs and receiving social care support should ideally be kept within their local area to ensure continuity of care and support. It is likely that very few of those in commissioned accommodation will have social care support in place, but where this is the case, it should be captured to ensure the relevant authority is aware. Some people may need a social care assessment, and referrals should be made where appropriate. More information can be found in the Care Act COVID-19 easements guidance (https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities).

3. Contacts

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

Annex 1: Homeless Response Checklist

HM Government

COVID-19 homeless response checklist

This checklist provides important information to people and groups helping those sleeping on the streets, in night shelters and hostels to access accommodation and to keep them and others safe. It can also be used to assist this same group needing to leave hospital or being released from prison.

1. A simple approach to triaging, assessing and accommodating people is essential. There are three groups to consider:
    1. **The symptomatic** group would include people anyone (i.e. regardless of risk group) with a new persistent dry cough and fever/temperature over 37.8°C. This group should be placed in **COVID-CARE** sites.
    2. **The asymptomatic high clinical risk group** would include people who are eligible for the flu vaccination, and those who are extremely vulnerable. This group should be placed in **COVID-PROTECT** sites.
    3. **The asymptomatic and low risk** group would include people not included in either of the groups above. This group should continue to use current service provisions or be placed in accommodation to meet current guidance on self-isolation.

    Existing risk management protocols for accommodation for specific client groups (for example people with substance dependency, mental ill health, a history of violent behaviour, and women) should be applied. More guidance on this will be available in due course.

    This protocol should be implemented by local staff (e.g. outreach workers, hostel staff) following guidance and, where needed to identify clinical risk, instruction from NHS professionals either in-person or remotely (i.e. over the phone).
2. All partners need to be involved in a coordinated and planned way including:
    - **Local Authority** – for leading on securing and funding accommodation, Local Authority public health including commissioned drug and alcohol treatment services, social care and support
    - **NHS** –for commissioning and provision of primary care, community services, urgent and emergency care, hospital discharge and mental health
    - **Voluntary Sector** – providing shelters, hostels, outreach support and food banks.
3. The multi-agency response should be organised and coordinated through local emergency response arrangements, specifically with:
    - Local Resilience Forums to support those in our communities who are at the highest risk of severe illness

- **NHS** priority - leadership for people in COVID-Care (symptomatic) and COVID-Protect (asymptomatic, high clinical risk) using the COVID-19 emergency response structures
- **Local Government** priority - leadership for people in the asymptomatic and low risk group.

4. If accommodation is provided it must be suitable for successful self-isolation, and should include:
    - **Single ensuite rooms** with **catering** facilities, or alternative food provision
    - **Accessible** accommodation for people with disabilities
    - **Protocols** to respond appropriately to **on site alcohol** and **potential drug use**. Further guidance will follow but protocols will need to balance the risk of ongoing transmission of COVID-19.
5. Working together with local drug and alcohol treatment providers, local protocols should be agreed for prescribing, needle exchange and the provision of naloxone. Further substance misuse guidance will be provided.
6. Local COVID response teams need to agree a coordinated plan for effective distribution of appropriate Personal Protective Equipment (PPE). This will include identifying where staff should collect PPE, and staff training in the use of PPE. The following is proposed:
    1. **Hospital-based** pathways teams to pick up from their **Trust**
    2. **GPs** and **primary care** staff to pick up from their **practice**
    3. Sites taking symptomatic people (COVID-Care) and clinically vulnerable (COVID-Protect) to pick up appropriate PPE from the nearest **Trust**.

    Outreach staff do not routinely need PPE **unless** they are in close contact with symptomatic or confirmed cases of Covid-19 disease, in which case surgical masks, gloves and aprons and goggles/visors are recommended (PHE guidance).
7. Outreach and support staff should practise social distancing whenever possible as well as good hand and respiratory hygiene, such as regular handwashing for more than 20 seconds (https://www.gov.uk/government/news/public-information-campaign-focuses-on-handwashing).

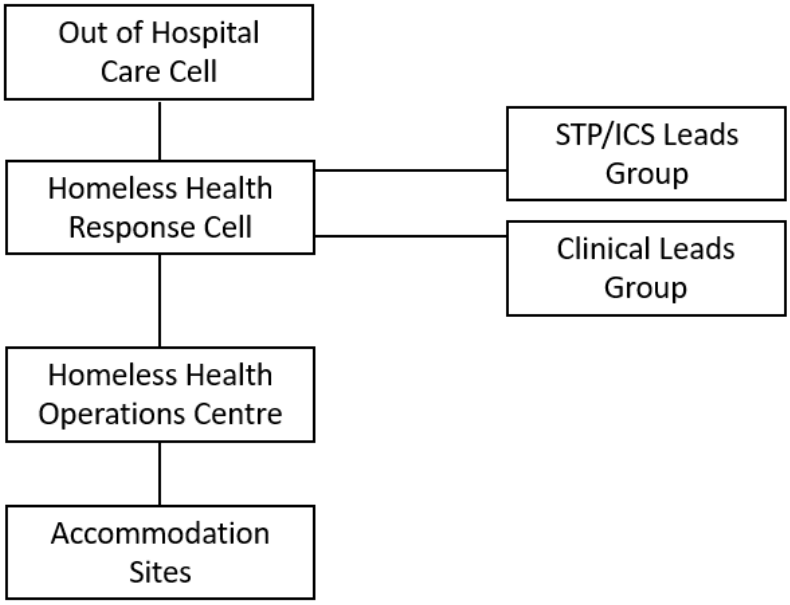
Additional advice, guidance and protocols will be shared as the situation develops.

Annex 2: Example of London structures

Across London all STPs/ICSs are working in partnership with MHCLG, GLA and local authorities to provide health support to accommodation sites within limited capacity. A command and control structure is in place and has been adapted to provide oversight as well as operational support.

The structure is in continuous development due to the rapidly developing environment for this work.

Command and control structure overview



London COVID-19 Homeless Health Response Cell

The London COVID-19 Homeless Health Response Cell is accountable to the Out of Hospital Cell. Its purpose is to oversee the planning, requirement setting and development of a pan-London model of care for implementation across temporary accommodation sites for London's homeless population.

The aim is to ensure that planned facilities are fit-for-purpose for healthcare provision, minimise the transmission of COVID-19 and reduce mortality through early identification of clinical deterioration providing supportive care and rapid escalation to critical care NHS facilities if needed. The cell provides direction on the following:

- Implementation of the COVID-19 Homeless Sector Plan; ensuring a sustainable and robust approach is in place for each element of the implementation
- Oversight and direction to the service planning process; ensuring a methodical approach is taken to inform program scope, approach, key priorities, schedule/timeframes, project governance, risks and outcomes;
- Development of a pan-London model of care, referral pathways and discharge planning.

A daily London COVID-19 Homeless Health Response Cell meeting is chaired by an acting incident director for homeless health on behalf of Senior Responsible Officers from the Greater London Authority (GLA) and a London STP/ICS.

Membership includes the following:

- Senior Responsible Officers, as above
- NHS England/Improvement London Region
- GLA Health / Public Health
- GLA Rough Sleeping / Accommodation
- Sustainability and Transformation Partnerships (STP) leads
- Westminster Clinical Commissioning Group/LB lead
- ADASS[4] lead(s)
- London Councils
- Primary Care
- Mental Health
- Drug and Alcohol
- Step Up/Step Down & Palliative Care
- Homeless Health Operations Centre
- PHE London Region
- NHS E/I National
- MHCLG[5]
- Communications
- Delivery Group Operations Lead and Secretariat

London COVID-19 Homeless Health Operations Centre (HHOC)

The London COVID-19 Homeless Health Operations Centre (HHOC) is staffed by a Healthy London Partnerships team and is responsible for the operational management and escalation of issues and risks as they occur in real time.

[4] Association of Directors of Adult Social Care

[5] Ministry of Housing, Communities and Local Government

It brokers communication between MHCLG/GLA accommodation sites and each STP / service area to coordinate a response, deliver regional enablers and progress service model development (e.g. workforce, equipment and supplies, digital support).

It facilitates or provides support on the following:

- Convening a virtual daily meeting amongst members to discuss issues from previous day and priorities going forward
- Facilitating regular meetings with partners in the system and detailing actions to be taken
- Regular liaison with STP/ICS and clinical leads
- Regular liaison with the sites
- Maintaining regular reporting/sit-reps and actioning requests received through the generic inbox (see Annex B for an example)
- Identification of digital opportunities for providing more remote telemedicine to accommodation sites and seeking an additional health workforce (e.g. Medecins Sans Frontieres, Greenlight) to bolster capacity for care planning.

The operations centre also convenes two sub-groups that report into the Homeless Health Response Cell (HHRC); the STP Leads Group and the Clinical Leads Group.

London COVID-19 Homeless Health STP Leads Group

The purpose of the Homeless Health STP Leads Group is to support STP delivery of health services to temporary accommodation sites including clinical workforce, resourcing and allocation, and to co-develop a pan-London model of care.

STP leads have been identified for all five STPs/ICSs and are responding to specifications for each site identifying the required health and care input with local primary care providers, mental health trusts and ADASS colleagues. It is intended that this group will be chaired by one of the STP homeless health leads.

Each STP has been engaged as the regional MHCLG and GLA hotel sites have been identified and ‘stood up’.

STPs are also being approached by London local authorities to provide additional health input to locally sourced accommodation.

London COVID-19 Homeless Health Clinical Leads Group

The primary purpose of the Clinical Leads Group is to provide clinical advice and direction on the development of a pan-London model of care for implementation across temporary accommodation sites.

Annex 3: London Region Sit-Rep

Example: Daily Sitrep: Covid-19 Homeless Response Cell

Date	8 April 2020	Issue #	6
Current position	1. **Site capacity:** There are currently x rooms available in the pan-London sites, of which x (%) are occupied (see Appendix A for full breakdown). 2. **COVID CARE:** x hotel is due to go live on Thursday as the first COVID CARE site. Access to COVID CARE sites will be based on clinical decision by the receiving clinician. Anticipated not more than 20 beds to be filled this weekend. All have been asked to urgently clarify transport arrangements and who is managing this before the weekend. X site is being looked at as a possible second COVID CARE site. 3. **Hospital discharge:** Hospital discharge teams can refer to the COVID CARE site. Access will be health led as per point 2. above. Full process TBC tomorrow. 4. **Hostel survey:** this is going out to hostels today to gather information on the current status of residents in hostels. 5. **Equipment:** A full list of equipment has been ordered for the COVID CARE site. Additional equipment will be ordered for the other sites as well now that a procurement route has been agreed. 6. **Primary Care:** A team is being stood up to coordinate the primary care model for each site. They met at 15:30 today. STP leads have fed some considerations into this discussion. 7. **Clinical staff contracts:** provider X and provider Y have been approached re: taking these staff onto their staff bank. A list of staff is being collated for agreeing contracts with one of these two asap. 8. **New hotels:** the current status is that no new hotels will be stood up due to both a lack of budget and the capacity in the system to support. Agreed that the totality of accommodation will need to be revisited to use capacity fully, while maintaining the ratios agreed for each of the three groups. 9. **Early release for some detainees:** information has come to us that there may be more movement of detainees out of prison imminently. We are seeking further information.		
Key risks & issues	10. Establishing enough COVID CARE capacity is an ongoing priority and risk to effective triage and cohorting of this group to avoid outbreaks as the pandemic progresses, especially with the potential for more detainees to be released early from prison. 11. **Clinical governance and accountability** arrangements need to be established for all sites as well as for remote and out of hours support across sites. 12. **Additional accommodation** needs to be secured to protect this vulnerable population as the pandemic progresses.		
Author			
Acting Incident Director			
Incident Control Centre			
Contact			

Healthy London Partnership

Appendix A – site capacity

Updated: [insert date]	Total Capacity	Occupied	Vacancies	Occupancy Rate:
Hotels:				
Other:				
Totals:				
Of which are hotels				
Change on previous night				