Brief Health Needs Assessment

GLA COVID 'Prevent' Limehouse and City hotels - May 2020

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Introduction

This document summarises what was known about the health needs of clients on site at two Prevent (low medical need) hotels in London: Limehouse (150 beds) and City (200 beds) on two days in early May. It has been compiled by Pathway Nursing Fellow Samantha Dorney-Smith, who provided clinical input into these two hotels from 20th March 2020 – 1st May 2020.

We hope the report contributes to consideration of future health service input needed, to support effective move on and capitalise on the advantage of having this currently homeless population housed temporarily.

Things to note:

- More is known about the health needs of the clients at Limehouse, because Limehouse had a Covid symptomatic floor up until 24th April (12 beds including a couple for much of the time), so two nurses were deployed on site for most of the time until the end of May. There has only been one nurse on site for City, and that was only from week two.
- City hotel has a rather different profile to Limehouse. Many more of the clients at City were not previously known to services, or have previously not engaged. Even those previously on the CHAIN database are mostly rough sleepers who have not previously been in any of the hubs (and thus have never been key worked).
- Although the percentage or prevalence of health problems may seem low in the health needs assessment this is representative of a number of factors including:
  a) the fact that these clients were actually triaged to have been low medical need, **but in addition:**
  b) health screening has so far been focused on immediate needs (rather than underlying potential conditions)
  c) prior low contact from this particular group of clients with health services suggests that many conditions may yet be un-diagnosed
  d) language difficulties in some cases
  e) the prevalence of phone assessments over face to face assessments making assessment challenging
  f) suspicion from some clients about the reasons for asking the questions
  g) at City the high number of assessments still to be completed (48 at the point of writing)

However, there are identified high medical need and higher support need clients at both sites, and there has been closer contact with many of these individuals, enabling greater health profiling. This papers therefore includes 6 case studies which typify some of the clients at the hotel that do have support needs, and demonstrate that whatever the numbers are there are many individual clients who will need a lot of support to move on successfully. These case studies are important to read before progressing on to the discussion. It is also important to note the specific context at these hotels of very high number of EEA nationals and/or clients with NRPF.

Finally, this report then discusses some of the caveats on this data, what the data tells us, and what should be done now.

Limehouse hotel health summary – 5th May 2020

150 potential beds, 144 clients in on the day – note that there is a constant turnover of a few clients a day, so the client base is always changing

Previously on CHAIN (i.e. previously known to London outreach services)

CHAIN	101	70.1%
Newly on CHAIN	40	27.7%
? Not on CHAIN	3	2.2%
Not previously known	43	**29.8%**

Sites referred from: NSNO / Hubs 93, Night shelter 28, Hospital discharge 2, Rough sleeper 5, Heathrow 16

Gender

M	110	76.4%
F	34	23.6%

Average age – 39.3

Immigration status

UK national	36	25%
Likely UK status (ILR or similar)	17	9.7%
Total likely to have UK benefits eligibility	53	**36.8%**
EEA	53	36.8%
Rest of world – not UK / not EEA	21	14.5%
Unknown immigration status	17	9.7%

Born in UK - 31

34 countries represented

Languages

27 languages, 24 individuals **need** an interpreter for all interactions

First language (most common)

English	40
Polish	18
Romanian	12
Amharic, Punjabi, French	5 each

Literacy – several people have literacy issues, with six so far identified as unable to read and write or very poor literacy

Ethnicity

White British	15	10.4%
Black British	14	9.7%
Black	31	21.5%
White Other	45	31.2%
Arabic / Asian	24	16.6%
Unknown	15	10.4%

GP registration on arrival

- No GP – 44 - **30.5%** (although some of those registered have non-local GPs)
- Registered since arrival – 24 – 16.6%
- Other registrations being worked on

Health conditions

It is important to note that:

- 9 people had still not been assessed on the day this report was prepared
- most assessments have not been carried out by a homeless health specialist
- clients may be under reporting substance misuse because a) their hotel contract states they should not use alcohol or drugs on site and they will be evicted if this is found and b) they may be worried about information sharing with the Home Office
- the low levels of identified smoking in this population (compared to other homeless populations and the observed reality) suggests that comprehensive assessment information is missing.

Physical health problem	71	49.3%
Meets homeless medical vulnerability criteria	29	20.1%
Mental health	55	38.2%
Seen by EASL mental health service during stay	37	25.7%
Alcohol issues	23	16.0%
Drug issues	36	25.0%
Smoking	67	46.5%

Drug use break down:

4 on Methadone, 2 Poppy seed, 2 recent heroin users, not currently on a script

All others are Cannabis / Cocaine

Chronic conditions break down:

Epilepsy – 4, Asthma / COPD – 12, Cardiovascular disease – 12, Diabetes – 3

Immune compromise – one with Immune Thrombocytopenic Purpura; one who had aggressive skin cancer removal 2 weeks ago (with more surgery planned), and has enlarged lymph nodes; one with sickle cell; two with anaemia

Needs OT - 9 clients have been identified to benefit from St Mungos Occupational Therapy input

City hotel health summary – 6th May 2020

200 potential beds, 194 clients in on the day – note that there is a constant turnover of a few clients a day, so the client base is always changing.

Previously on CHAIN (i.e. previously known to London outreach services)

On CHAIN	125	64.4%
Newly on Chain	63	32.5%
Not on CHAIN	6	3.1%
Not previously known	66	**35.5%**

Sites referred from: Rough sleeper 100, Night shelter 26, NSNO 6, Heathrow 35, others unknown

Gender

M	168	86%
F	18	9%
Unknown currently	8	4%

Average age – 38.4

Immigration status

UK national	29	14.9%
Likely UK status / recourse	12	6.1%
Total likely to have UK benefits eligibility	41	**21.1%**
EEA	73	37.6%
Rest of the world - Not UK / not EEA	30	15.5%
Likely not UK / not EEA no status	15	7.7%
Unknown	35	18%

N.B. EEA known to have benefits currently - 3

Born in UK – 25

38 countries

Languages

26 languages, 26 **need** an interpreter for most interactions

First language (most common)

English	40
Polish	23
Romanian	15
Arabic	11
Bulgarian	7
Punjabi	6

Ethnicity

White British	15	7.7%
Black British	9	4.6%
Black	41	21.1%
White Other	67	34.5%
Arabic / Asian	21	10.8%
Other	3	1.6%
Unknown	38	19.6%

GP registration on arrival

- No GP – 62 (**31.9%**)
- Unknown whether has GP – 38 (19.5%)
- No GP or unknown (51.5% overall)
- Registered so far – 26 (12.3%)
- Other registrations being worked on

Health conditions

It is important to note that:

- **48** people had not yet been assessed on the day this was undertaken
- overall, these clients seem to have been more disengaged with services, and thus there may be more underlying conditions undiscovered
- many assessments have been by **non-medical volunteers**, or by staff who are not homeless health specialists
- clients may be under reporting substance misuse because a) their contract states they should not use alcohol or drugs on site and they will be evicted if this is found and b) they may be worried about information sharing with the Home Office
- the low levels of identified smoking in this population (compared to other homeless populations and the observed reality) suggest that some assessment information is missing

As such these numbers may be **much lower** that the reality, but it is important to remember that the existing numbers themselves still represent a high number of people with support needs.

Health conditions

Physical health	44	22.5%
Meets homeless medical vulnerability criteria	12	6.2%
Mental health	43	22.1%
Alcohol issues	19	9.7%
Drug issues	21	10.8%
Smoking	59	30.4%

Drug use break down:

15 opiate / crack users, 10 on script

Others are Cannabis / Cocaine / Spice

Chronic conditions break down:

Epilepsy – 1, Asthma / COPD – 2, Cardiovascular – 10, Diabetes – 1

Needs OT - 7 clients have been identified to benefit from St Mungos Occupational Therapy input

Case studies of clients with significant support needs

These case studies are aggregates of case studies of real people. This assures anonymity.

Case study: Sarah, 34

Sarah has very limited English, and no known family. She was sleeping rough in London until being housed in a hotel in March. She was assessed by a mental health team in the hotel who feel she probably has a borderline Learning Disability. She needs occupational therapy, and casework to find her appropriate housing, and ongoing specialist support. She is at high risk of significant harm if she is discharged back to the street. She comes from an area outside London, but does not want to go back.

Case study: Joe, 28

Joe is a failed asylum seeker, and has no recourse to public funds. Joe has a diagnosis of bipolar and is not on medication. Before being housed in a hotel, he was sleeping in a building where he was also working. There are concerns that he is a victim of modern slavery. This is his first contact with services in five years. He also has a newly diagnosed physical health care condition that require ongoing care. He needs further assessment, ongoing care and suitable housing.

Case study: Bill, 52

Bill used to work in the City and has high blood pressure and a history of smoking crack. He has been recently estranged from his family. He was sleeping in a car prior to being in the hotel. He has suffered significant weight loss in the last few months, and is being investigated for this. He is engaging with substance misuse services for the first time.

Case study: Paul, 54

Was living in Heathrow. Paul appears paranoid, and reluctant to engage or talk about why he was living there. Very little is known about him, although he says he used to be a teacher. Has not declared any health problems, and says he has no family. He appears to have issues with short term memory loss, and drinks heavily at times. Says he wants to travel the world, but also says he has no money.

Case Study: Sarah Jane, 34

Came in from rough sleeping. Recently split from male partner, after a long history of domestic violence. Newly on Methadone script, and has stabilised with alcohol use. Has asthma. Would now like to engage with counselling and screening. Not from London orginally.

Case study: Kristov, 21

Came from EEA country seeking work, and to ‘get away from family’. Describes very difficult upbringing. Has already lived in multiple countries. Drinking heavily, and occasional spice. Says does not want to return home, and wants support to find work.

Health work undertaken so far

So far, the health work at both sites has been focused on:

- Supporting the development and maintenance of a safe public health approach at the hotels
- Screening and monitoring of symptomatic clients (during the time in which Limehouse was the symptomatic site this was the key part of the work)
- Health needs triage for all clients
- Identification of acute health issues and referral to other teams / hospital as necessary
- Minor illness / minor injury management
- Wound management (there have been several post-operative wounds and a couple of chronic leg wounds)
- Identification of withdrawal symptoms and referral of clients to addictions services, and support to manage treatments
- Registering clients with GPs
- Ensuring prescriptions are transferred over to local pharmacies

Health work needed going forward

The following health work has not been done at either site, and ideally needs to be done:

- Full physical health screen, particularly for those new to services
- Review all people with physical health / mental health / addictions / other care or support needs with a view to summarising these issues for housing and or to make referrals to social care
- Alcohol issues – FAST screening, risk profile assessment (withdrawals, A&E attendances etc), vitamins, brief intervention advice, referral as needed, LFTs, GGT
- Opiate clients – risk profile assessment, Narcan, check re BBV screening, physical health
- Public health screening review – e.g. checking on vaccines, cervical cytology, other cancer screening etc

Current staffing complement

4 full time nurses are supporting the 2 GLA hotels and 5 Local Authority hotels

The GLA hotels are larger, so it is likely that there will be an average of one nurse for each GLA hotel going forward.

As such, as an example, two (non- specialist) nurses currently have responsibility for:

- 57 outstanding assessments
- 115 people with physical health problems
- 41 people who are medically vulnerable
- 42 clients with alcohol problems
- 57 people with drug issues including 23 opiate or crack users, 14 who are currently scripted

This is before starting to undertake any discharge focused work.

In terms of what might be needed for discharge:

Discharge focused assessment and initial documentation - minimum 30 mins.

350 clients across both Limehouse and City hotels.

175 hours of work (4.6 weeks for one person), **but** that doesn't take into account letter writing, case management etc which will be needed for a small number of these clients – e.g. 50 clients may require another 1 hour each, taking it to 6 weeks work

However, there is the other ongoing background work needed - symptomatic patient management, addictions management, ongoing chronic disease monitoring, minor illness and minor injury work, which is probably another 4 weeks work. And then if you were going to public health focused work that could easily be another 30 mins per patient (or another 4.6 weeks).

6 + 4 + 4.6 = 14.6 weeks (or 7 weeks work per nurse)

This doesn’t allow for any sickness, annual leave or management time.

Discussion

In the GLA hotels alone there are around 1200 people split across 14 hotels, and 3 staging posts. Across all the sites we have:

- 3 Staging Posts - most chaotic individuals
- 1 Covid Care hotels
- 3 Protect hotels (Medically Vulnerable)
- 10 Prevent hotels (Not Medically Vulnerable)

Thinking about the data produced for these two hotels the following is likely across all Prevent sites:

- Around 30% will be previously unknown to homeless services
- Around 60% - 70% will not be eligible
- Around 30% will not have a GP
- It is likely that at least 20% - 25% will have a health condition requiring current input that could be used to support a priority need or Care Act assessment case, or would require health follow up.

In the 14 hotels, the clients have mostly not been formally key worked by the voluntary sector during their stay so far, due to staffing capacity. Staffing has been directed to essential work such as delivering 3 take away meals a day, COVID symptom screening, welfare checks, giving out essentials like phones, clothing, toiletries etc. and keeping the hotels calm and peaceful, and managing behaviour. It is important to know that staffing is very stretched – the same staff that were supporting people in the NSNO hubs, now have the additional workload of all the people that were in the night shelters, Heathrow and many rough sleepers. As such key working is only starting to happen now, mostly via the 'working from home staff' (7 at Limehouse, 3 for City), who are now extending from doing welfare check calls to look at move on plans.

However even with these staff, the key working task is very challenging in terms of timescale and the numbers of people with NRPF or no local connection. The City hotel is currently due to close on June 1st, and Limehouse on July 1st. The managers of both Limehouse and City hotels have spoken about the challenges of finding accommodation for these clients such a short time period allocated with low levels of resource. Both managers say it represents a huge issue, with the City manager describing the situation as 'overwhelming'. The usual allocation of keywork staff is 3 staff to around 20-25 clients in NSNO.

Health work preparing for discharge is similarly challenging. Although initial health triage has been undertaken with large numbers of clients to identify urgent primary care, mental health and addictions issues in these hotels, this health triage process has NOT been targeted at identifying underlying health and social care needs in order to plan for discharge. This needs to take place now, alongside the housing key work. Arguably this is a specialist job (commonly associated with homeless health nurses working in Pathway

teams), and there are not many of these specialists around. This needs to take place alongside outstanding basic assessments, and any ongoing health support work required.

This seems to need the ongoing provision of at least one nurse per site. In fact, percentages don't illustrate very well the underlying needs for case work e.g. it may be that only 25 out of 200 people (12.5%) have a complex case, but those same 25 people may require a huge amount of fast input if they need to be rapidly and satisfactorily discharged. By way of comparison a Pathway team homeless hospital discharge team with an ongoing caseload of 25-30 usually has at least 4 staff – a GP, nurse, OT and housing worker.

It is important to reiterate that many cases the clients in these hotels have never previously been key worked by any statutory agency, and thus there is no pre-existing information or story. Many do not have a current GP, have never been registered with a GP before, or where they have, have not seen the GP for many years. As such any key working from both health and housing perspective is beginning at the beginning in many cases.

This challenge is exacerbated by the fact that significant percentage of these clients are not UK nationals and have language difficulties, and also because many are EEA nationals or others that have no recourse to public funds and thus have few housing options. These clients broadly come into 3 groups:

- EEA nationals who potentially could work, who have low support needs and few health problems. These clients would ideally be supported back into work (e.g. farm work currently). If this could be backed up by temporary housing, support to get an NI number, and light touch primary care support (to enable low level mental health and drug and alcohol support), this could resolve many cases. A formal health assessment would help to identify any barriers to accessing work, and low-level health needs.

- EEA Nationals or others with NRPF who have high health, care and/or support needs, often due to mental health, learning disabilities / cognitive concerns or addictions. These clients need a thorough holistic health assessment and supported referral to Social Care for a Care Act Assessment. A concern with this is the long lengths of time often taken to access an assessment, and the skill level required for the negotiations involved. Another concern is that many of these clients have been living under the radar for a long time, and even now lack visibility because they have been living behind closed doors (with their meals brought to them). Their vulnerabilities could easily still now be ignored.

- Failed asylum seekers, overstayers etc with NRPF with no or low level, health, care and support needs. It is not clear what can be done for this group other than skilled immigration support, and support to access primary care.

Finally, the lack of direction and guidance (understandable in these unprecedented times) is leaves some areas completely unprepared for the potential of an immediate closure.

Key recommendations

- Homeless people are particularly vulnerable to Covid 19 due to high levels of multi-morbidity. They should stay in until the last stages of ending the lock down – at the stage when large gatherings are again permissible, dormitory accommodation acceptable, and crowded drop-in centres opened.
- Ideally there should be an amnesty on 'priority need' rules, which would reduce the workload of moving people on who have eligibility
- Additionally, for the small proportion of those with complex needs who have been evicted or chosen to return to the streets they should not be treated as intentionally homeless
- Immediate 'Exit health strategy' recommendations should be drawn up ASAP to guide health work on the ground at the individual hotels
- All GLA hotels to be asked to summarise their immediately known health needs as per the above, and identify the clients of most concern in terms of move on as soon as possible
- Assessments of future health staffing required going forward should be based on this summary and forwarded to local CCG leads
- Ideally every person currently brought in should have a comprehensive assessment to plan for a permanent onward placement
- All hotels to start to have a weekly case management focused MDT meeting looking at engagement / recovery / move on options for all clients
- All GLA hotels to have a named member of health staff to support move on
- A work scheme to be made available to clients in the hotels (with a particular focus on EEA nationals)
- Immigration advice to be made readily available to all clients at all hotels and advertised from now
- Depending on likelihood of extension at hotels, public health / screening strategy to be drawn up to guide future work at the hotels if the hotels are extended and screening becomes possible
- All newly housed people will need long-term funded support, ranging from light touch floating support, to a full range of bespoke health and housing support service included in the 'Housing First' offer. The need to offer support remotely might actually result in some improved access, as it can be more flexible and saves on travel time.
- Many EEA Nationals will ultimately be entitled under the EU Settlement Scheme to benefits, and could be supported to gain this by immigration legal advice. A temporary right of access to public funds (12-24 months) could be given which would allow the same housing routes to be accessed while long term rights are established.

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