Rough Sleepers in accommodation: The Wisbech Picture (14/05/20)

- This is a golden opportunity to get everyone registered with GP whilst people are less transient.

- Focus on vulnerable people – inc. rough sleepers. What is the NHS guidance? What are the gaps? What is feasible? What can we do going forward?

- 57 rough sleepers are housed in 2 B&Bs (Rose & Crown & White Lion), at the Ferry Project's hostel and in Peterborough hotels and two self-contained FDC properties leased from Clarion as temporary accommodation (18 people)

- 6 people living on the street (they either declined accommodation or have been evicted).

- The B&B owners are managing the accommodation and daily welfare phone calls are being made by CGL with each person with a named support worker (eg. to help with passports, documents, etc) from the homelessness support hub – a three way partnership between FDC, Ferry Project and CGL: https://www.fenland.gov.uk/article/14282/New-HUB-opens-to-help-reduce-homelessness.

- Welfare calls cover whether they are showing any Covid 19 symptoms, daily action plan and access to food – if any health issues are picked up they will call the GP, 111 or the ambulance. B&B staff also actively call the hub if there are any issues.

- There is a fund that can help with incidental things, e.g. glasses, prescriptions.

- They are all receiving food packs.

- All but one person has a phone.

- There is not the ability to have hot and cold sites. People can self-isolate in the B&B accommodation but not at the Ferry hostel. There are shared facilities at all sites – B&B owners are staggering use and cleaning between these staggered times.

- Common issues coming up in accommodation – people feeling bored, isolated, quite anxious. Problems with engagement e.g. man needing healthcare but reluctant to go to GP/hospital – can we get nurse/doctor to him?

- **GP registration:** Nearly all people are registered with a GP (either Clarkson or North Brink) – FDC think this result is because:
  - GP registration is actively picked up during assessments by the Hub
  - Hub outreach workers can register on behalf of people and
  - They don't need an address to register.

- **Primary Care:** There are no dedicated, specialist GPs but people can see any GP at Clarkson or North Brink. Their can be a language barrier, the hub has access to interpreters. Issues regarding delayed call back (see issues below).

- **Medication:** GP surgeries send prescriptions to the pharmacy (even to Peterborough pharmacies) which is working well. They are moving to 4-month prepaid prescriptions. The Ferry Project often collect medication from the pharmacy on behalf of people (do hub workers also do this?). The homelessness support hub project there is a Bespoke Intervention Fund which covers incidentals – this covers prescription costs for those who have no recourse to public funds.

- **Drug & Alcohol Services**: As CGL is part of the hub, referrals into CGL's drug and alcohol services is straightforward. FDC believe they also do Hep C testing.

- **Mental health services:** This is a major issue for rough sleepers. Minimal input, slow progress. In Peterborough mental health crisis team drop in, not in Wisbech. There is serious lack of local mental health services (see issues below). The hub are in the process of recruiting a mental health nurse via CPFT. The Ferry Project is often the ones to 'pick up the pieces', for example when hospitals (mainly Queen Elizabeth at King's Lynn) discharge directly to Ferry project with no contact made. There are challenges with clients who are chaotic in Ferry , the Ambulance Service has said that individuals have capacity so they are unable to assist.

- **Sexual health & HIV:** Not an issue as far as FDC are aware. Could access if needed via GP.

COVID (care/protect etc) specific questions

- Sleeping arrangements? All private rooms, since COVID (prev shared in shelters).

- Any split of people into those who are high risk or not? No.

- Any special/specific accommodation for shielding population (ie cohort 2 who should in theory go to COVID protect facility) – No. All in together. All have own private rooms. All advised to stay in rooms, but communal areas for food, socialising.

- What happens to anyone with COVID symptoms (cohort 1, who "should" as per guidance go to COVID-care facility)? Symptoms – self-isolate in room, contact 111 – liaise with public health protection re' testing.

- Do they have any medical equipment, e.g. thermometers? They recently had a delivery of thermometers - yet to be distributed, will be distributed with food packages.

- Any health checks in any of facilities? Not by medical professionals, but welfare checks include asking about health.

- Any triage into housing/cohorts? No, not really feasible.

4 current gap & challenges:

- GP call backs can take up to 4 hours: During this time the outreach worker stays with their client, which amounts to a lot of wasted staff time. *Can this call back time be shortened at all or is there an easy way to get consent so the outreach worker can talk on behalf of the client?*

- Lack of local mental health services: The hub are very willing to support their clients to access MH services and could host, help overcome language barriers and integrate this into their hub. *Can we be more consistent with services in, for example, Peterborough (CPFT dropping into accommodation) or Cambridge (dedicated dual diagnosis post)? New MH Nurse at Hub will help.*

- There are a couple of people with urgent health issues: One person has had a plastic cast on his leg for 6 months but is scared of health services and ran away from an ambulance. *Is it possible to have a one-off drop-in in a non-health environment e.g. Ferry Project – could this incorporate physical and mental health? Could be co-ordinated through video conferencing and supported by the Hub.*

- Hospital discharge has been challenging: One person was discharged with a broken leg to the Ferry Project where you can't stay all day which mean he was on the streets with a broken leg. The Homelessness Trailblazer Project (another project looking at early homelessness prevention) is looking at pathways – *Is this linked up with Discharge colleagues?*