

Comparing the initial *Everyone In* COVID-19 London response to the resurgence of Dec 2020-Feb 2021

Supplementary Memorandum submitted to the Public Accounts Committee – 19 February 2021

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Executive summary

1. The discontinuation of the *Everyone In* programme was not included in the National Audit Office evaluation, which covered the period March – November 2020
2. *Everyone In* included the principles of the clinical homeless sector plan (triage/test/cohort/care) which was reliant on the provision of self-contained accommodation to provide safe harbour by limiting the spread of infection
3. Failure to provide additional self-contained capacity for Severe Weather Emergency Provision alongside closure of many hotels resulted in increased density of residents within the existing hostels making infection prevention and control and self-isolation extremely challenging
4. This coincided with the emergence of a more transmissible strain (Variant of Concern B117)
5. Compared to Wave 1, when the *Everyone In* programme was operating, the risk of infection in hostels was:
 - a. 4 times higher than in Wave 2. (Relative Risk (RR) = 4.47 p=0.0001).
 - b. 5.6 times higher than in the remaining hotel accommodation. (RR 5.59 p=0.017).
 - c. 2 fold higher than in the general population (RR 2.02 p<0.0001)
6. The impact of this on mortality has yet to be determined

Introduction:

This Supplementary Memorandum presents results from COVID-19 outreach testing targeted at homeless accommodation facilities and rough sleepers across London and quantifies the number of outbreaks in these facilities detected through outreach testing throughout the pandemic. The testing results reflect the overall effectiveness of the multi-agency response and inform the authors conclusions.

Findings

Figure 1: Number of people testing COVID-19 PCR Positive and Negative 1 Apr 2020 – 10 Feb 2021

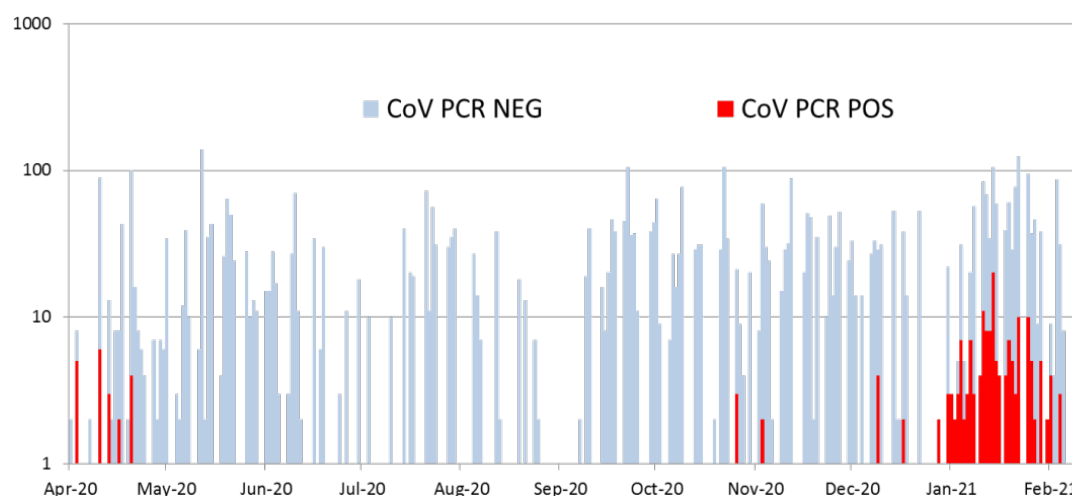
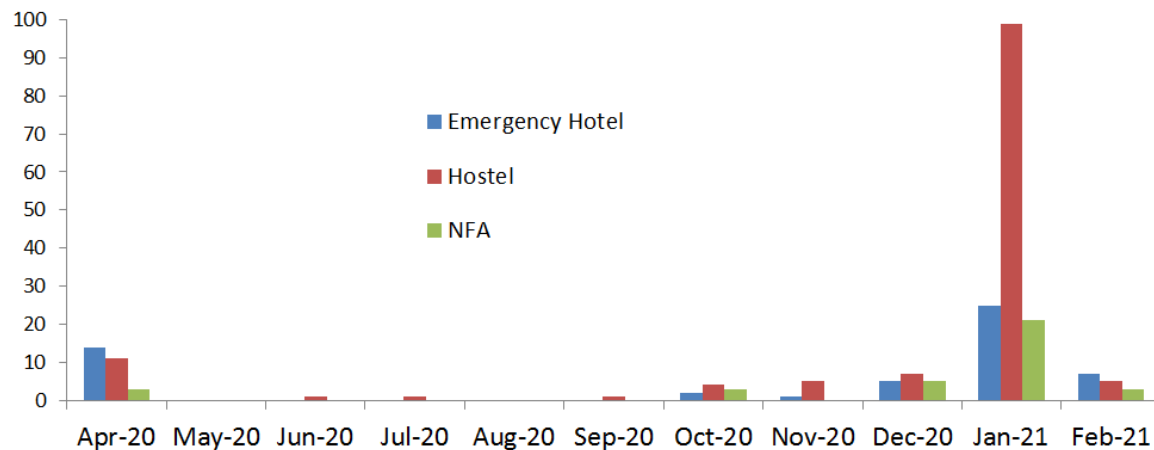


Figure 1 shows 5,823 COVID-19 PCR test outcomes between 1 Apr 2020 and 10 Feb 2021. Testing was provided by UCLH Find&Treat team through a Peer led outreach service targeting people accommodated in Emergency Hotels, Homeless Hostels and Rough Sleepers. Number of COVID-19 PCR positive residents and rough sleepers in each of these settings over time is shown in Figure 2.

Figure 2: COVID-19 PCR +ive cases diagnosed through outreach testing by setting 1 Apr 2020 – 10 Feb 2021



These data broadly divide the pandemic into two Waves (Table 1:) as also reflected in the general population case data. Due to availability of swabs and viral transport media testing commenced on 1 April 2020, one week after the launch of the Governments Everyone In strategy on 26 March 2020. Since that time testing capacity has remained stable, so increases are not due to increased capacity. If anything, the capacity has been stretched in the second wave due to many more symptomatic people. Our data likely severely underestimate the true number of cases as we were unable to routinely capture cases diagnosed through A&E attendance, hospital admission or testing through the national Test and Trace system or community testing centres.

Homeless people reporting symptoms were over four times more likely to be COVID-19 PCR positive following triage and outreach testing in Wave II compared to Wave I (Relative Risk (RR) = 4.47 $p=0.0001$). The proportion of tests that are positive amongst symptomatic people is a sensitive indicator of the prevalence of disease in the population. In wave 2 this peaked at 18% in the general population, and across the three settings (Hostels, Emergency Hotels and Rough Sleepers) the mean proportion testing positive in Wave 2 was 58% across all settings and 72% in rough sleepers, suggesting a markedly increased prevalence in people experiencing homelessness, particularly in rough sleepers compared to the general population.

Early in the pandemic, international data in homeless populations highlighted a high background PCR positivity rate, predominantly among asymptomatic cases found through sentinel testing all residents who would accept PCR testing in homeless facilities regardless of symptoms. Our outreach testing service initiated sentinel testing in April 2020 and continued to monitor the background positivity rate throughout the pandemic.

Table 1: Proportion testing PCR positive by setting in Wave I and Wave II

Wave 1 (Apr-May 2020)	Reason for Test	CoV Tested	PCR POS	%POS
Hostel	Symptomatic	37	4	10.80%
	Sentinel	366	6	1.60%
	Outbreak	50	1	2.00%
Emergency Hotel	Symptomatic	46	4	8.70%
	Sentinel	363	7	1.90%
	Outbreak	40	3	7.50%
Rough Sleeping	Symptomatic	10	3	30.00%

Wave 2 (Dec 2020-Feb 2021)	Reason for Test	CoV Tested	PCR POS	%POS
Hostel	Symptomatic	93	51	54.80%
	Sentinel	682	33	4.80%
	Outbreak	473	32	6.80%
Emergency Hotel	Symptomatic	52	25	48.10%
	Sentinel	231	2	0.90%
	Outbreak	147	9	6.10%
Rough Sleeping	Symptomatic	39	28	71.80%

During Wave I in London, the background positivity rate in Hostels and Emergency Hotels was 1.6% and 1.9% respectively (RR 0.85 $p=0.77$). During Wave II, 683 residents were sentinel tested in 27 separate Homeless Hostels, and 231 residents were sentinel tested in 8 Emergency Hotels between 1 December 2020 and 4 February 2021. The residents in Hostels had 5.6 times the risk of testing COVID-19 PCR positive when compared to residents tested in Emergency Hotels (RR 5.59 $p=0.017$). The mean positivity rate on sentinel testing during this period was 4.8% among Hostel residents and 0.9% among residents in Emergency Hotels.

During this same period, the mean percentage of people testing positive in London, according to the ONS Coronavirus (COVID-19) Infection Survey, was 2.37% (peak 3.76%). Compared to this London-wide figure the rates through sentinel testing in hostels is 2.02 fold higher ($p<0.0001$) whilst the proportion testing positive in emergency hotels is not significantly different from the general London population ($p=0.15$)

Interpretation

Multiple factors potentially contributed to the large increase in cases detected in Wave 2 in comparison to Wave 1.

1) Rapid emergence of variant B117 as the dominant strain: With an estimated >50% increase in transmissibility; new variant B117 rapidly displaced other circulating strains in London from November 2020. This will have contributed to the increase in the proportion of cases testing positive but does not explain the variation in positivity observed in different accommodation settings as B117 was likely to be emerging as the

dominate strain across all settings, or the much higher rates of infection observed in the homeless compared to the general population in Wave 2.

2) Increased density of occupancy and mixing of cohorts: The Government's initial *Everyone In* policy made an unconditional offer of self-contained emergency accommodation to all rough sleepers and people at risk of rough sleeping. The National Audit Office (NAO) [Investigation into the housing of rough sleepers during the COVID-19 pandemic](#) found that the public health driven *Everyone In* approach had been highly effective reducing the risk to this vulnerable population, and at preventing wider transmission. The NAO report primarily covered the period between March and November 2020, prior to the resurgence of COVID-19 in December 2020, but noted that the response to the resurgence did not appear as comprehensive as the initial *Everyone In* approach.

From our experience, which is clearly reflected in the outreach COVID-19 testing data, the effectiveness of our efforts to implement the [Clinical homeless sector plan](#) during the resurgence, Wave II, was markedly different to our experience in Wave I. The markedly increased transmission in hostel but not in emergency hotel accommodation in Wave 2 compared to Wave one is evidence of the protective effect of self-contained accommodation even in the face of a more transmissible variant. The failure to provide this to a meaningful level in Wave 2 has had a substantial impact on the number of cases and outbreaks. s (Figure 3:), We feel is largely attributable to the discontinuation of the *Everyone In* approach which was replaced with the more restrictive and conditional *Protect* programme.

Figure 3: COVID-19 outbreaks* detected through outreach testing by setting 1 Apr 2020 – 10 Feb 2021



* Outbreak defined as per PHE definition of two or more test-confirmed cases of COVID-19 or clinically suspected cases of COVID-19 among individuals associated with a specific setting with illness onset dates within 14 days. All these outbreaks involved >2 cases.

In Wave I, the density of occupancy in the Hostels was reduced in many facilities to maximise the number of residents who had their own room and minimise sharing of communal facilities. This was achieved by moving elderly and vulnerable residents into self-contained Hotel accommodation where they could self-isolate effectively. Throughout the summer and autumn months, the majority of this additional capacity was closed and residents decanted back into the Hostel system. In addition, many of the Local Authority and GLA funded Emergency Hotels also closed and a substantial proportion of the residents remaining in these facilities were also decanted back into the Hostels.

Density of occupancy in the Hostels was further exacerbated in December 2020 through to January 2021 when the Severe Weather Emergency Provision (SWEP) protocol was activated. Due to the high risk of COVID-19 transmission in communal airspace Cold Weather shelters, MHCLG had already issued guidance that communal shelters should be a 'last resort'. In the absence of additional self-contained accommodation, the majority of bed capacity needed for the SWEP was found within the existing Hostel system. This further increased the density of occupation making social distancing and implementation of essential Infection, Prevention and Control (IPC) measures extremely difficult.

Equally importantly, this approach mixed together cohorts from multiple settings, Hotels, Hostels with the Street population, and in doing so, amplified transmission risk resulting in outbreaks. This mixing of cohorts also facilitated transmission between younger mobile homeless people and older more clinically vulnerable people who had, thus far, remained safely sequestered in their own rooms. Between 1 December 2020 and 10 February 2021, many of the 172 COVID-19 cases diagnosed across 54 different facilities were among people who had remained in situ while the risk of exposure in their accommodation increased due to density of occupancy and influx of new cohorts from higher risk settings, including the street population, 72% of who were COVID-19 PCR positive following symptomatic testing at this time (Table 1:).

Risk of mixing cohorts was clearly illustrated by the experience in a North London Hostel that remained COVID-19 free throughout the pandemic until January 2021. This Hostel population was reduced in Wave I to minimise sharing of bathrooms and communal facilities. In November the occupancy increased significantly following the closure of local Emergency Hotel accommodation. In late December 2020, any remaining space in the Hostel was used to accommodate rough sleepers following activation of SWEP. Then followed an outbreak with multiple hospitalisations; 1:4 residents tested positive, including a gentleman in his 90's.

3) Continued flow of rough sleepers onto the streets over the summer and autumn: Everyone In exposed a significant discrepancy between the estimated and actual number of people sleeping rough nationally and in London especially. The street population continued to increase over the summer and autumn, although accurate estimates of the scale of this increase remain difficult to obtain. The street population comprised people who had either left, been evicted or excluded from Emergency Hotel or Hostel accommodation and a substantial number of people who were new to the streets due to loss of jobs, housing tenure, relationship breakdown, domestic abuse, prison release and a myriad of other reasons linked to increasing social and economic insecurity.

In contrast to studies elsewhere, which have demonstrated a lower rate of COVID-19 infection among rough sleepers compared to homeless people accommodated in communal Hostels, in London the proportion of rough sleepers testing positive during Wave II strongly suggests very widespread infection and high rates of transmission. Our Clinical homeless sector plan recognised that mitigating the risk from COVID-19 among rough sleepers would present immense challenges, and recommended that all rough sleepers and people at risk of rough sleeping be provide with self-contained accommodation until social distancing and other restrictive measures were no longer in place.

Our experience, supported by data from the outreach testing, indicate that the increasing street population in London throughout the latter half of 2020 were at significantly higher risk of infection compared to accommodated homeless people and the general population. This population represented a serious reservoir of infection driving onward transmission in a context where public health measures were almost impossible to implement, especially within the context of a more transmissible strain (variant B117). The

epidemiological impact of mixing the street population with Hostel residents following the activation of SWEP in December 2020 is clearly apparent in our data.

4) Reduced application and effectiveness of IPC measures: This is not systematically quantified, but is based primarily on observations by the outreach team who have visited the vast majority of homeless facilities across London throughout the pandemic. As noted by the NAO report, the number of people in need of accommodation assistance during the pandemic was far higher than initially estimated by MHCLG. This discrepancy between the actual and estimated number of people sleeping rough or at risk of rough sleeping underlies why the frontline health and social care workforce available to support this population was and is not commensurate with need. As the pandemic progressed, its toll on the frontline workforce, driven by high rates of infection and ‘burnout’, became increasingly apparent. Third sector providers contracted to staff the accommodation facilities became increasingly reliant on inexperienced and temporary agency workers. This resulted in a decline in the effectiveness of IPC measures, especially mask wearing, symptom checks and encouraging residents to socially distance and remain in facilities. Increased density of occupancy, combined with mixing of cohorts and a far more transmissible strain further compounded the problem.

Conclusions:

1. The January 2021 NAO report noted that the government’s response to rough sleeping during the resurgence did not appear as comprehensive as the initial *Everyone In* approach. Our data and experience of delivering testing in homelessness settings during both waves suggests that this is the case, specifically that the current approach has contributed to an increase in the density of occupancy in the Hostels, where mixing of cohorts from different risk settings, especially large numbers of rough sleepers, resulted in widespread transmission, multiple outbreaks, hospitalisations and an as yet unquantified mortality.
2. The experience of an unconditional offer of self-contained accommodation, food and support from highly experienced health and social care professionals was transformative for tens of thousands of people. In addition to the resulting widespread transmission, we consider that the lack of a clearly communicated and longer-term commitment to the *Everyone In* programme led to many missed opportunities to address the multiple and complex needs of rough sleepers. This missed opportunity comes at a significant future cost to both these individuals and our wider society and should be factored into the NAOs forthcoming value-for-money report due for publication later in 2021.
3. The absence of, and inaccuracy of available data on the size and characteristics of the population rough sleeping or at risk of rough sleeping, and size and characteristics of the accommodation and support on offer to this population, hampered efforts to plan and mobilise resources that were commensurate with needs. COVID-19 is now an endemic pathogen and, even with high levels of vaccine uptake, ongoing transmission and outbreaks are inevitable making the need for robust data systems and information sharing a public health imperative.

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AS and AH co-authored the [Clinical homeless sector plan](#) in March 2020. This plan set out the clinical advice and guidance on delivering a health-led, multi-agency approach to reducing the risk of infection and severe illness among the homeless population as a result of COVID-19. AS is the founder and Clinical Lead for the Find&Treat outreach team who were re-purposed to implement the COVID-19 homeless sector plan across London including triaging symptomatic rough sleepers; outreach COVID-19 PCR testing; clinical assessment and cohorting clinically vulnerable rough sleepers; and staffing a COVID-CARE isolation unit for infectious rough sleepers.