Coronavirus (COVID-19)

# Clinical homeless sector plan: triage – assess – cohort – care

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# Contents


Summary ..... 2

Aims ..... 2

Homeless people at increased risk of severe illness from COVID-19 ..... 3

Reference to other guidance ..... 3

1. Rationale and key components ..... 5

Key components of the strategy ..... 6

2. Plan ..... 9

Establish homeless COVID-COMMAND ..... 9

Establish COVID-CARE facilities ..... 10

COVID-CARE facilities ..... 10

Referral routes to COVID-CARE ..... 10

Isolation of suspected COVID-19 cases ..... 11

Minimising transmission risk to staff and other patients ..... 11

Staff deployment to COVID-CARE ..... 12

Monitoring, supportive care and clinical escalation ..... 13

Discharge from COVID-CARE ..... 15

Guide for equipment checklist ..... 16

Establish COVID-PROTECT facilities ..... 17

Aims of COVID-PROTECT facilities ..... 17

Referral routes to COVID-PROTECT ..... 17

Minimising transmission risk to staff and other patients ..... 18

Staff deployment for COVID-PROTECT: ..... 19

Discharge from COVID-PROTECT ..... 20

Implementing the COVID-19 triage and assess protocol ..... 20

Settings where the protocol can be implemented ..... 21

Practical steps to implementing the protocol including minimising transmission risk to staff and service users ..... 21

Triage assess questionnaire ..... 22

Transfer arrangements ..... 24

Establish COVID-19 triage and assess teams to operate in the community throughout the pandemic ..... 24

# Summary

This document sets out 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 coronavirus (COVID-19). The guidance is primarily for health professionals but can be used by anyone involved in delivering its aims and activities.

We recognise that there are different definitions of homelessness. Where the term 'homeless' is used in this document, it is intended to capture rough sleepers and people with a history of rough sleeping in temporary, communal accommodation. It is not intended to capture the broader definition of homelessness that encompasses families living in temporary accommodation provided by the local authority.

This guidance is the standard that areas should work to achieve but will need to be implemented based on an assessment of the priorities within, and the needs of, the local cohort. Therefore, local areas may need to adapt it to local circumstances and to respond to the additional needs of this population group and capacity to implement it safely.

## Aims

This guidance sets out a triage–assess–cohort–care approach that aims to:

1. Protect homeless people at increased risk of severe illness from COVID-19 (see next section).
2. Reduce transmission risk for residents and staff.
3. Prevent outbreaks in residential services and congregate settings.
4. Minimise impact on NHS and other essential services – prevent inappropriate A&E and secondary care attendance, and reduce the need for hospital admission by effective supportive care in the community.
5. Prevent mortality.

Delivering the stated aims will require:

- Implementation of a triage process based on symptoms and clinical risk factors that can be conducted by non-NHS frontline homeless sector workers supported (remotely if necessary) by NHS staff.

- Use of the triage process to:
  - identify symptomatic individuals (cohort 1), who should then be placed in sites suitable to their needs (termed ‘COVID-CARE’ sites)
  - identify asymptomatic individuals at increased risk of severe illness from COVID-19 (cohort 2), who should then be placed in sites suitable to their needs (termed ‘COVID-PROTECT’ sites)
  - identify asymptomatic individuals with no increased vulnerability (cohort 3), who should continue to use current service provisions or, where possible, be placed in accommodation that enables them to meet the current guidance on social distancing.
- Accommodation with self-contained rooms that include, where possible, an en-suite and catering facilities (or an alternative suitable provision).
- Suitable transport to accommodation for people in cohorts 1 and 2 that prevents cross-contamination.

Further information is set out in the key components section of this guidance.

## Homeless people at increased risk of severe illness from COVID-19

Some people within the homeless population will be at increased risk of severe illness from COVID-19. They include those who:

- Meet the existing definition of ‘extremely vulnerable’.
- Are at increased risk as a result of underlying health conditions, as set out in existing guidelines (eg any adult instructed to get a flu jab each year on medical grounds)
- Are aged over 55. For the general population, those over 70 are considered to be at increased risk. However, given that the average age of death for rough sleepers is 45 for men and 43 for women, we recommend the age limit is reduced to 55 for the purpose of operationalising this guidance.

## 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 and follow the latest guidance on COVID-19 (coronavirus) via the NHS (www.nhs.uk/conditions/coronavirus-covid-19/) and government websites (www.gov.uk/coronavirus).

Protocols on supporting residents with substance misuse needs will be needed for accommodation. Further guidance will follow.

# 1. Rationale and key components

In March 2020 the government announced that all those who are at increased risk of severe illness from COVID-19 should be particularly stringent in following social distancing measures [those who are 70 or older (regardless of medical conditions); those under 70 with an underlying health condition who meet the clinical criteria for influenza vaccination; and those who are pregnant][1].

Further guidance is required to help those working with the homeless population on the basis that:

- 60% of homeless people are at increased risk of severe illness from COVID-19 – primarily due to high levels of chronic illness.
- People who are street homeless, living in hostels (with shared dining, bathroom and toileting facilities and sometimes with shared rooms) and emergency accommodation will not always be able to follow government advice.
- There is strong evidence of premature aging in the homeless population with the average age of death being 45 for men and 43 for women. Homeless people over the age of 55 will have an underlying co-morbidity, although this may not be diagnosed due to lack of access to services.
- Many homeless people who develop symptoms of COVID-19 cannot currently follow government advice to self-isolate.
- In communal settings there will be a very high likelihood of outbreaks with high attack rates.
- High levels of co-morbidity will result in high case fatality rates for those infected.

[1] https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults

## Key components of the strategy

1. Local authorities should continue to work with their local resilience forums to provide a multi-agency response, and to set up a centralised co-ordination function for the efficient deployment of resources – this may be at a sub-regional or regional area level depending on what is locally appropriate. These structures are referred to as **HOMELESS COVID-COMMAND.**

2. This strategy should prioritise resources for cohorting the population according to those who are symptomatic and those who are at increased risk of severe illness.

3. Local areas will need to identify accommodation that could be used as **COVID-CARE** and **COVID-PROTECT** sites. COVID-CARE sites will need to provide individuals with their own room and bathroom facilities – eg local hotels or high specification hostels. COVID-PROTECT sites should provide individuals with their own room and bathroom facilities wherever possible. Where this is not possible, the sharing of bathrooms should be minimised to reduce the risk of disease transmission and outbreaks. Local providers should make best use of hostel provision in the local area; this should be considered to prioritise single rooms and restrict the sharing of bathroom facilities.[2] Particular attention should be paid to frequent and regular cleaning of shared facilities.[3]

4. Once COVID-CARE and COVID-PROTECT sites are established, it is necessary to **triage** the homeless population into three **cohorts**.

   - **The symptomatic group** (cohort 1) which includes anyone (ie regardless of risk group) with a new or worsening persistent dry cough and/or a fever/temperature over 37.8°C.[4] This group should be placed in **COVID-CARE** sites.

[2] https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19
[3] https://www.gov.uk/government/publications/covid-19-decontamination-in-non-healthcare-settings/covid-19-decontamination-in-non-healthcare-settings
[4] This includes those with a self-reported fever where thermometers are not available **or** when assessing people by telephone.

- **The asymptomatic group at increased risk of severe illness** from COVID-19 (as defined in this document) (cohort 2). This group should be placed in **COVID-PROTECT** sites.
- **The asymptomatic and low risk group** (cohort 3) which covers those not included in either of the cohorts above. This group should continue to use current service provisions or be placed in accommodation to meet current guidance on social distancing.[5]

5. COVID-CARE and COVID-PROTECT facilities **ideally need to be in separate buildings with separate staff**. Where this is not possible, there must be clear separation so that there is no risk of COVID-PROTECT residents being exposed to COVID-CARE patients. COVID-CARE staff should ideally not enter COVID-PROTECT facilities.
6. To support the aims of this guidance, processes should be put in place that enable:
   - The transfer of all suspected COVID-19 cases to COVID-CARE or local acute NHS services if severely unwell.
   - The provision of supportive medical care for all persons experiencing COVID-19 symptoms and/or other acute clinical needs.
   - Rapid identification of clinical deterioration and escalation to NHS intensive respiratory/life support.
   - The continuation of community-targeted triage and assessment throughout the epidemic.

**Additional notes**

Local areas will have a clear understanding of the levels of health need in the local homeless and rough-sleeping population, including substance dependence and related health issues that may increase their vulnerability. This should be used during the triage and assessment process.

Existing risk management protocols for accommodation for specific client groups (eg 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.

[5] https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance

**This guidance can be implemented by local staff** (eg outreach workers, hostel staff) with clinical oversight from local health teams. Instruction and supervision from clinical staff may be in person or remotely (ie over the phone).

# 2. Plan

## Establish homeless COVID-COMMAND

This will need to be agreed locally as arrangements vary. It will require senior homeless sector leaders from the local authority and voluntary sector, with identified leads from relevant NHS providers, including primary care and mental health along with local authority and/or voluntary sector substance use services. COVID-COMMAND will need admin and logistics capacity to act as a co-ordination and information centre. This is likely to be a multi-agency command centre drawing on expertise and resources from all partners.

COVID-COMMAND will need to provide:

1. Clinical and facilities management and logistics for all COVID-CARE and COVID-PROTECT facilities.
2. Prioritisation of venues for **triage and assess teams** to visit – based on initial prioritisation of venues that cannot facilitate social distancing and of those homeless people at increased risk of severe illness from COVID-19.[6]
3. Information and awareness advice for the sector – web-based/telephone.
4. Information resources and materials – hand washing/respiratory hygiene/social distancing and infection control.[7]
5. Management of logistics/distribution and stock management of PPE,[8] hand and respiratory hygiene materials and medical equipment across the sector.
6. Phone and web hotline capable of taking direct requests from across the sector and organising referrals/transfer to COVID-CARE and COVID-PROTECT facilities throughout the epidemic.
7. Management of transport logistics for referrals/transfer to COVID-CARE and COVID-PROTECT facilities throughout the pandemic.

[6] https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19
[7] https://www.gov.uk/government/collections/coronavirus-covid-19-list-of-guidance
[8] https://www.england.nhs.uk/coronavirus/publication/guidance-supply-use-of-ppe/

8. Central registry of location, status and priority alerts for all persons prioritised according to current guidance for testing (NHS-PHE agreement) – using an electronic medical record system with proven interoperable capability across the NHS. Patients should be registered with a GP practice[9], if they are not already registered then practices should register them as a temporary patient, in which case the primary healthcare record should be used.
9. Central registry of staff (including experts by experience/peers and volunteers) to maximise efficiencies in deployment, provide direct advice, support and training and recruitment as needed.

# Establish COVID-CARE facilities

## COVID-CARE facilities

**COVID-CARE** facilities aim to prevent mortality through early identification of clinical deterioration, and provide supportive care and rapid escalation to critical care NHS facilities if needed. COVID-CARE will isolate those with possible symptoms of coronavirus (COVID-19), minimise transmission risk to staff and other patients, and monitor and manage clinical progress.

Hostels, unused hotels, student accommodation or NHS/private sector clinically appropriate specification (accessibility, ventilation, lift access, corridor width, etc) facilities can be used. Residents of these facilities **must** have their own rooms with en-suite bathrooms.

## Referral routes to COVID-CARE

These facilities will take referrals of **Cohort 1** – suspected cases (with new or worsening[10] continuous cough and/or fever of 37.8°C or higher **or** self-reported fever). Referrals will come from:

- homeless sector professionals working in any relevant setting
- mobile assessment teams supporting triage in the community throughout the epidemic

[9] https://www.england.nhs.uk/coronavirus/publication/preparedness-letters-for-general-practice/
[10] Over half of people who are homeless will have a pre-existing cough.

- acute NHS hospitals – symptomatic inpatients with or without a confirmed RT PCR diagnosis who can be appropriately discharged[11] **and** symptomatic patients attending A&E services who do not need hospital admission
- primary care services – patients who can be assessed and appropriately diverted from A&E services
- ambulance service – patients who can be assessed and appropriately diverted from A&E services.

Referrals should consider how long the individual has been symptomatic. It is unlikely that patients will continue to be infectious after seven days of the onset of their symptoms. Patients with COVID-19 symptoms will be accepted into COVID-CARE within the first seven days of the onset of their symptoms, or later if they are clinically unwell with symptoms of COVID-19 but do not require admission to hospital.

## Isolation of suspected COVID-19 cases

**All suspected cases should be isolated** in COVID-CARE facilities in a single room with their own bathroom for 14 days[12] unless they require high intensity/ critical care in a hospital. This is because people will be discharged from COVID-CARE to COVID-PROTECT or another institutional environment accommodating people at increased risk of severe illness.

Where COVID-CARE capacity is limited, an individual who is clear of symptoms after seven days may be moved from COVID-CARE to COVID-PROTECT. See section on discharge for further information.

## Minimising transmission risk to staff and other patients

The primary approach to infection control in COVID-CARE is the isolation of patients in their own self-contained rooms.

Staff should follow DHSC guidance on infection prevention and control in healthcare settings: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control. This includes information on all aspects of COVID-19 infection control in healthcare settings. The most up-to-date guidance should be followed which may supersede this guidance.

[11] https://www.england.nhs.uk/coronavirus/publication/covid-19-hospital-discharge-service-requirements/
[12] https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance

## Transfers within the COVID-CARE facility

The movement and transport of patients within the accommodation should be limited to essential purposes only. Staff at the receiving destination must be informed that the patient is suspected to have COVID-19.

- If transport/movement is necessary, consider offering the patient a fluid-resistant (Type IIR) surgical mask (FRSM) to wear during transportation, to minimise the dispersal of respiratory droplets when it can be tolerated.
- Patients must be taken straight to and returned from clinical departments and must not wait in communal areas. **Patients with alcohol, drug or nicotine addiction should be able to access a variety of approaches to prevent withdrawal, with input from specialist addiction services to minimise their need to leave isolation.**

## Staff deployment to COVID-CARE

It is recognised that COVID-CARE facilities are being rapidly deployed on an emergency basis and that they will support 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 provide 24-hour medical care – GP onsite and/or providing telephone advice/remote support, with nursing and healthcare assistant support.

Current implemented models (eg in Westminster) use 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.

This team is supported by specialist clinicians providing advice as necessary on addictions, mental health, acute medicine, infectious disease, palliative care and close liaison with local A&E services.

COVID-CARE should be supported by a local intensivist/respiratory/infectious disease clinician, ideally with experience of managing severe cases of COVID-19.

The unit should follow NICE guidance for referral into critical care: COVID-19 rapid guideline: critical care

NHS staff should work alongside experienced workers, experts by experience/peers and ancillary workers who are redeployed from existing local homeless organisations and allied support services. Following the triage process set out in this document will significantly reduce demand for existing provision in the community.

## Monitoring, supportive care and clinical escalation

On arrival at COVID-CARE all residents should have their temperature, blood pressure, oxygen saturation, pulse and respiratory rate recorded to guide initial care. This can be carried out by a non-clinician with appropriate clinical oversight.

The initial assessment should use the critical frailty score to inform future decisions about escalation to critical care, in line with NICE guidance. The critical care algorithm highlights that those who are frail are unlikely to benefit from intensive care support and their level of frailty should inform discussions with families and secondary care staff. https://www.nice.org.uk/guidance/ng159/resources/critical-care-admission-algorithm-pdf-8708948893

**Clinical Frailty Scale**

**1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

**2 Well** – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

**3 Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

**4 Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

**5 Mildly Frail** – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

**6 Moderately Frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

**7 Severely Frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

**8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

**9 Terminally Ill** – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

**Scoring frailty in people with dementia**

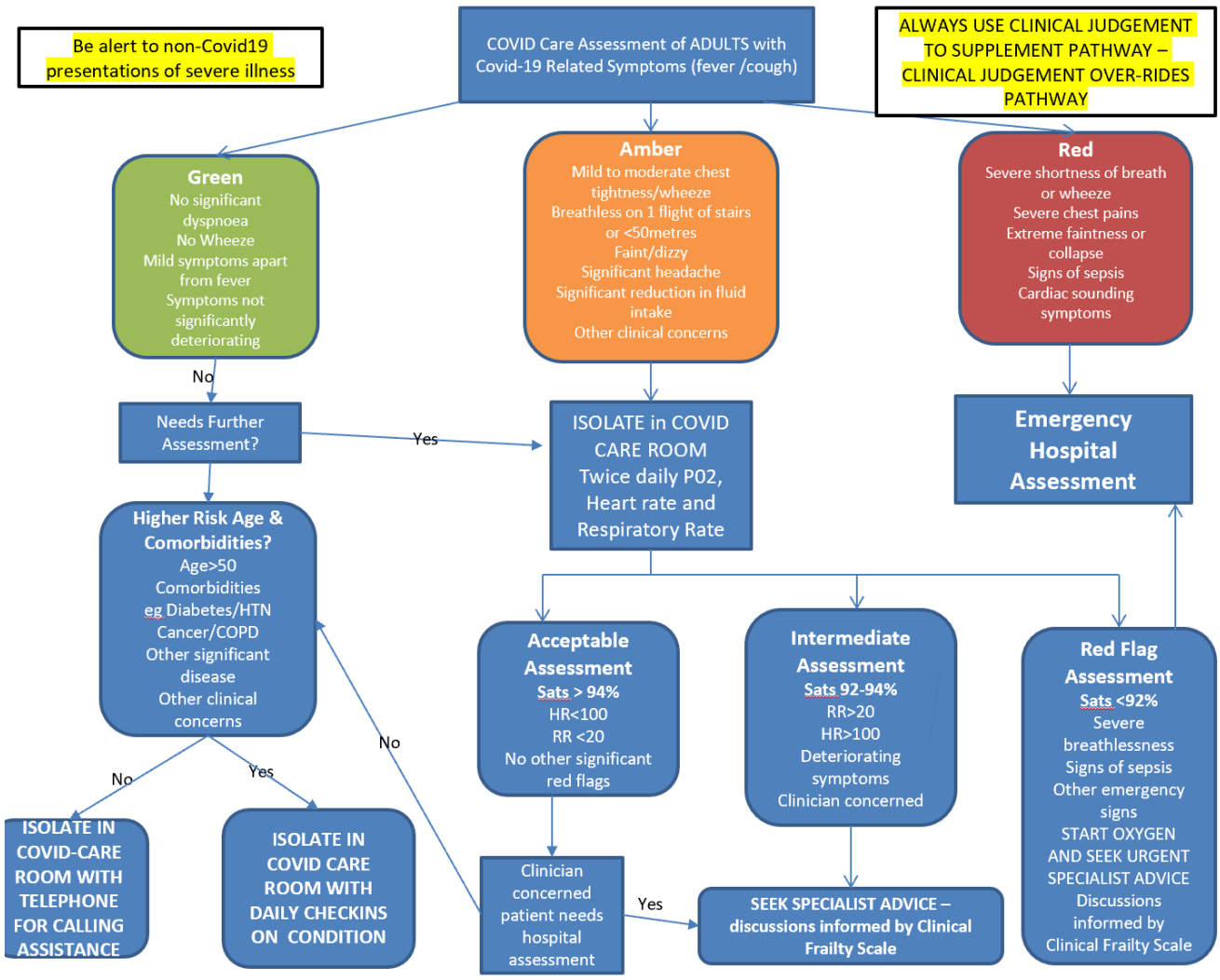
The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

**Clinical monitoring should follow the schema below, which has been adapted from primary care protocols, for management of suspected COVID-19 patients who are self-isolating.** To reduce unnecessary contact between staff and residents, each room should have pulse oximeters and thermometers that can readily be used by the patient and read from a distance. COVID-CARE should also consider using wearable wrist bands/watches that can continuously monitor $pO_2$, pulse and temperature. Consideration should be given to providing patients with a smartphone if they do not have one, to enable staff to use videoconferencing to clinically assess them without physical exposure. Where appropriate, an alternative

could be use of a shared tablet that is wiped down between each use. Where patients already have a smartphone, free access to Wi-Fi should be provided to enable videoconferencing.




## Discharge from COVID-CARE

Discharge planning, including liaison with local authority housing departments, should start from admission to COVID-CARE.

Patients who have been isolating for 14 days, who are recovering with mild and resolving symptoms and who are not considered at increased risk of severe illness can be considered fit for discharge to either:

- residential hostel accommodation
- local authority support to secure tenancy.

Patients recovering with mild and resolving symptoms who are considered to be at increased risk of severe illness should be offered discharge to COVID-PROTECT.

| Discharge from COVID-CARE | Age | Defined as at increased risk of severe illness | Discharge to: |
|---|---|---|---|
| Recovering with mild and resolving problems | <55 | No | Residential hostel accommodation*<br>Local authority support to secure tenancy* |
| | | Yes | COVID-PROTECT |
| | ≥55 | No | Residential hostel accommodation*<br>Local authority support to secure tenancy* |
| | | Yes | COVID-PROTECT |

*Provided they are able to self-isolate in the community as per current PHE guidance.[13] If no suitable accommodation is identified, they should be moved to the temporary accommodation being provided in response to the pandemic or to COVID-PROTECT.

## Guide for equipment checklist

This list includes essential equipment required for COVID-CARE.

- desktop PC with electronic medical record system.
- telephone, video call facility and internet access.
- peripheral devices for data entry.
- PPE supplies.[14]
- cleaning equipment and consumables.
- handwashing consumables.
- waste disposal equipment and consumables.
- essential drugs – including paracetamol, analgesics, antibiotics.
- facilities for oxygen administration

[13] https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection
[14] https://www.england.nhs.uk/coronavirus/publication/guidance-supply-use-of-ppe/

- pulse oximeters
- thermometers
- sphygmomanometer with disposable cuff covers
- crash trolley
- NEWS charts
- patient sampling kits.

Local consideration needs to be given to additional equipment that may be required.

## Establish COVID-PROTECT facilities

### Aims of COVID-PROTECT facilities

1. **Maximise the ability to protect those at increased risk of severe COVID-19 morbidity and mortality.**
2. **Prevent outbreaks in unsuitable congregate settings with shared facilities.**
3. **Reduce pressure on NHS acute care services.**

Hostels, unused hotels, student accommodation or NHS/private sector clinically appropriate specification facilities can be used. COVID-PROTECT sites should provide individuals with their own room and bathroom facilities wherever possible. Where this is not possible, the sharing of bathrooms should be minimised to reduce the risk of disease transmission and outbreaks. Local providers should make best use of hostel provision in the local area; this should be considered to prioritise single rooms and restrict the sharing of bathroom facilities.[15] Particular attention should be paid to frequent and regular cleaning of shared facilities.[16]

## Referral routes to COVID-PROTECT

These facilities will take referrals of **cohort 2 cases** – those homeless people who are at increased risk of severe illness from COVID-19 but **not** suspected of COVID-19.

[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878099/Admission_and_Care_of_Residents_during_COVID-19_Incident_in_a_Care_Home.pdf
[16] https://www.gov.uk/government/publications/covid-19-decontamination-in-non-healthcare-settings/covid-19-decontamination-in-non-healthcare-settings

Referrals will come from:

- homeless sector professionals
- patients discharged from COVID-CARE who meet the previously specified criteria for discharge (see Discharge from COVID-CARE)
- mobile and outreach teams supporting triage in the community throughout the epidemic
- acute NHS hospitals – inpatients at increased risk and those attending A&E services who do not need hospital admission **and** are not suspected of COVID-19
- primary care services – patients not suspected of COVID-19 identified as being at increased risk of severe illness
- ambulance service – patients not suspected of COVID-19 identified as being at increased risk of severe illness.

## Minimising transmission risk to staff and other patients

### Outbreak prevention

COVID-PROTECT facilities are low-risk environments for homeless people without new symptoms of COVID-19. The infection control emphasis is on protecting those at increased risk of severe illness, severe morbidity and mortality.

Although single-room, own-bathroom accommodation where possible should reduce the risk of outbreaks compared to remaining resident in a hostel with shared facilities, a risk of outbreaks remains. It is critical within COVID-PROTECT to maintain separation between those at increased risk of severe illness while in 14-day quarantine. A range of measures will be needed to minimise this risk:

- On arrival at COVID-PROTECT all residents should have their temperature taken. If they have a self-reported fever or temperature of >37.8$^{o}$C and/or a new or worsening persistent cough, they will be transferred to COVID-CARE.
- To prevent residents who are in the incubation period of COVID-19 from spreading infection, COVID-PROTECT facilities must quarantine residents in their own rooms for the first 14 days[17] or, if testing is indicated, until a

[17] https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults

negative swab result taken after seven days of admission (whichever is sooner).

- At the end of the quarantine period residents will be offered free movement and socialisation, provided they remain within the facility.
- COVID-PROTECT facilities **must** maintain vigilant observation for COVID-19 symptoms and **prompt transfer to COVID-CARE (assessment)** for all symptomatic cases.
- To prevent outbreaks of COVID-19, residents will need to participate in daily active surveillance of symptoms and temperature throughout their stay.
- Residents who refuse to remain in the facility will be denied access to the social areas and either accommodated in a separated area with access to an exit or asked to leave the facility.
- COVID-PROTECT facilities must be closed to unauthorised visitors.
- COVID-PROTECT facilities must support continued hand and respiratory hygiene measures as set out in PHE guidance for healthcare settings.[18]
- Each resident should have their own room with en-suite bathroom facilities, where possible.
- Communal socialisation/dining/entertainment areas for asymptomatic residents post 14 days quarantine who do not require shielding should be set out to support social distancing[19]
- Staff should follow PHE guidance[20] for self-isolation if they or their household members develop symptoms and must not enter COVID-PROTECT facilities if they have symptoms of COVID-19.

## 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. Staff should make every effort

[18] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control
[19] https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people
[20] https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance

to ensure that a very high proportion of residents elect to remain in COVID-PROTECT facilities during the period of intense community transmission.

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 triage process should significantly reduce demand for existing provision in the community.

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

### Discharge from COVID-PROTECT

- Remaining in COVID-PROTECT facilities is voluntary, so residents are free to self-discharge but then cannot be guaranteed readmission.
- Residents who self-discharge and then return must be isolated for 14 days as if they were a new admission.
- Residents developing symptoms of COVID-19 must be transferred to COVID-CARE facilities.
- Discharge planning should begin on arrival. This should include liaison with local authority housing departments.
- The admission to COVID-PROTECT should be used as an opportunity to seek stable housing arrangements for all those admitted.

## Use of PPE

PPE guidance has been updated by PHE and the Academy of Medical Royal Colleges. This guidance is reviewed regularly and the latest advice is available at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control and https://www.england.nhs.uk/coronavirus/publication/guidance-supply-use-of-ppe/.

## Implementing the COVID-19 triage and assess protocol

The aim of the triage and assess protocol is to enable frontline workers to determine who to refer to COVID-CARE and COVID-PROTECT facilities and who can remain in the community.

This triage and assess protocol should be implemented as soon as COVID-CARE and COVID-PROTECT facilities are established.

This protocol should be initiated as soon as it can be safely implemented.

## Settings where the protocol can be implemented

A) Community setting: hostels, day centres, emergency accommodation, street services for rough sleepers.

B) A&E departments and hospitals

C) Primary care settings

D) Ambulance services.

- This protocol will be implemented by local staff following guidance and in-person or remote (telephone) instruction from NHS professionals.
- The aim is to achieve a rapid cohort process of symptomatic suspected cases (cohort 1) and high-risk asymptomatic cases (cohort 2) who are at increased risk of severe illness.
- After this initial period, homeless residential services and services supporting rough sleepers should **continue to implement the protocol** throughout the pandemic.
- Implementing the protocol should result in a significant reduction in service users. This will enable a co-ordinated redeployment of some staff to cover COVID-CARE and COVID-PROTECT facilities.

## Practical steps to implementing the protocol, including minimising transmission risk to staff and service users

Achieving a high level of engagement and acceptance from service users is **critical** to prevent high levels of serious illness and death.

**Triaging** and **assessing** homeless people into the three defined cohorts (see key components of the strategy) can be done by non-clinical staff using a simple series of questions (see below).

These questions should be asked at a distance of greater than 2 metres or over the telephone.

Local staff and teams should organise implementation, taking their local circumstances into account. Examples could include:

- obtaining a list of phone numbers of hostel residents and calling to undertake triage
- marking out areas on the pavement to allow regulated queues with spacing of 2 metres, and staff conducting triage behind a table with a distance marker for residents to stand behind.

## Triage assess questionnaire

The questionnaire aims to identify patients with new or worsening cough or shortness of breath or symptoms of fever (for transfer to COVID-CARE) and to identify those who are at increased risk of severe illness (for offer of transfer to COVID-PROTECT).

**Has the person got COVID-19 symptoms?**

**Q1. Have you got a cough?**

If Yes – go to Q2.

If No – go to Q4.

**Q2. Is your cough new?**

If Yes – transfer to COVID-CARE.

If No – go to Q3.

**Q3. Has your cough got worse in the last week?**

If Yes – transfer to COVID-CARE.

If No – go to Q4.

**Q4. Do you feel short of breath?**

If Yes – go to Q5

If No – go to Q7.

**Q5. Is this shortness of breath new?**

If Yes – transfer to COVID-CARE.

If No – go to Q6.

**Q6. Has your shortness of breath got worse in the last week?**

If Yes – transfer to COVID-CARE.

If No – go to Q7.

**Q7. Do you feel like you have a high temperature or fever?**

If Yes – transfer to COVID-CARE.

If No – go to Q8.

**Identifying people at high risk of death from COVID-19**

**Q8. How old are you?**

If aged ≥55 years – offer transfer to COVID-PROTECT.

If aged <55 – go to Q9.

**Q9. Has your doctor ever offered you the flu vaccine?**

If Yes – offer transfer to COVID-PROTECT.

If No – go to Q10.

**Q10. Do you have any of the following chronic illnesses?**

A problem with your lungs, heart, kidneys, liver or spleen?

Diabetes?

Parkinson's disease or motor neurone disease?

Have you got a learning disability?

A weak immune system from an illness like HIV or from medical treatment including cancer treatment?

Are you on steroids?

If yes to any of these questions or the person is visibly very obese – offer transfer to COVID-PROTECT.

Q11. Are you pregnant?

If yes – offer transfer to COVID-PROTECT.

If No – inform and advise about action to be taken if symptoms develop, respiratory and hand hygiene.

### Establish COVID-19 triage and assess teams to operate in the community throughout the pandemic

These teams can consist of trained NHS and homeless sector staff, peers and volunteers with access to private transport facilities (car or minibus). Further guidance on outreach will be provided.

## Transfer arrangements

### Transfer to COVID-CARE (symptomatic)

Public transport should not be used. If travelling in a car or minibus with no partition between the driver and patient, both should wear a surgical mask and the windows should be left open for the duration of the journey.

Surface cleaning of passenger areas should be performed after transfer.

### Transfer to COVID-PROTECT (asymptomatic at risk)

Where available, public transport or taxis can be used. If a shared minibus is used to transfer groups of people to COVID-PROTECT, windows should be left open to maximise ventilation.