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Novel coronavirus (COVID-19)

Guidance for supporting step-up/step-down healthcare in the adult secure and detained estate during the COVID-19 pandemic

This guidance is correct at the time of publishing. However, as it is subject to updates, please use the hyperlinks to confirm the information you are disseminating to the public is accurate.

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1. Summary

This guidance sets out the advice and resources required for the adult health and justice secure and detained estate in planning and managing the step-up and step-down care of patients during the COVID-19 pandemic

It is recommended that all prisons should put in place an operating procedure for the management of COVID-19 as rapidly as possible during December 2020, including an enhanced primary care model adopting the COVID-19 oximetry@home model used in the community.

This guidance is for prison healthcare providers, prison governors and NHS England and NHS Improvement regional teams and is supported by Her Majesty's Prison and Probation Services (HMPPS). Implementation plans need to be worked up locally and agreed locally within each NHS England and NHS Improvement region. The children and Young People Secure Estate (CYPSE) is out of scope for this guidance.

The care pathway for patients who are COVID-19 symptomatic or are recovering from COVID-19 infection and require clinical care within a prison enhanced primary care unit are:

1. **Compartmentalisation of confirmed or suspected symptomatic and asymptomatic COVID-19 patients**: All prisoners who fall into this category will receive appropriate care within the secure and detained settings
2. **Routine healthcare:** This includes agreed usual commissioned healthcare, as well as clinical management for mild COVID-19 symptoms
3. **Enhanced primary care:** Patients should be triaged and there should be consideration of an enhanced low-level provision within a small number of patients. Enhanced primary care can be used as either a step-up or step-down from acute care
4. **Emergency/critical/intensive care:** Patients should be assessed and transferred to acute hospital COVID-19 provision based on clinical need
5. **End-of-life care:** Patients at the end-of-life, with non-COVID-19 conditions or COVID-19 will be individually assessed for either secure and detained end-of-life care provision or for transfer out of prison for hospice or hospital care.

In all care pathways for COVID-19 management, healthcare staff should consider associated psychological and behavioural responses experienced by prisoners. Use of psychological first aid can build resilience and reduce distress reactions and risky behaviours

2. COVID-19 care pathway

The operational plans and procedures to deliver COVID-19 care will be determined by a number of factors, including:

- Current services delivered, including 24-hour healthcare provision, the required additional workforce, capacity and capability, and prison infrastructure requirements;
- Feasibility of access and clinical use of oxygen via oxygen cylinders, with oxygen used for the relief of hypoxia in moderate COVID-19 cases, symptomatic relief for those at end of life due to COVID-19, or other indications.

Please note that information on the use of oxygen in the adult secure estate to support providers in developing their own local oxygen policies will be shared separately

Assessing clinically vulnerable patients

All clinically vulnerable patients who are not on a palliative and end -of life care pathway should be assessed for frailty in line with NICE guidance (NG) 159 COVID-19 rapid guidelines: critical care in adults.

3. Delivering the COVID-19 care pathway

3.1 Compartmentalising of confirmed or suspected symptomatic and asymptomatic prisoners

Compartmentalising of the prison secure and detained population is being implemented across establishments as per HMPPS guidance for prisons during the COVID-19 period (November 2020). An up-to-date copy is available from prison governors/directors and will be based on their current level of regime and compartmentalising as described in the HMPPS COVID-19: National Framework for Prison Regimes and Services. Supporting guidance is provided in Preventing and controlling outbreaks of COVID-19 in prison and places of detention.

Preventing and controlling outbreaks of COVID-19 in prisons and places of detention

3.2 Routine healthcare

Providers should agree with partners and NHS England and NHS Improvement commissioners what services are provided as routine healthcare provision within each establishment. This may be affected by factors such as workforce capacity or local COVID-19 surges.

The Royal College of General Practice (RCGP), in conjunction with the British Medical Association (BMA), has produced guidance on workload prioritisation during a COID-19 surge, which may support providers in their approach and discussion with HMPPS and commissioners

Patients confirmed of having COVID-19 should be managed in line with Public Health England advice regarding location and infection control measures, including access and use of PPE, and HMPPS guidance.

3.3 Enhanced primary care

Enhanced primacy care during the COVID-19 pandemic aims to support healthcare providers and prisons deliver care to meet the needs of their

population, reactive to their needs, supporting the wider impact and pressure on the healthcare system. It allows NHs England and NHS Improvement regional commissioners, prison healthcare providers and governors/directors to agree an enhanced model of care for their population.

In this section, we describe and include resources for enhanced primary care delivery for both COVID-19 and non COVID-19 care

3.3a COVID-19 care pathway

Any patients, clinically assessed as acute and requiring increased clinical intervention, included CPAP therapy or ventilation will be required to be transferred to hospital as per point 4.

For patients who have mild COVID-19 symptoms (either confirmed or suspected) NICE have produced NICE Guideline (NG) 165 COVID-19 rapid guide: managing confirmed or suspected pneumonia in the community and NG 163 COVID-19 rapid guide: managing symptoms (including end of life care) in the community

3.3b COVID-19 Oximetry in Secure and Detained Setting

As the treatment of COVID improves, earlier detection of (silent) hypoxia at home could further reduce mortality. Following successful testing in various parts of the NHS, NHS England and NHS Improvements are now recommending that healthcare providers put in place a COVID-19 Oximetry in Secure and Detained Setting model, as part of the ongoing response to the pandemic.

Sometimes called a COVID- 19 ‘virtual ward’, the recommended model is based on patient self-monitoring. The Standard Operating Procedure draws from learning to date and from pilots completed over the summer and early autumn. This document provides full detail of the model and can be easily adopted for use across the adult secure and detained estate. HMPPS nationally have approved the use of pulse oximeters, where clinically indicated, to support healthcare management of a certain criteria of symptomatic patients. Healthcare providers, governors and commissioners will need to ensure local security and risk assessments, similar to in possession risk assessments, are agreed prior to implementation. In addition, assessment and care pathways will need to be agreed and supported by local acute care departments.

All supporting documents and resources can be found on the Digital – Secure and Detained Settings NHS Futures Platform:
https://future.nhs.uk/TelemedicineSecure/grouphome

Enhanced primary care provision can act as a step-up in care as well as a step-down for those admitted to hospital and transferred back to prison, once medically stable.

3.3c Non-COVID-19

Medicines in addition to normal provision for enhanced care

To delivery an enhanced primary care during the COVID-19 pandemic to non-COVID-19 patients during the pandemic, the following could be needed:

- Intravenous (IV) and subcutaneous administration: The use of IV medicines will be decided by individual providers for the selected establishments. An IV route is advised only where staff currently deliver this, appropriate clinical monitoring is available or where a skills gap can be easily filled to deliver care safely and continuously. If IV is used, providers need to ensure (a) competency and (b) information about dose preparation, reconstitution, diluent and volumes, etc. Switch IV to oral therapy at earliest opportunity.

- Oxygen cylinders and related equipment
- Dressing and other products and devices needed to deliver the agreed enhanced care model;
- Antibiotics in line national guidance.

Oxygen

Issues to consider when including oxygen in the enhanced primary care Model include:

- Use cylinder-based approach. Guidelines used in mental health trusts and community healthcare are being sourced to support health and justice plans.
- Clinical advice on how to manage this in secure and detained setting will be provided as separate guidance.
- Need estimate of average flow rate and thus, how long the largest G cylinder will last for expected patient numbers needing enhanced and end of life care package – overall and in each selected site.
- Cylinder procurement, delivery and return of empty cylinders
- Some medicines stock, including oxygen, may be via restricted routes during COVID-19.

Other supporting advice and national guidance:

- Secure and detained clinicians should follow the NICE COVID-19 rapid guidelines (NG) 165, link above, which advises on the diagnosis of pneumonia and differentiation of viral and bacterial infection, and on antibiotic choice for bacterial infections.
- As with other oral antibiotic prescribing, this should be via a named patient supplies for the course length indicated. Ideally, pre-packs should be procured via licenced providers.
- NICE COVID-19 rapid guideline NG168: community-based care of patients with chronic obstructive pulmonary disease (COPD) and NICE COVID-19 rapid guideline NG166: severe asthma for people with asthma
- The British Thoracic Society (BTS) provide guidance for healthcare professionals treating patients with asthma and COPD, including advising patients to follow usual self-care management plans. Oral steroids are not currently prescribed as part of the treatment for COVID-19.
- Maintained robust antimicrobial stewardship activity during the COVID-19 pandemic is challenging, but non-essential indiscriminate and excessive use of antibiotics can put patients at risk of *Clostridioides difficile* infection and antimicrobial resistance and will reduce the availability of antibiotics across the healthcare system.
- NHS England and NHS Improvement and PHE have published guidance to remind organisations how to retain robust antimicrobial stewardship activity during the COVID-19 pandemic. The management of common infections should follow NICE antimicrobial prescribing guidelines.

Environment to nurse patients safely and effectively

- Availability of and ability to use hospital beds and hoists
- Premises chosen for enhanced primary care (if not a person's cell) are fit for purpose and not over-crowded. For step-down beds, lessons can be learnt from the mental health trust approach and from Nightingale hospitals
- Local health and justice PHE teams will advise on requirements for any conversion of non-healthcare areas or locations
- Risk assessment for use of oxygen cylinders in the cell environments (e.g. smokers, psychoactive substances users). High risk individuals may need to be transferred to hospital.

Joint working with wider integrated care system as well as local acute trust teams.

This is essential for agreeing the basis for the prison's enhanced primary care model and how this links with local acute care provision.

- Agreeing threshold criteria for admitting health and justice patients from enhanced primary care to acute care and back again:
  - NICE COVID-19 rapid guideline (NG159): critical care in adults
  - Critical care admission algorithm
- Primary Care and Community Respiratory Resource pack for use during COVID-19
- Providing clinical advice about the available health and justice care packages, e.g. oxygen flow/guidelines for enhanced primary care patients.
- Providing advice on individual patients where complex issues arise
- Local procurement pathways for medicines, e.g. regional procurement routes for oxygen and local in-reach team service arrangements

Local pathways and additional community support

- Use of local community telehealth initiatives.
- Social care provision and support – current position and offer
- Access to local medicines stock hubs within Clinical Commissioning Groups (CCGs) or primary care networks for contingency planning

3.3d Patients requiring emergency/critical/intensive care

Any patients clinically assessed as requiring hospital admission must be transported to the local hospital as per clinical urgency. Assessment for patients requiring emergency, critical or intensive care the National Early Warning Score (NEWS2) is the recommended tool to use.

Any delay in prisoner accessing critical care can impact on their outcome as well as length of time in hospital. The prison governor should agree a local process for ensuring timely access to staff for escort and bed-watch.

Regional commissioners and the Governor/Director should work with the local healthcare system and agree local management of admissions. This includes ambulance trusts for urgent/emergency access to establishment and patients.

3.3e Palliative and End of life care

This point Is relevant to all establishments regardless of the identification of enhanced primary care provision.

The Ambitions Dying Well in Custody Charter should be used to support the palliative and end -of0life care pathway in the secure and detained estate. All establishments should have:

- a palliative and end-of-life care register;
- advanced care planning in place for all patients on the end -of-life care register
- access to social care to ensure patients are assessed and requirements met.

Symptomatic relief and end of life

Use of end-of-life medicines including controlled drugs should align with NICE COVID-19 rapid guidelines NG163: managing symptoms (including at the end of life) in the community. The following national medicines information should also be used:

- To maximise medicines supply efficiently and avoid wastage, bulk stock should be used for palliative care medicines and not named patient labelled supplies. Stock must be accessed via usual wholesaler routes of advised procurement routes in line with NHS Guidance. For urgent medicines unavailable through these routes, local end -of-life medicines access hubs within CCGs should be used.
- Guidance for the re-use of end-of -life medicines in care homes and hospices can be applied to health and justice settings where a named patient supply has been accessed (i.e. where a stock supply hasn't been available)
- Due to the short supply of syringe drivers and associated ancillaries, individual bolus subcutaneous doses will need to be used. NHS guidance is available for advice on using formulations when the parental route is not available.
- Anticipatory prescribing should follow information in NICE guidelines (NG31) Care of dying adults in the last days of life and community end-of-life guidance.
- Due to supply constraints, minimal stock to manage current patients is advised, with regular ordering to top this up from wholesalers.
- Regulatory requirements for storage of controlled drugs need to be considered. Advice from NHS England and NHS Improvement or a providers' controlled drug accountable officer may be needed

Additional guidelines to support delivery of COVID–19 palliative and end-of-life care

- NICE: Care of dying adults in the last days of life. NICE Guidelines (NG31)
- Advance care planning guidance and template
- Government COVID-19 guidance for care of the deceased
- Deciding Right: Professional FAQ v12