of social media, political and personal viewpoints can drive a narrative that undermines public health efforts or cause confusion.

So how do we move forward over the coming months, with all the uncertainty, change, and difficulties for children and families? How do we ensure that we do not overtreat children with self-limiting illness or miss the handful of children with severe or life-threatening disease? The answer is we need to get the basics right—thankfully, mechanisms are in place to enable this.

As a community we need to learn, rapidly, how to manage COVID-19; we need to use data, from the right sources, in the right way, at the right time. There are four ongoing data collection processes: the Public Health England programme uses detailed information for crucial surveillance purposes. In the Clinical Characterisation Protocol, funded by the National Institute of Health Research, data from all adults and children admitted to hospital with proven COVID-19 are collected, to enable rapid and robust understanding of the disease. The National Child Mortality Database are working to analyse possible emerging patterns of child deaths that might be linked to COVID-19. Finally, NHS England have funded and developed a secure webtool for collecting minimal granular data from children admitted with suspected and proven COVID-19, to feed this into a real-time dashboard for paediatricians on the front-line, and to enable clinically relevant understanding of disease progression. All these endeavours are important if we are to learn how to manage COVID-19.

We must try and manage children in an evidence-based way, despite having very little evidence at our disposal. A national guideline for the management of children with COVID-19 is hosted and maintained by the Royal College of Paediatrics and Child Health. These guidelines will be updated as we learn more about the epidemiology and treatment of COVID-19 in children. The challenge will be to strike the right balance between doing this in a pragmatic, timely way and yet maintaining scientific rigour to ensure the most evidence-based approach to care.

We need to communicate well with children and families in hospital. Personal Protective Equipment will look strange to us, but it will be absolutely terrifying for children, many of whom will have heard about COVID-19 in the news or might even know of an adult with the disease. We need to be compassionate and precise with our language and move from classifying children as high-risk to children with pre-existing conditions, in guidelines, the media, or in scientific publications. Parents may believe that there is no treatment for COVID-19, but we must help them understand that supportive therapy is likely to be all that is needed. We also need to communicate well at a wider level. Policy makers and leaders will need to be honest when communicating the huge societal and health-care changes about to unfold. The media, and scientific researchers, will need to be responsible with their reporting. Transparency in these situations prevents misinformation and misinterpretation, and their associated dangers. At a time of such great uncertainty and anxiety, the truth is one of the most effective tools we have.

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For the **PHE programme** see https://www.england.nhs.uk/coronavirus/publication/letter-covid-19-hospitalisation-in-england-surveillance-system-chess-daily-reporting/

For the **Clinical Characterisation Protocol** see https://isaric.tghn.org/UK-CCP/

For the **National Child Mortality Database** see https://www.ncmd.info/

For the **NHS England webtool** see https//www.covidinchildren.co.uk

For the **RCPCH national guidelines** see https://www.rcpch.ac.uk/resources/covid-19-guidance-paediatric-services

Efforts escalate to protect homeless people from COVID-19 in UK

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Across the UK, a large team is working at breakneck speed to put in place systems to protect homeless people from the potentially devastating effects caused by coronavirus disease 2019 (COVID-19). Homeless people often have multiple chronic conditions and live together in shared and cramped accommodation, or on the streets; they are, therefore, vulnerable to high rates of infection and mortality without urgent intervention. There are an estimated 30 000–40 000 homeless people sleeping rough or in temporary hostel accommodation in the UK, among the 320 000 total people classified as homeless by the homeless charity Shelter (which includes those in temporary flats and other forms of accommodation).

A team of doctors, people in the voluntary sector, local and central governments, and other agencies are in the final stages of a plan that is being rolled out during the week of March 23, 2020, to allow homeless people, with and without symptoms, to be effectively separated. The plan aims to avoid concentrated outbreaks of the disease that would likely spread quickly among this vulnerable

Ashley Cooper

For the **media release by UK Communities Secretary Robert Jenrick** see https://www.gov.uk/government/news/3-2-million-emergency-support-for-rough-sleepers-during-coronavirus-outbreak

population. NHS England, Public Health England, the Great London Authority (which represents all 32 London Boroughs), and the UK Ministry for Housing, Communities and Local Authorities are all part of the team, as are general practitioners (GPs) with extensive experience in providing outreach services for the homeless and outreach specialists in London and nationwide.

The COVID-19 Homeless Sector Plan has been put together by Andrew Hayward, Professor of Infectious Disease Epidemiology and Inclusion Health Research at University College London (London, UK) and Dr Alistair Story, Founder and Clinical Lead of the pan-London Find & Treat Service based out of University College London Hospitals, which for several years has been helping diagnose cases of tuberculosis among the homeless population in London, UK.

The plan follows an announcement by the UK government that rough sleepers, or those at risk of rough sleeping, will be supported by £3·2 million of initial emergency funding if they need to self-isolate to prevent the spread of COVID-19. The funding will be available to all local authorities in England and will reimburse them for the cost of providing accommodation and services to those sleeping on the streets to help them successfully self-isolate. UK Communities Secretary Robert Jenrick said in a media release, "public safety and protecting the most vulnerable people in society from coronavirus is this government's top priority. We are working closely with councils and charities to ensure they have the support they need throughout this period".

UK government guidance issued on March 16, 2020, said that anyone who would normally qualify for influenza vaccination (those aged 70 years or older, or with chronic conditions) should self-isolate—a message UK Prime Minister Boris Johnson and medical experts have emphasised repeatedly in daily news briefings that began that same day. Updated guidance given on March 22, said that vulnerable people must stay at home for at least 12 weeks. "We must urgently provide safe accommodation for everyone who is on the streets and in our hostel system. Almost half of homeless people fall into this vulnerable category, largely due to the high prevalence of chronic conditions, such as lung disease, diabetes, and cardiovascular disease", explains Hayward. "However, people who are living on the street or in multioccupancy hostels, with shared dining, bathroom, and toileting facilities, and sometimes with shared rooms, will not be able to follow government advice to self-isolate if they become ill. Homeless people are likely to delay seeking care if ill and most are dependent on emergency and hospital accident and emergency services."

There will be a central command team consisting of doctors and public health experts to coordinate resources, and facilities will be divided into two categories—COVID-CARE, for people who are symptomatic or have tested positive, and COVID-PROTECT, for people who have other medical vulnerabilities who are asymptomatic or screen negative, but who also need to self-isolate. The team has been offered an increasing number of unused hotels from commercial operators, which can be used as either CARE or PROTECT facilities, although these need to be separate from one another. Each person will have their own room and bathroom. "Our partners in the Greater London Authority have been instrumental in securing this hotel accommodation across London", explains Zana Khan, GP Clinical Lead for the King's Health Partners, Pathway Homeless Team at Guy's and St Thomas' Hospital, London, UK. "In the PROTECT facilities, staff will need to be extremely vigilant for anyone displaying symptoms, so that they can rapidly be transferred to a CARE facility. CARE facilities will be in separate locations, with separate staff."

The CARE facilities could also be unused hotels or other facilities adopted for this purpose. "Here, people who are symptomatic or confirmed as COVID-19 positive will need to be supported to self-isolate for a minimum of 14 days following symptom onset", explains Caroline Shulman, GP in homeless and inclusion health, Kings Health Partners, London, UK. "At the moment, the availability of testing is limited, so where it is not available, we will be basing our decision-making on signs and symptoms only."

The CARE facilities will provide medical support to confirmed cases, with facilities expected to have an increased medical presence as the pandemic progresses. Pulse oximetry and vital signs monitoring will be essential, with discussion with hospital colleagues if people start to deteriorate. "In an ideal situation, we would like a hospital consultant to be able to do rounds of the CARE facilities to

assist with the most urgent patients. We are also looking at options for palliative care for those patients who are deteriorating and for whom intensive care therapy in hospital is not an option", she adds.

Additionally, many people who are homeless have a range of other needs: more than half have mental health problems or drug or alcohol addiction, or both. "Wherever possible, we will offer holistic, person-centred support. The people using these services are likely to experience even greater mental distress, and those with addiction issues will need urgent tailored support to prevent symptoms of withdrawal and further suffering", adds Shulman.

The government and NHS have approved the roll out of the plan across London and nationwide, following the agreement of details with local authorities across England. As the strategy is implemented, fewer homeless people will be entering day centres or overnight hostels. These centres will wind down their operations, allowing some or all of their staff to be deployed to COVID-PROTECT centres.

"Our fear is that over these next weeks, the crisis among homeless people will become very apparent", explains Hayward. "Our absolute priority is to identify who is symptomatic as this project rolls out and to get them to a CARE facility. For those who are asymptomatic but vulnerable, we need to get them to a PROTECT facility. This will protect the most vulnerable, reduce and delay transmission, prevent explosive outbreaks, reduce pressure on the NHS, and ultimately reduce the number of deaths." He adds, "The analysis we have completed suggests our strategy could prevent thousands of hospital admissions from this group, helping reduce the pressure on intensive care beds in this time of national emergency."

Other countries appear not so well prepared for the effect of COVID-19 on the homeless population. In Australia, the rate of new cases of COVID-19 is beginning to increase rapidly. "Sadly, Australia has no coordinated strategy whatsoever regarding homelessness and COVID nationally", says Lisa Wood, Associate Professor at the School of Population and Global Health, University of Western Australia, Perth, WA, Australia. "Only two states, Victoria and Queensland, have come out with an early strategy and package around supporting rough sleepers to get into accommodation. Our fears for the homeless population are escalating the longer the pandemic grows without any clear government guidance, strategy, or resourcing." She adds, "Those working in the sector, and homeless people themselves, feel abandoned as there has been no guidance at all and a lack of proactive action for this vulnerable high-risk group. Both in our national and state governments, homelessness crosses a number of government portfolios, and it seems to be falling through the cracks."

At the time of writing, Australia had just gone into full lockdown nationwide, yet Prime Minister Scott Morrison has still not been clear on what facilities for the homeless, if any, count as vital services. "As in other countries, homelessness and community services across Australia are calling for urgent funding and identification of accommodation options for people sleeping rough. We have many vacant hotels, and we would like to follow the lead of the UK and France in arranging for them to be used for this purpose", Wood adds. "We need to identify and house first those most at risk of COVID-19, particularly those with risk factors for mortality, such as existing respiratory illness or heart disease. We need to work quickly nationally and within Australian states and territories to follow the UK lead in developing and implementing a dedicated strategy to reduce the risk of exposure and spread, detect infection, and triage the health care of those affected to reduce preventable fatalities. Each day that passes without such a plan, we see the number of confirmed cases and community transmission in Australia escalating."

Along with Khan and another co-author Andrew Davies (Medical Director of Homeless Healthcare, a charity based in Perth), Wood has published a preprint article on the crisis facing homeless people everywhere. In the article, they conclude, "The higher risks of COVID for people experiencing homelessness, and consequently, those working closely with them, present an enormous challenge that has no easy answers—but as new precautionary measures are being announced daily, it is critical that further marginalisation for this group is not an unintended consequence."

Tony Kirby

For more on the **Victoria strategy in Australia** see https://www.premier.vic.gov.au/more-homelessness-and-public-housing-support-in-covid-19-fight/

For more on the **Queenland strategy in Australia** see https:/ /www.qshelter.asn.au/wp-content/uploads/2020/03/Communique-Housing-and-Homelessness-Response-24-March.pdf

For the **preprint article** see *Med J Aus* 2020; published online March 16. [preprint]

Respiratory disease and Ramadan

Fasting during the month of Ramadan is observed annually by most of the 1·9 billion Muslims worldwide and is one of the five core pillars of Islam. Most able and observing Muslims fast and abstain from food, liquids, and sexual activity between dawn and dusk for spiritual growth, seeking redemption and striving to better themselves through self-reflection and control. As such, individuals might fast for up to 18 h a day, depending on where they live. Although there are exemptions for young children, older people, travellers, pregnant women, and the sick, many Muslims nevertheless try their best to participate, given the month's religious significance. As acute or severe illness might rekindle spirituality, patients can unsurprisingly become more resolute in their desire to fast. With significant lifestyle changes during the month in terms of eating habits, physical activity levels, sleep schedules,

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