From the Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care

Department of Health & Social Care

39 Victoria Street
London
SW1H 0EU

020 7210 4850

28 March 2020

To my brilliant colleagues in social care,

The last few weeks have been difficult for all of us. I am acutely conscious that you, along with colleagues across the health and social care system, are on the front line caring for and supporting people in incredibly challenging circumstances. Many of the people you care for will be in groups that are at higher risk from Covid-19 and I know that you will have naturally felt concerned for them. At the same time, you will have been grappling with the same issues we all face: how we can best keep ourselves and our loved ones healthy, juggling our own personal caring responsibilities, and looking out for our friends, our neighbours and communities.

My main message to you is simple: thank you.

Thank you for going the extra mile to make sure the people who rely on you are supported. Thank you in advance for the difficult decisions you will have to make that will keep as many people as possible safe. Thank you for taking on extra shifts to cover for those who need to isolate or have their own caring responsibilities. Thank you for doing the right thing by isolating if you or somebody you live with has symptoms. Thank you for everything you are doing this week, next week and in the months to come.

We face more difficult times ahead and I know you will have been personally impacted by the measures we have had to take to reduce the spread of Covid-19. Whilst many people are now staying at home, I know that is not an option for most of you as your work, caring for others, cannot be done from home. We will do all we can to make your lives easier during this period, including, for example, making parking on council owned on-street spaces and car parks free for those who work in social care.

The Government is releasing advice and information updates daily and we are working round the clock to make sure you and your employer have the information, equipment and resources you need. For those of you that use Twitter, please follow the Department for Health and Social Care (@DHSCgovuk) for the latest information. We will also make it available through other channels. I also want to reiterate what the Chancellor has said: we are committed to doing whatever is needed; that promise applies just as much to social care as it does for the NHS.

Thank you again for everything you do.

Yours ever,

MATT HANCOCK

Department of Health & Social Care

Steve Oldfield
Chief Commercial Officer
Second Floor South, 39 Victoria Street, SW1H 0EU
E Steve.Oldfield@dhsc.gov.uk

1st April 2020

Dear Colleague,

Update on plans to support access to PPE Equipment across the health and care system

This communication is intended as an update for health and care sector providers about access to medical supplies and equipment during the current response to COVID-19.

We appreciate the challenges providers may have experienced in obtaining PPE supplies over recent weeks. An increase in demand for both PPE and non-PPE products has put the supply chain to deliver such products under significant pressure.

It is therefore important that usage of PPE equipment across the sector is in line with national guidance which is available at:

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control.

Whilst there are stocks of PPE items in the supply chain, there have been capacity constraints in the NHS Supply Chain network. To address this, DHSC, NHSE/I, NHS Supply Chain and the Army have worked together to develop a Parallel Supply Chain (PSC) to support the normal supply chain. This is a dedicated PPE channel, and core PPE products for COVID-19 will flow through this.

The PSC will improve speed and reliability of delivery for these items, whilst relieving pressure on the established supply chain to deliver business as usual products.

In the interim period, until this new solution is fully operational, we are doing two things. First, working to provide stock of PPE equipment to wholesalers and distributors for pharmacies, GPs, dentists, adult social care providers (such as care homes), and the third sector (such as hospices). This should allow more providers to order PPE through their BAU supply chains.

Second, we have mobilised the **National Supply Disruption Response (NSDR).** Providers who have an urgent requirement for PPE, which they are unable to secure through their business as usual channels, should contact the **NSDR** via the 24/7 helpline: 0800 915 9964 (Freephone number in the UK), and a Direct Line from overseas: 0191 283 6543

Required information:
Before calling the NSDR hotline, please ensure you are able to provide the following details to the call handler:

- Name, email and telephone number of the requestor;
- Name, email and telephone number of a contact for the next **24 hours** (e.g. out of hours cover if the original requestor will be unavailable);
- Delivery address, including postcode; and named contact for receiving deliveries;
- Confirmation that your organisation is able to receive the delivery outside of normal business hours;
- Number of COVID-19 patients being treated (confirmed and suspected);
- Number of beds in your organisation (if appropriate);

- How long your current PPE stock provides cover for (e.g. <24 hours; 1-2 days, or more than 2 days);
- Which products you are requesting and in what quantity

Given the possibility of ongoing localised disruption in the short-term, providers are advised to also make contact with their local health and care sector partner organisations to explore options for mutual aid, via local redistribution of supplies to priority local services.

If this does not prove satisfactory, councils should elevate the issue to their Local Resilience Forum who take a leadership role in their area in managing the supply and demand in an emergency, including by working with military planners. Local Resilience Forums have been asked to provide information on local PPE supply, and we would like councils to work with LRFs to help with this process.

FAQs

When should I contact the NSDR?

You should only contact NSDR if you have followed business as usual processes to access PPE stock (such as ordering from NHS Supply Chain, or your usual wholesaler or distributor) and are still unable to acquire PPE stock. Please see above for the required information you will need to have before contacting NSDR.

The NSDR is focussed on fulfilment of emergency orders, e.g. orders required in less than 72 hours. We do not have access to the full lines of stock held at other large wholesalers or distributors; but we are able to mobilise small priority orders quickly.

I am an NHS Supply Chain customer, but they are out of stock can NSDR help?

The NSDR has access to some pre-packed kits, similar to those delivered in the Government 'push' deliveries. At a minimum an NSDR kit will contain 100 Type IIR facemasks; 100 aprons and 100 pairs of gloves. Additional items can be requested (e.g. goggles) and if we have stock of these they can be included in your delivery.

The delivery will be shipped with whatever products can be fulfilled (e.g. partial fulfilment). The delivery will not be delayed waiting for any additional items to be in stock. Once a delivery has been shipped your order will be closed; if you still require additional items you should raise a new case through the NSDR.

I have contacted the NSDR hotline but they cannot tell me when my package will be shipped.

The NSDR contains a number of functions and the contact centre is the 'front end' customer facing function. A call handler will capture details of requests on our system which will support triage of the case based on the information provided. These cases are then picked up by a case management team with knowledge of the health and care sector. This team reviews cases; follows up with requestors for any additional information required and will check requests against available NSDR stock then arrange for a package to be delivered.

Our express freight service then pick, pack and deliver the emergency package. These processes have been stood up at short notice and are not supported by sophisticated warehousing and delivery tracking software. As a result call handlers do not have visibility of the other steps in this process, or live delivery tracking information.

I contacted NSDR and received a package but it didn't contain everything I needed

The NSDR is focussed on fulfilment of urgent orders. The delivery will be shipped with whatever products can be fulfilled (e.g. partial fulfilment) at the time of picking. The delivery will not be delayed waiting for any additional items to be in stock. Once a delivery has been shipped your order will be

closed; if you still require additional items you should raise a new case through the NSDR; if you received a case reference number for your previous case please provide these details to your call handler.

We are unable to keep track of items which we have not been able to fulfil against emergency orders, because we do not have a robust digital system in place to manage partial orders and to manage subsequent fulfilment and delivery. In parallel to any requests to NSDR providers should be trying to meet their needs through business as usual supply channels.

I contacted the NSDR before but haven't received any delivery.

At present we are receiving a very high volume of cases and are working as quickly as possible to resolve priority cases first. We are working in parallel to improve our systems so that we have better management information on cases that will ensure we are able to respond efficiently.

A number of cases logged with NSDR have not included clear indications of what stock is required, or attempts have been made to contact the requestor have been unsuccessful. Once details of cases raised are recorded they are sent to a case management team which reviews and instructs an express freight service. Call handlers do not have visibility of delivery schedules and cannot answer queries about future deliveries.

I contacted NSDR and the call handler said there is no PPE stock/ I need to order my own PPE stock through distributors

As the role of NSDR has flexed to respond to the rapidly evolving supply chain, the advice issued to call handlers has changed. At the time of the Government 'push' deliveries, the handling advice was that providers needed to order their own stock through BAU. Given that Government intervention is still required to support the supply chain during this time of peak demand, the latest lines call handlers should be using have been updated.

If you do receive advice to order stock through business as usual, which you have followed and have been unsuccessful with, please ask your call handler to check your case details and complete an NSDR PPE Supply Disruption form for you. The call handler will then process this information and generate a case in our internal system.

I have placed a BAU order for more PPE stock but it will not arrive for 5 days and I will run out of stock in three days, should I contact NSDR.

Yes, you should contact NSDR with all required information indicated above to arrange enough stock to cover the 2 day anticipated gap in stock cover.

I don't usually require PPE; what distributor should I be contacting to place business as usual orders?

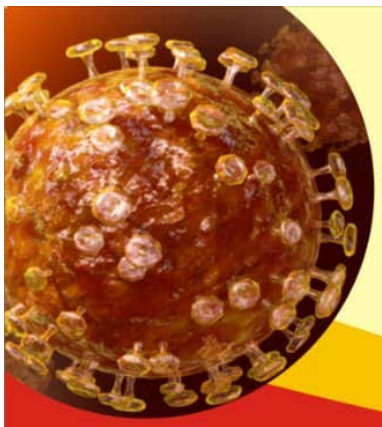
Organisation	Healthcare Sector
Alliance / NWOP 0330 100 0448 Customerservice@alliance-healthcare.co.uk	**Pharmacy**
Phoenix	**Pharmacy / GP Surgery**
Mckesson / AAH Pharma 0344 561 8899 Register at aah.co.uk	**Pharmacy**
Williams Medical Supplies 01685 846 666 sales@wms.co.uk	**GP Surgery**
HenrySchein 0800 023 2558 sales@henryschein.co.uk *	**Dentist**
DD Group	**Dentist**

0800 585 586 salessupport@ddgroup.com	
Wright Health Group 01382 834 557 nhsorders@wright-cottrell.co.uk	**Dentist**
Trycare Ltd 01274 885544 Mark.Hackin@trycare.co.uk	**Dentist**
Careshop coronavirus@careshop.co.uk	**Social Care** (e.g. community care, home care, hospices)
Blueleaf 03300 552 288 emergencystock@blueleafcare.com *	**Social Care** (e.g. community care, home care, hospices)
Delivernet 01756 706 050 lee.morris@delivernet.co.uk	**Social Care** (e.g. community care, home care, hospices)
Countrywide Healthcare 01226 719 090 enquiries@countrywidehealthcare.co.uk	**Social Care** (e.g. community care, home care, hospices)

Most distributors are open Mon-Fri, 8/9am- 5/6pm (varied); * indicates preferred contact method.

Yours sincerely,

Steve Oldfield
Chief Commercial Officer



NIGERIA NURSES CHARITABLE ASSOCIATION UK

Staying connected with health and care BAME staff during and beyond

COVID-19

SPEAKERS:

Cherron Inko-Tariah MBE,
CEO of The Power of Staff Networks Consultancy & NED at Homerton University Hospitals

Roger Kline
Research Fellow, Middlesex University Business School

FREE WEBINAR:

WE WILL SURVIVE:
HOW BAME STAFF CAN SURVIVE THROUGH & POST COVID-19 CRISIS

Join us on

8th May 2020 Time: 7.00pm

* Emotional and mental wellbeing * Pastoral care * Hearing from frontline staff
* How to navigate through this challenging period * Networking * Referral to additional support

Email: info@nncauk.org | Register @ www.eventbrite.co.uk/e/104256528082

Beyond Words
empowering people through pictures

Beating the Virus

illustrated by Lucy Bergonzi

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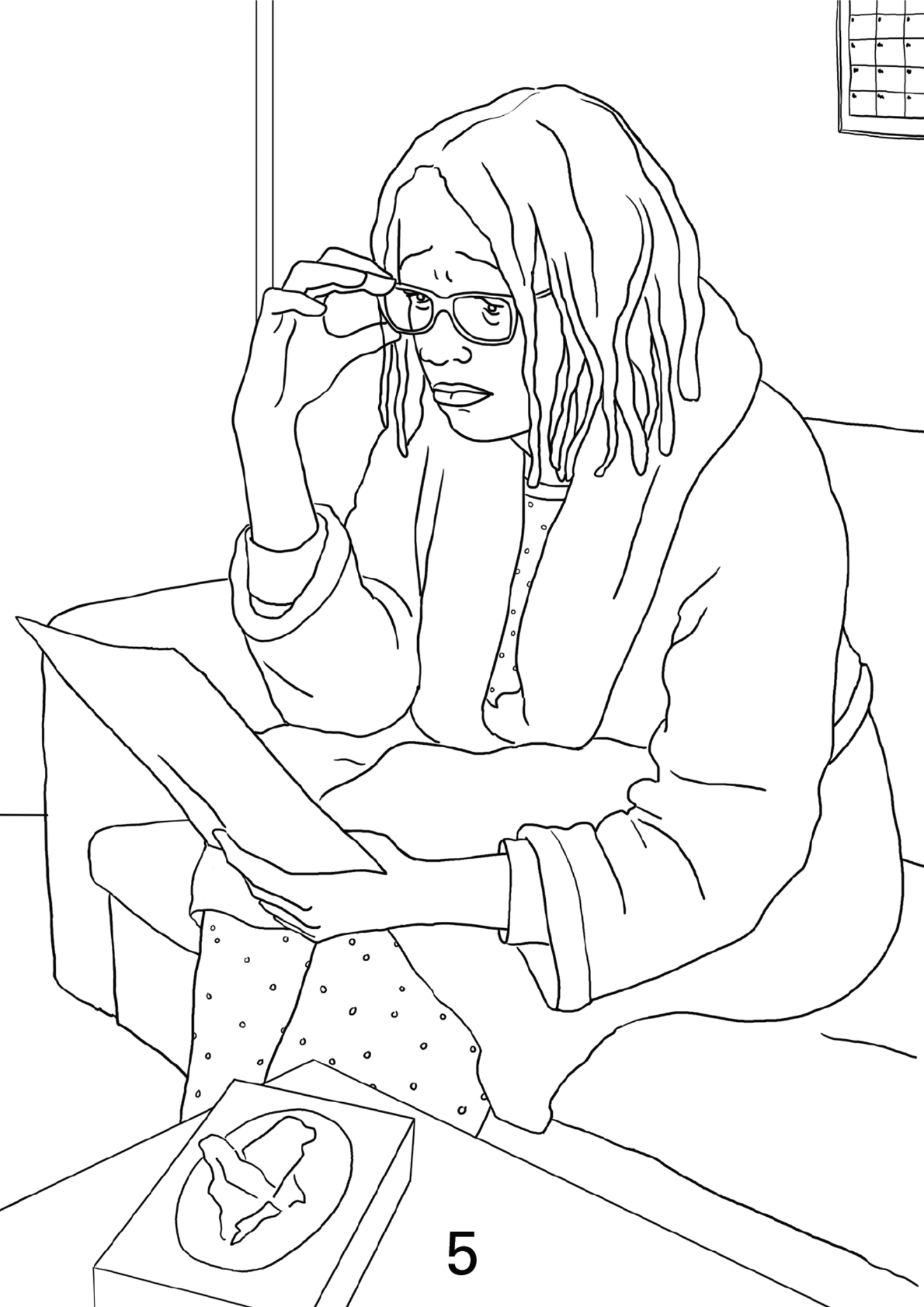

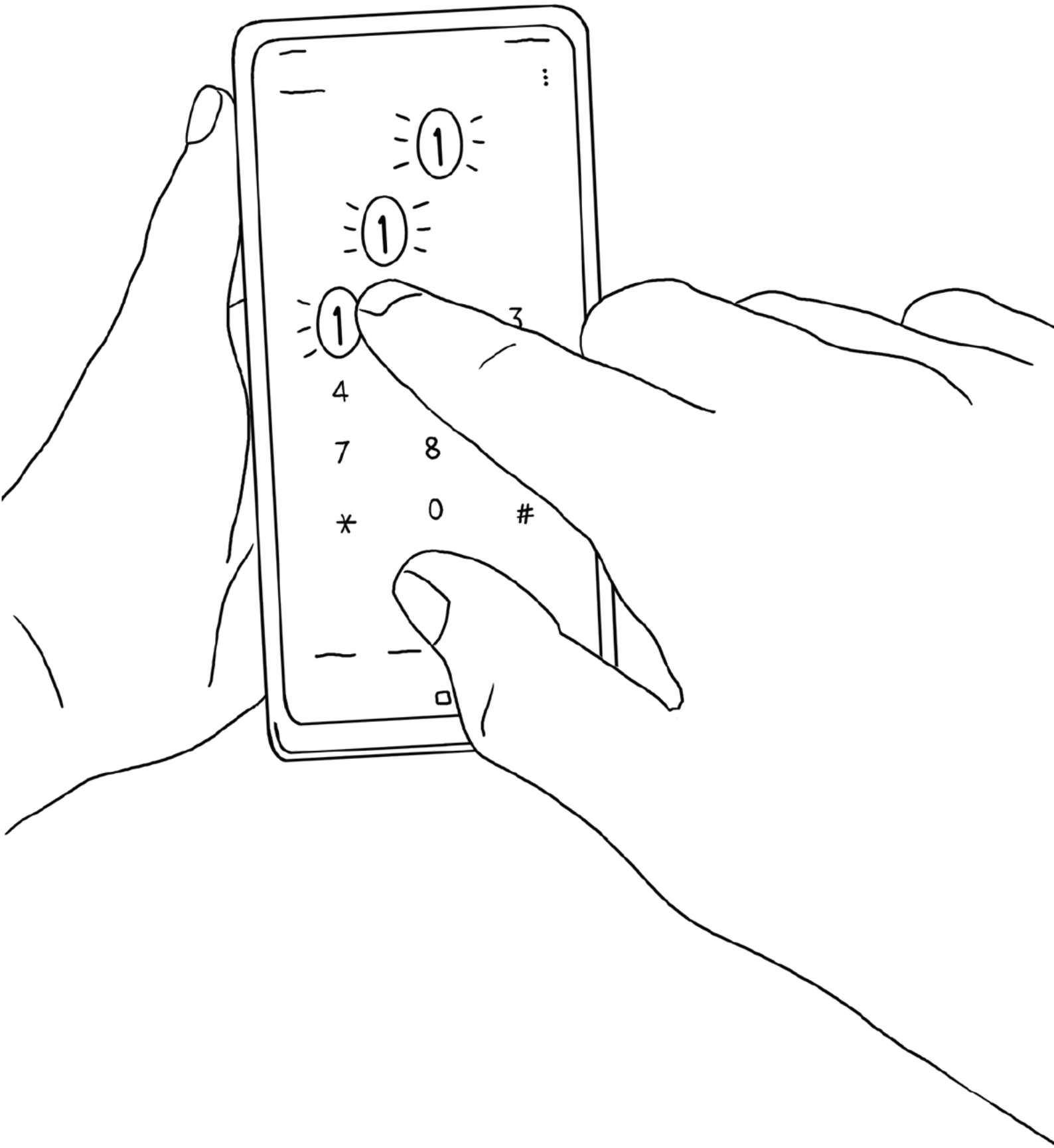
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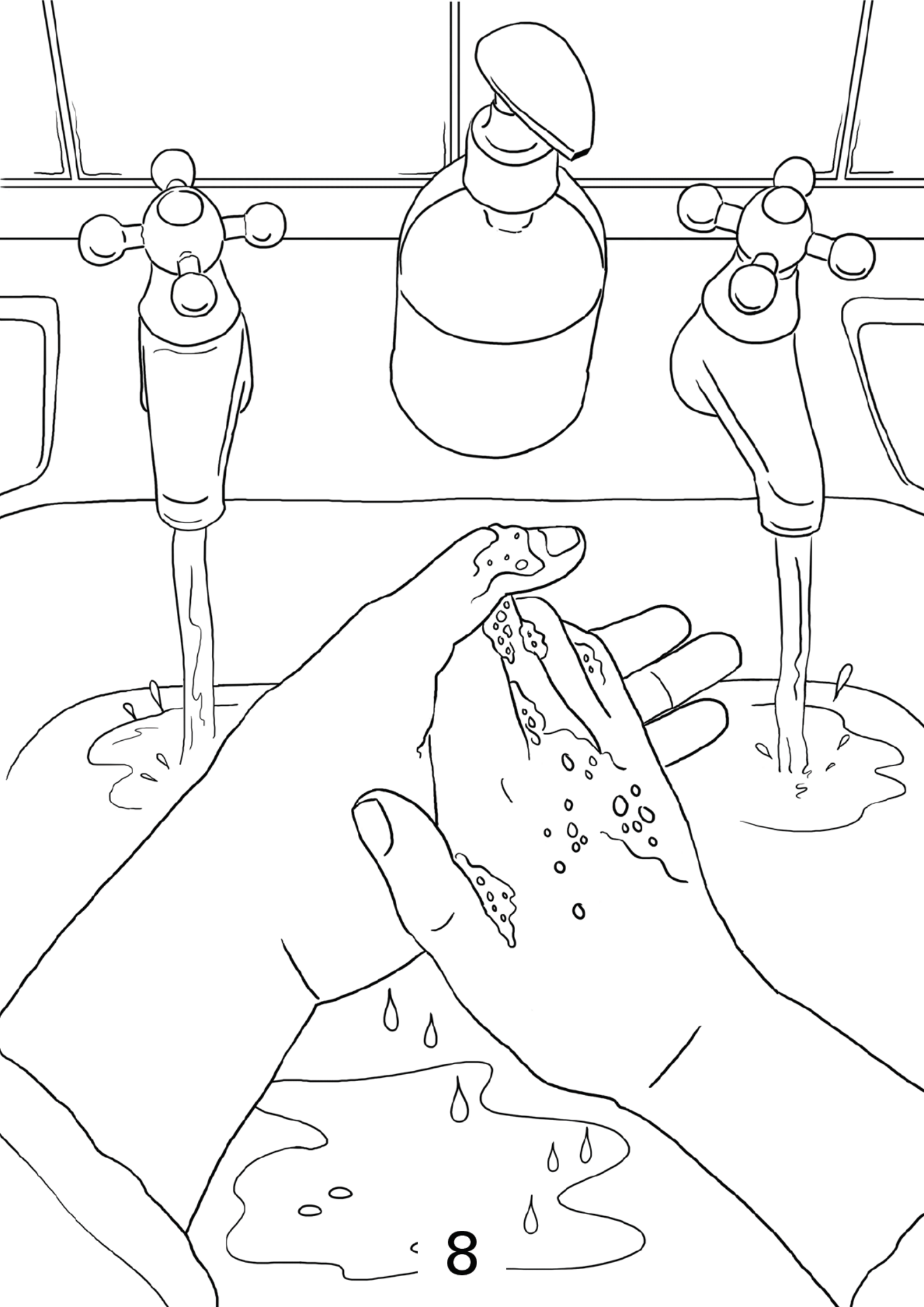
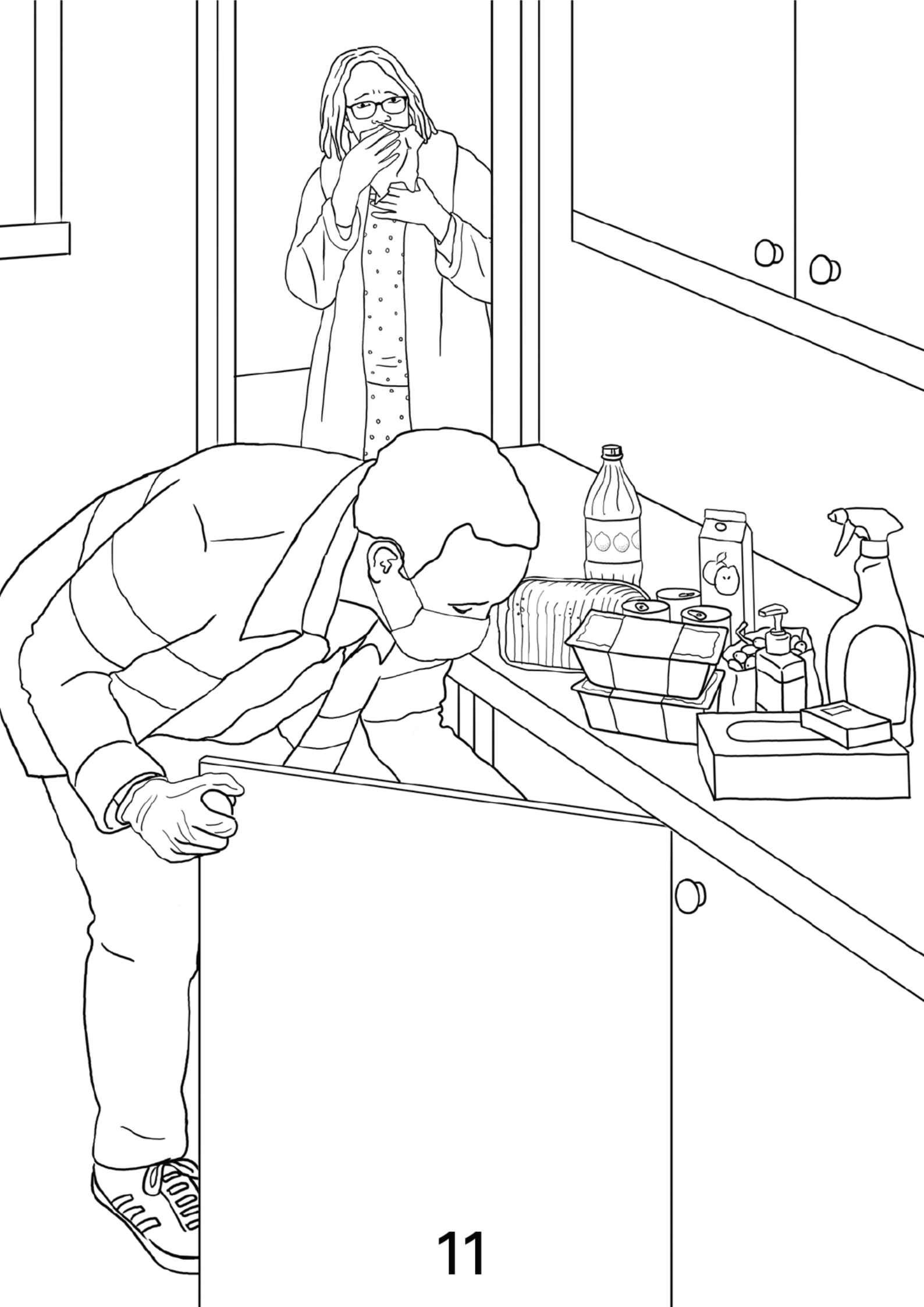
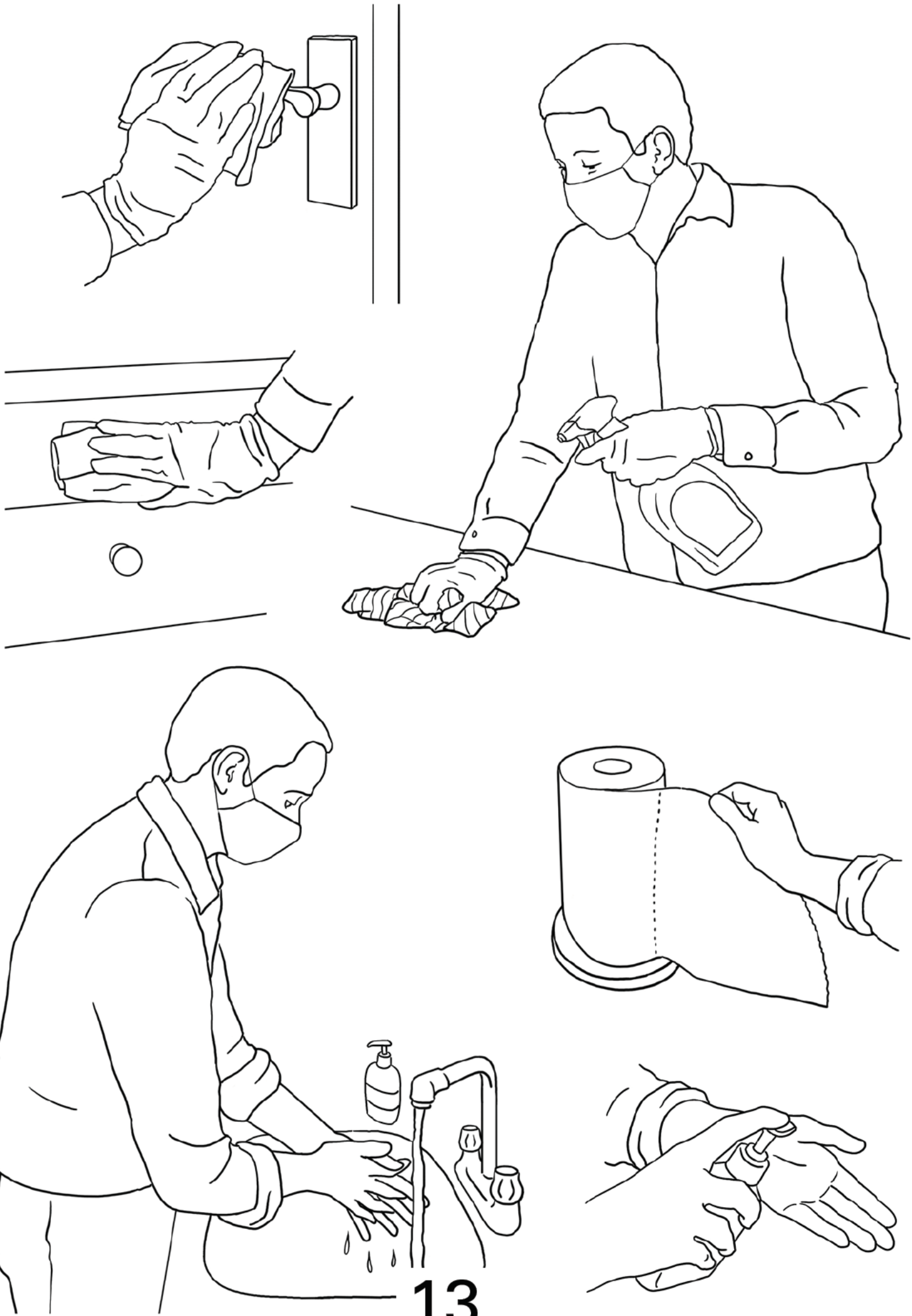
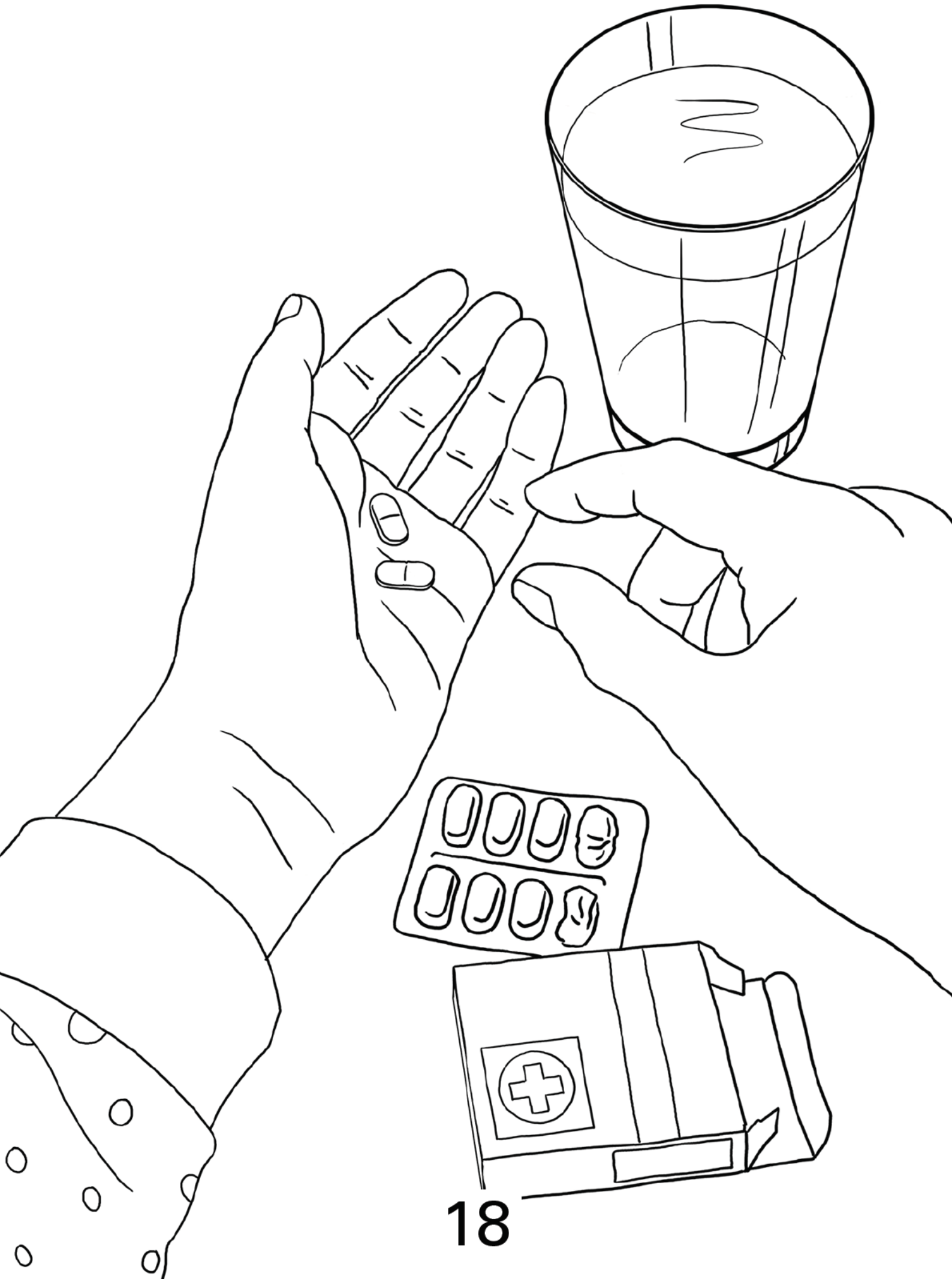
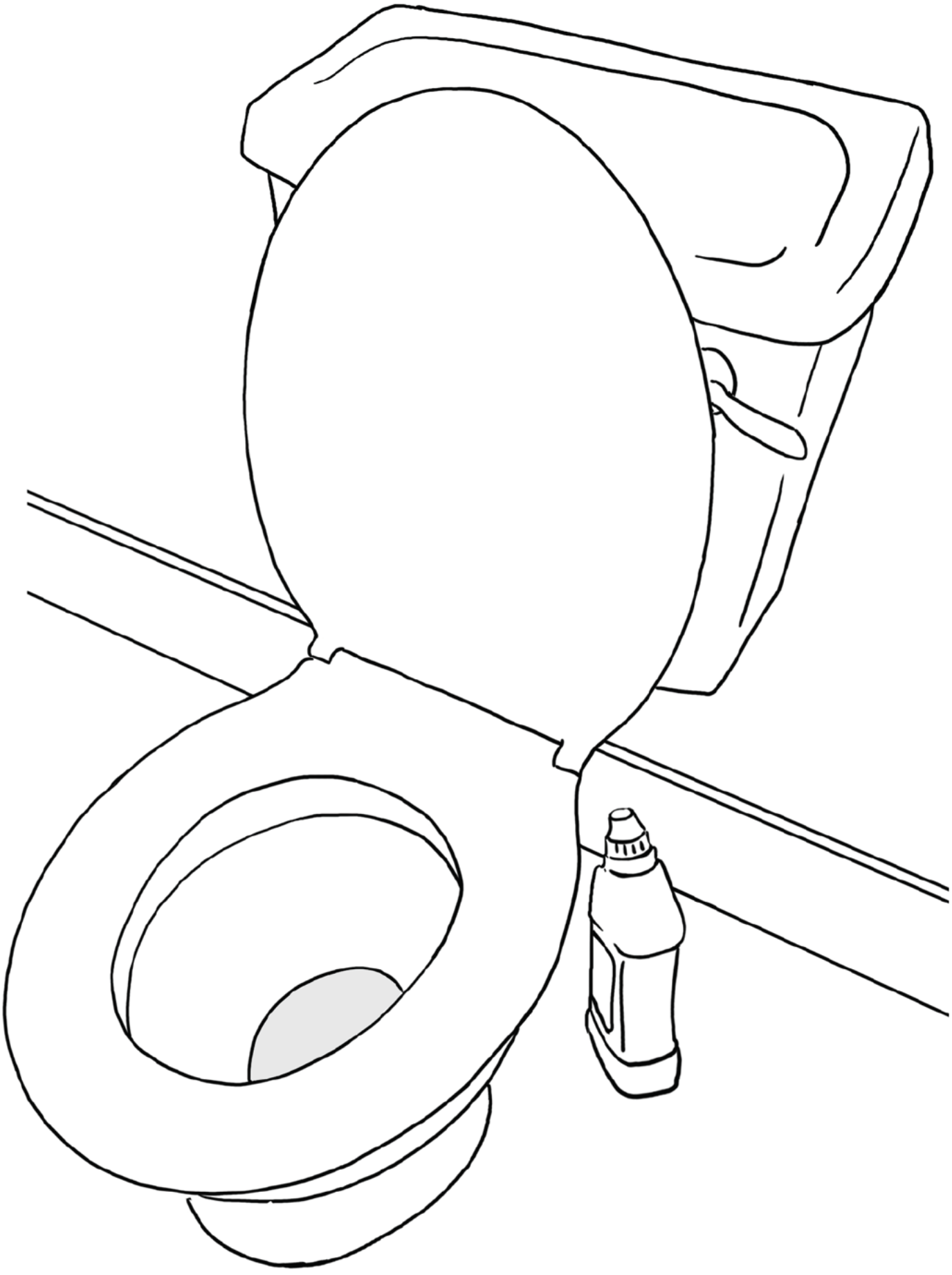










Beating the Virus – a story

This story is about a woman we call Kali and a man we call Stefan who helps her. Kali and Stefan are two much-loved characters from another wordless story, Belonging, but you can choose whatever names you would like to call them. In this story, Stefan could be Kali's friend, but he could be her carer/ support worker or a family member. You can decide.

Kali is living alone and feels scared when she gets ill, especially because of all the things on TV about the virus and about people going to hospital. She looks at the leaflet she was given about the virus, but she doesn't understand it. Just like many other people, she finds it hard to understand the words. She doesn't know what's best to do, and she doesn't know how to get online, but there is a telephone number on the leaflet. The trouble is that it might take a long time for anyone to answer. (Links to easy read leaflets about the Coronavirus can be found under **Useful resources** and will be kept up to date.)

In this story, Kali is the one who is ill, and Stefan is keeping well. The story shows how careful Stefan is being, so he doesn't catch the virus. He keeps several steps away from Kali – it's called social distancing! He washes his hands when he arrives. He puts the shopping away and then he wipes down the kitchen surfaces and the door handles with disinfectant. He washes his hands well for 20 seconds and dries them on kitchen paper and throws it in the bin. Next time he comes he will stay outside and just deliver her shopping.

Kali doesn't need help with her personal care. If she did, then Stefan would need to wear disposable gloves and a face mask.

Getting help if you are unwell

So, what should Kali do? She mustn't go to the doctor's surgery! Her Mum told her that!

But Kali may not know when to call the GP. She may not know how ill she has to be before asking for help. **But it's OK to call 111 if you are not sure and if you can't get online.**

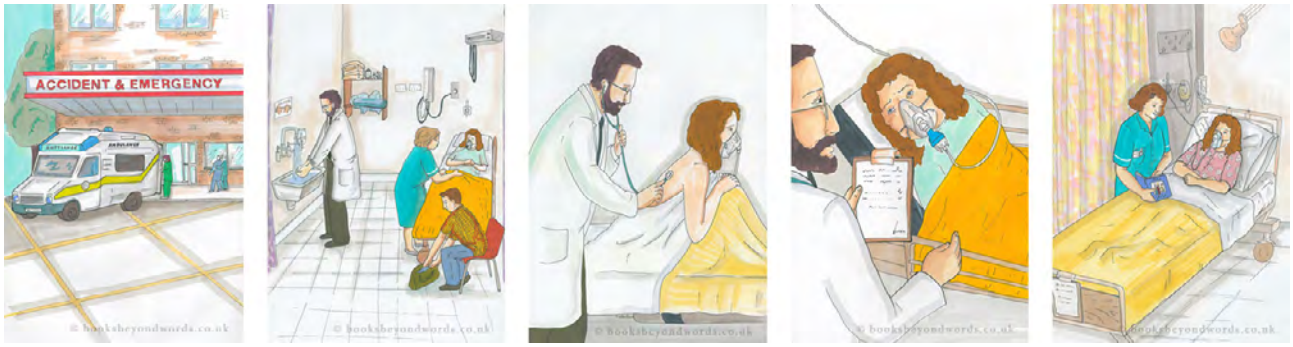
When she calls 111, Kali can tell them that she has a learning disability. Hopefully she has had her annual health check and can explain what her particular health needs are. They will ask Kali if she has underlying health conditions such as diabetes.

Kali probably doesn't have a thermometer, but she can tell them she feels very hot. They will tell her that a carer, family or friend needs to keep an eye on her and make sure she calls 111 again if she is getting worse.

They will advise Kali how to look after herself. They will tell her to drink lots of water and sugary drinks. This is because, if she doesn't drink enough, she may be at risk of getting sepsis. This is a serious infection that can make the body stop working (with organ failure) and always needs urgent hospital treatment.

They will suggest she takes paracetamol. They may check if she is taking any treatment that suppresses her immunity and advise her to talk to her doctor about whether to stop taking it. This is because she needs a strong immune system to fight the infection.

If she takes a turn for the worse or finds it hard to breathe, Kali must call 111 again. They will make sure she gets the help she needs, and if she is really ill, they will arrange for an ambulance to take her to hospital, like in the pictures below.



*These pictures were taken from Going into Hospital. All the pictures from this story can be found in the **BW Story App** (see App Store/ Google Play Store).*

What should the local area response be?

Local service providers may need advice about whether and when to continue or suspend their usual activities, and to rethink how they provide support. They will need to re-focus their staff on checking that the people they support have got everything they need to keep safe. They need to make plans to provide anyone receiving personal care with protective equipment for their carers to wear when it becomes available.

In this story, Kali may be in supported living, or living in an independent tenancy. She still needs someone to keep an eye on her. Understanding how to keep safe may be difficult for Kali and her peers. The government advice is difficult to understand. Their usual support and everyday activities have been stopped, and they don't understand why they can't go out. "What happened to making my own choices?" they might reasonably ask! How can people who care about Kali keep her mentally well as well as physically safe?

Everyone will have heard that some people have died after getting the virus. The estimate is that as many as 1 in 100 people who get ill may die. This means that some people with learning disabilities may die, or some of their family members or carers may die.

It's a good idea to know how to talk about death and dying and to be prepared. Our stories on grief and bereavement can help support these conversations: When Somebody Dies, When Dad Died, When Mum Died and Am I Going to Die?.

About Books Beyond Words

There are 60 wordless (and therefore non-language dependent) stories in the Books Beyond Words series, all co-created with people with learning disabilities and autistic people. All the stories are available as paperbacks and eBooks via the Beyond Words website: www.booksbeyondwords.co.uk.

The stories have also been broken down into 400 shorter, searchable snippets in the **BW Story App** designed for smartphones and tablets. You can download a free version (with a few sample short stories) from the App Store (Apple/iOS devices) or the Google Play Store (Android devices).

If you are new to Books Beyond Words, you can learn how to get the best out of the stories in our hour-long introductory e-learning module or by following our suggestions below. Find out more about e-learning and how to subscribe via our website: www.booksbeyondwords.co.uk/elearning/foundation-module.

How to read this book

This is a story for people who find pictures easier to understand than words. It is not necessary to be able to read any words at all.

1. Some people are not used to reading books. Start at the beginning and read the story in each picture. Encourage the reader to turn the pages at their own pace.

2. Whether you are reading the book with one person or even online with a group, encourage them to tell the story in their own words. You will discover what each person thinks are happening, what they already know, and how they feel. You may think something different is happening in the pictures yourself, but that doesn't matter. Wait to see if their ideas change as the story develops. Watch, wait and wonder.

3. It can help to prompt the people you are supporting, gradually going deeper into the meaning, for example:
   - I wonder who that is?
   - I wonder what is happening?
   - What is he or she doing now?
   - I wonder how he or she is feeling?
   - Do you feel like that? Has it happened to you/ your friend/ your family?

4. You don't have to read the whole story in one sitting. Allow people enough time to follow the pictures at their own pace.

5. Some people will not be able to follow the story, but they may be able to understand some of the pictures. Stay a little longer with the pictures that interest them.

A Suggested Storyline

1. Kali lives alone and she is not feeling well.
2. She is feverish and feels really ill.
3. Kali just keeps coughing. It's a horrid dry cough. She coughs into her elbow or a tissue and throws the tissues in the bin.
4. She goes to the toilet and her urine (wee) is very dark.
5. She looks at the leaflet about Coronavirus, but she doesn't understand it.
6. She rings NHS 111.
7. The person she talks to says she must stay at home, drink lots and take paracetamol. But not more than four times a day.
8. She washes her hands well – she watches a fun video to learn how to do it. (You can watch one, here: https://vimeo.com/134952598)
9. She phones her friend, Stefan and says she is not well. She asks him to get some shopping for her including paracetamol if he can buy any – lots of shops have run out.
10. Stefan comes and Kali opens the door. She holds a tissue over her mouth – she doesn't want Stefan to catch her illness.
11. Stefan puts on a face mask (if he has one) and puts everything away: some food, such as grapes, bread and milk, and other useful things, including hand sanitiser, an antibacterial surface spray, paracetamol, kitchen towel and paper tissues. They stand three steps away from each other. It feels very strange!
12. He tells Kali it's important to drink lots, so she has a drink and takes the paracetamol.
13. He puts on some disposable gloves, sprays and wipes the kitchen surfaces and the door handles. He washes his hands well and uses the hand gel.
14. Stefan puts the grapes and some drinks next to Kali, who relaxes on the sofa. Then he says goodbye to Kali and leaves.
15. Kali has a drink and some grapes, but she isn't hungry.

16. She fell asleep on the sofa. Now it's dark, and she wakes up coughing again!

17. She brushes her teeth and gets ready for bed.

18. Kali takes some more paracetamol with water.

19. Now, Kali goes to bed. She has water beside the bed and some tissues.

20. Next morning, she is still feverish.

21. The days pass. Now Kali is looking a bit brighter. She gets a fresh drink of juice.

22. Stefan brings her some microwave meals, tins of soup, milk and fruit – he doesn't come in.

23. Kali is gradually getting better and enjoying her food.

24. Her urine is a better, paler colour as well. That's good – it means she is drinking enough.

25. Kali has been ill for a whole week! Each day she marked it on the calendar. The calendar shows that seven days have been marked off.

26. Then one day Kali rings Stefan to ask if they can go for a walk. She says they can walk a few steps apart – just to be safe!

Useful resources

Help using NHS 111
NHS England has produced a video to help people with a learning disability, autism or both, to use the NHS 111 service: www.england.nhs.uk/learning-disabilities/about/resources/help-for-people-with-a-learning-disability-autism-or-both-to-use-nhs-111/

The Hand Washing Rap
A fun video produced by the Purple All Stars demonstrating good handwashing:
https://vimeo.com/134952598

'Hand Washing Tips for People With Sensory Difficulties'
Hand washing is crucial in reducing the risk of contracting the Coronavirus (COVID-19), but people with difficulties with sensory integration or sensory processing can experience aversion to the smells, images, sounds and the tactile sensations of hand washing; have problems with balance, tone or coordinating their hand movements; or not understand the step-by-step process of hand washing.
Any kind of soap is really good at killing the virus. People can use whichever soap they find easiest, and some people may find an alcohol-based hand gel best. This article has more suggestions for encouraging and improving hand washing:
https://sensoryintegration.org.uk/News/8821506

Easy read resources on the Coronavirus (COVID-19)
- **Mencap** has produced an easy read leaflet, available to download from their website:
  www.mencap.org.uk/advice-and-support/health/coronavirus
- **Inclusion North** has produced an easy read leaflet, along with an audio copy. Both can be accessed via their website:
  www.inclusionnorth.org/coronavirus-easy-read-information
- **Photosymbols** have created some posters too:
  www.photosymbols.com/blogs/news/coronavirus

Keeping Informed and In Touch during Coronavirus
Learning Disability England has dedicated a space on their website to sharing information and resources about the virus and what you can to do to stay safe and well, and how people are staying connected and finding solutions:
www.learningdisabilityengland.org.uk/what-we-do/keeping-informed-and-in-touch-during-coronavirus/

'Guidance on social distancing for everyone in the UK and protecting older people and vulnerable adults'
Official guidance produced by Public Health England on limiting social interaction to reduce the spread of the Coronavirus:
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

Related titles in the Books Beyond Words series

Going into Hospital (2015, 2nd edition) by Sheila Hollins, Angie Avis and Samantha Cheverton, with Jim Blair, illustrated by Denise Redmond. This book helps to prepare and support people being admitted to hospital, by explaining what happens, covering planned admission and accident and emergency.

Am I Going to Die? (2009) by Sheila Hollins and Irene Tuffrey-Wijne, illustrated by Lisa Kopper. This story deals honestly and movingly with the physical and emotional aspects of dying.

When Somebody Dies (2014) by Sheila Hollins, Sandra Dowling and Noëlle Blackman, illustrated by Catherine Brighton. Mary and John are both upset when someone they love dies. They learn to feel less sad by attending regular bereavement counselling sessions and from the comfort and companionship of friends.

When Mum Died and **When Dad Died** (both 2014, 4th edition) by Sheila Hollins and Lester Sireling, illustrated by Beth Webb. Both books take an honest and straightforward approach to death and grief in the family.

skillsforcare

Building your own resilience, health and wellbeing

Welcome to this practical guide to building your own resilience, health and wellbeing.

This booklet is for anyone working in adult social care. It explains what resilience is and how you can build your own resilience.

Contents

1. What is resilience and why does it matter?

What do we mean by resilience?

Simply put, resilience is the ability to cope under pressure and recover from difficulties. A person who has good resilience copes well under pressure and can bounce back more quickly than someone whose resilience is less developed.

What does resilience look like?

Behaviours associated with resilience include:

- understanding and valuing the meaning of what you do
- greeting new situations, people and demands with a positive attitude
- doing what you can to get on with other people
- taking a problem solving approach to difficulty
- keeping a sense of perspective (and humour) when things go wrong
- being flexible and willing to adapt to change
- drawing on a range of strategies to cope with pressure
- recognising your thoughts and emotions, and managing them
- asking for help when you need it
- being willing to persevere when the going gets tough
- recognising and respecting your own limits, including what you can control and what you can't.

What makes a person resilient?

Where does resilience come from?

The way we behave is shaped by a range of factors including personality and past experience, as well as current circumstances and the people around us. All of these things influence a person's resilience.

Are some people naturally more resilient than others?

Everybody has resilience, but some people may have qualities that make them more resilient than others.

Why does resilience matter?

Being resilient will help you to manage stressful situations, protect you from mental ill-health and improve your health and wellbeing. At work, this ensures that you can continue to do your job well, and deliver high quality care and support. It can also support you in your personal life.

Resilient people benefit from:

- better job satisfaction
- personal development, including:
  - greater self-awareness and understanding of others, leading to better personal and working relationships
  - good self-management skills, such as the ability to set limits and better coping skills
- enhanced physical and psychological wellbeing
- better decision making skills - stress impairs our thinking process which can undermine our professional judgement, often just when it's needed the most.

Protection against stress

Stress is a significant cause of mental and physical ill-health. Work-related stress is a particular issue in social care. Yes, care work is rewarding - we make a positive difference to people's lives - but it's also inherently stressful.

It's not possible to take the stress out of care work, which makes it all the more important to do what you can to become more resilient.

The impact of stress on quality of care and support

The daily stressfulness of care work can contribute to:

- errors and misjudgements
- low morale
- sickness absence
- burnout
- staff turnover in the sector.

All of these undermine high quality care and support.

Task: How resilient are you?

Consider each of the questions below, then mark where you sit on the line between 'not much' and 'a lot'.

Afterwards, ask people who know you well if they agree.

If you think about yourself at work and outside work, is there any difference in where you are on the lines?

To what extent are you:	Not much A lot
in touch with your thoughts and feelings?	
able to live with an unresolved problem?	
positive and optimistic about life?	
able to think accurately about things?	
sensitive to how people around you are feeling?	
confident of solving problems?	
willing to embrace the new in order to grow?	

2. Recognising and coping with pressure and stress

What is pressure and when is it a problem?

Pressure means too much of something is pushing on something else. It can be in-the-moment or long term. Too much of either kind is harmful, both physically and psychologically.

In-the-moment pressure can arise from everyday situations such as being late to work, being short staffed or facing last minute demands.

Too much in-the-moment pressure makes people misread situations and react inappropriately, which can have consequences that last well beyond the moment. Repeated often enough, in-the-moment pressure also becomes a health risk.

Long term pressure builds up over time and could be affected by both home and work issues. It poses a much more serious health risk, as well as undermining people's judgement and behaviour.

Part of coping with pressure is recognising when it starts to become a problem. That means being:

- aware of how you're feeling
- alert to the signs and symptoms of too much pressure.

In-the-moment pressure

Recognising when in-the-moment pressure becomes a problem

People's reactions vary, but here are some typical early signs.

Physical	Digestive problems, nausea, light headedness, dry mouth, heart pounding, rashes or flushing
Emotional	Immediate emotional judgement, short temper, feeling overwhelmed, paranoia
Behavioural	Procrastinating, neglecting responsibilities, nervous habits such as pacing, nail biting
Thinking	Inability to concentrate, seeing only the negative, constant worrying, self-blame, poor judgement

Learning to recognise these early signs is one of the most important stages in developing resilience. It enables you to take action before the threat becomes overwhelming.

Task: What are your early signs?

Take a moment to think about what your early signs are. If it's helpful, imagine you're a person in a restaurant having their card rejected. What does that moment feel like?

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Strategies to cope with in-the-moment pressure

Strategies for coping with in-the-moment pressure focus on simple but highly effective techniques to relax, become more self-aware and regain control of your thoughts and feelings. Here are some examples that you might find useful.

Techniques to relax

- **Breathe**
  Breathe in for a count of seven, and out for a count of 11.

- **Tighten, then relax**
  Tighten all your muscles for a count of three, then let go.

- **Movement**
  Such as a quick walk, going up and down stairs, or stretching. It doesn't have to be strenuous - any sort of movement will help you to release pressure.

- **Targeted muscle relaxation**
  Muscle tension is a very normal reaction to pressure and can contribute to so-called 'stress headaches'.
  Your stomach, shoulders, neck and jaw are all other places where you might store tension. Notice where your body feels tight and consciously relax the muscles. Self-massage (e.g. pressing your fingertips into the muscles in the back of your neck or your shoulders) is good way to find and release muscle tension.

Techniques to manage your thoughts and emotions

- **Step out of the stressful situation**
  Literally walk away and give your attention to something else, even if only for a moment. It gives you a chance to calm down and regain control of your thoughts and emotions.

- **Talk to a colleague**
  Talking about your thoughts and feelings can help to release pressure. Putting things into words to another person gives you distance and helps you calm down. It can also give you a different perspective on the issue.

- **Notice what you're feeling**
  This is a mindfulness technique to help you manage emotion. Ask yourself, 'what am I actually feeling?' Identify the feeling (or feelings), such as anger, fear, or embarrassment. Don't judge yourself and don't fight your feelings. Just observe and accept them. Whatever they are, those are your feelings. Taking that step back, becoming aware of your feelings and accepting them puts you back in charge and lets you move on.

- **Break the cycle**
  When you have negative thoughts, deliberately turn your attention to something positive, such as a good memory, something good you're going to do or anything that makes you feel positive about yourself. This is a great distraction technique that takes you to a place that reaffirms the good things in your life.

- **Problem solve**

  When you find yourself worrying about something that's coming up or that seems overwhelming, stop and ask yourself, 'what do I actually need to do about this?' Mentally rehearse how you'll deal with the situation. Think it through logically. If you'll need help, think about who you can ask. This is a problem solving technique designed to put you back in charge.

- **Stop worrying and think positive**

  If you find yourself worrying about a problem, try talking to yourself in a calm and logical way. If you're given a challenging task at work, think of a time you have done something similar and tell yourself you can do it again. Instead of seeing the task as a negative, try and view it as a positive, for example 'this will be a great opportunity to move forward in my role' or to 'gain more experience'.

Techniques to become more self-aware

- **Use reflective discussion to support self awareness**
  Reflective discussion is simply thinking about, or reflecting on, what you do. Next time you experience in-the-moment pressure, think about:
  - what you did
  - what happened
  - what would you do different next time.

- **Know when to seek help**
  Being resilient is not about being self-sufficient. Resilience is about thriving under pressure. Sourcing help when you need it, is a very resilient behaviour.

- **Mindfulness**
  The essence of mindfulness can be summed up in three words, ‘be here now’.

  Mindfulness involves paying full attention to your feelings, thoughts and bodily sensations in the present moment.

  This means standing aside from any other thoughts, worries, upsets and plans that normally absorb and preoccupy our mind.

  Being mindful enables you to disengage from your worries and upsets, to give you some distance from everyday stress, and regain perspective and a deeper sense of self.

Mindfulness training is about acquiring techniques to focus your attention in that way. You can start by reminding yourself to take more notice of your thoughts and feelings. Tai-chi, yoga and meditation are more formal ways of practicing mindfulness.

- **Practice the techniques as a team**

  The techniques described here are quick and straightforward, that you can do anywhere. Often the trick is simply having the presence of mind to use them when you're caught up in the pressure of the moment. Team learning helps to make them a shared resource - colleagues can prompt each other and offer a different perspective.

Long term pressure

Recognising when long term pressure becomes a problem

Exposure to too much pressure over an extended period can result in chronic stress, which can have a range of negative effects.

You might feel:

- tense, agitated, irritable, tearful, moody, helpless, anxious and/or depressed
- weary - physically and mentally
- apathetic and/or withdrawn
- distracted and/or unable to concentrate.

You may experience problems with:

- relaxation and/or sleep
- judgement and/or memory
- muscle tension, headaches, dizziness, nausea and/or stomach problems
- frequent colds and/or minor infections.

You might also:

- worry constantly, see only the negative and/or feel lonely and isolated
- eat too much or too little
- use caffeine, tobacco, alcohol and/or drugs to help you cope
- put things off.

Feelings are infectious and behaviour is contagious. Too much pressure on one person can affect those working around them or the team as a whole.

This can lead to:

- conflicts and unhappiness
- sickness absence
- poor performance
- complaints and grievances
- people quitting.

Task: How are you coping at the moment?

Develop your self-awareness with this widely used self-assessment test*.

At work in the last month, how often you have felt...	Never	Almost never	Sometimes	Fairly often	Very often
Upset because of something that happened unexpectedly?	0	1	2	3	4
Unable to control important things in your job?	0	1	2	3	4
Nervous and 'stressed'?	0	1	2	3	4
Unsure about your ability to handle problems in your job?	0	1	2	3	4
Things are not going your way?	0	1	2	3	4
You can't cope with all the things that you have to do?	0	1	2	3	4
Unable to control irritations in your job?	0	1	2	3	4
That you're not on top of things?	0	1	2	3	4
Angry because of things that are outside your control?	0	1	2	3	4
Difficulties are piling up so high that you can't overcome them?	0	1	2	3	4
Add up your scores in each column					
Now add all your scores together for an overall score					

Add up your score

0-10 You feel able to cope with pressure at work – you may be practising resilient behaviours already.

11-14 You're coping with pressure at work most, but not all, of the time – start developing your resilience now.

15-18 You're only coping with pressure at work some of the time – this may be affecting your judgement, behaviour and relationships at work; over time, feeling like this may start to affect your health.

19+ You feel overwhelmed by pressure at work – feeling like this will affect your judgement, behaviour and relationships at work, and is likely to damage your health. If you're worried about your health, see a Doctor. Please note this questionnaire is not a professional diagnosis.

*Adapted from the Perceived Stress Scale developed by Dr Sheldon Cohen, Carnegie Mellon University.

Strategies to cope with long term pressure

Strategies to cope with long term pressure aim to help you develop sustainable ways to manage work demands. Here are some examples you might find useful.

Look after your physical health

For example:

- eating a healthy diet
- not smoking
- taking regular exercise
- getting enough sleep.

They help to protect your body from the effects of stress, and maintain emotional balance and optimism.

Look after your mental health

For example:

- connecting with other people
- physical activity
- doing something new
- taking an interest in your surroundings
- doing things for other people.

These things build your confidence and help you to flourish in the world in a positive way.

Task: Do you know how to look after yourself?
Can you answer the following questions about yourself?

- What foods should you eat to ensure you get an adequate supply of energy throughout the day?
- How many hours of sleep do you personally need to feel rested? How often in a week do you sleep that number of hours?
- How much exercise should you be taking in a week? How often do you take it?
- Identify three realistic changes you could make to improve your lifestyle.

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Get the right work-life balance

Life outside work has it's own pressures, which can lead to conflicts between your roles at and outside of work.

Establishing a boundary between work and home is key to establishing a sustainable work-life balance, and helps you manage role conflicts. What constitutes a good work-life balance is individual to you and changes over time, but it should ensure you have space to unwind properly, both physically and mentally.

Try to dedicate some time every day to an activity that gives a you time to yourself.

Task: Write down some activities that you enjoy and/or have been meaning to do. Make an effort to do them in the next month.

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Here are some tips to help you manage your work-life balance.

- **Know and stick to your limits**
  Care work is just as emotionally rewarding as it is demanding. The rewards come from helping people which makes you feel important, valued and good. That makes it hard to say 'no' and all too easy to say 'yes' when you're asked to do something. To manage long term pressure you have to recognise and respect the limits of your time and energy.

Set boundaries

Boundaries between work and home help you to protect your work-life balance.

In theory, boundaries at work are clearly defined by:

- job descriptions
- policies
- procedures.

In practice, the unpredictability of work makes them fuzzy, for example:

- a colleague has to go home early and asks you to cover
- a client needs help so you stay on after regular hours
- emails arrive after work hours.

Keep reminding yourself and others exactly where your boundaries are. Next time you're asked to do something beyond your boundaries, you could say: "I'd really like to help, but I can't swap shifts this weekend" or "It would be great to go out for a drink with you all, but I can't tonight."

Assertive communication

Being assertive means that you express yourself and stand up for your point of view, whilst also respecting the rights and beliefs of others. Here are some tips for assertive communication.

- Use 'I' statements, for example "I disagree" rather than "you're wrong."
- Practice saying no! Be direct and if an explanation is needed, keep it brief.
- Rehearse what you want to say.
- Use assertive body language. Keep your body upright, lean slightly forward, keep eye contact, keep a neutral facial expression and don't use gestures such as crossing your arms.

Time management

Effective time management helps you maintain boundaries and can extend the limits of your time and energy, which makes it easier to deal with the unpredictability and uncertainty of work. Here are some tips for effective time management.

- Plan! Write a list of everything you have to do.
- From this list, prioritise the tasks by importance and urgency.
- If you work in an office, block time out in your calendar to complete tasks.
- Have a simple routine for your day, but allow for unexpected issues.

Task: What are your limits?

Use this exercise to become more aware of your limits. If possible, do the exercise with a colleague. Observe yourself over the course of a week. Notice when you feel pushed beyond your limits. At the end of each day, reflect on what happened.

Think through:

- the situation – what happened, what led up to it, who else was involved and how did you feel at the time
- how it affected you – what buttons it pushed, the thoughts that went through your head, the feelings you experienced and how you reacted physically
- the demand – what was actually being asked of you
- how you responded – what options you felt you had at that moment, how you chose to respond and what prompted you to respond that way
- what the result was – for you and for others
- what other ways you could have responded
- what you can learn from the experience about your limits and how to respect them.

Jot down your answers in bullet form. At the end of the week, get together with a colleague or friend and explain to each other what you've learned about recognising and respecting your limits.

Support from others
Research has found that support networks offer important protection against stress. Building networks of support is a resilient behaviour.

Some types of support are quite structured, such as supervision and appraisal meetings at work. Others are much less formal, such as social networks of colleagues and friends.

They help you to manage pressure in two ways. On a practical level, they're a problem solving resource. On a more personal level, they provide reassurance and make work feel safer.

Bullying and harassment
Bullying and harassment can be significant sources of workplace stress and will undermine efforts to build resilience.

Forms of bullying include:

- excluding people
- belittling them
- gossiping about them
- humiliating them
- giving them unachievable or meaningless tasks
- undervaluing them.

If you experience or witness bullying or harassment, report it. There are well established ways of dealing with it.

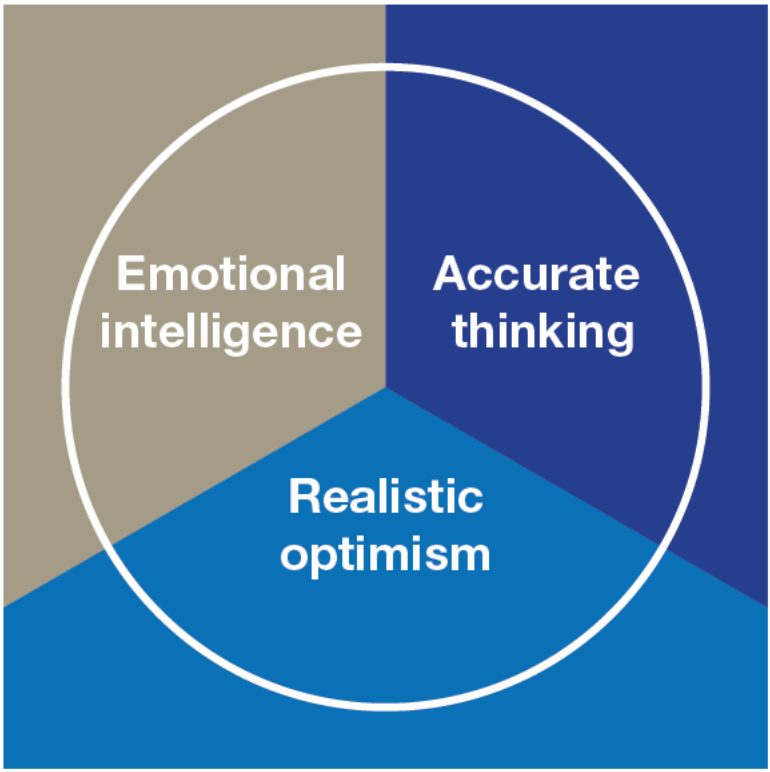
Feeling stressed for a long time can take its toll.

Do something about it now!

3. Building your own resilience, health and wellbeing

Everybody can develop their personal resilience.

There are lots of things that you can do to develop your resilience. We've grouped them under these three headings.



Emotional intelligence

Emotional intelligence is the ability to identify and manage your own emotions, understand what they're telling you and respond thoughtfully to other people's emotions.

It requires:

- **self-awareness –** the ability to identify your feelings
- **self-management skills** – the ability to control your feelings
- **empathy –** sensitivity to other people's emotions
- **interpersonal skills –** the ability to connect with other people and sustain constructive relationships.

There's lots of advice and information about emotional intelligence and how to develop it, on the internet. In the end, it boils down to noticing and reflecting on your own and other people's reactions and responses to things. Here are some tips to help.

Tips for developing your emotional intelligence

- Notice the clues (physical, emotional, thinking or behavioural) that suggest you're finding it difficult to cope, and use a technique (such a 7/11 breathing) to help you manage it.
- Practice identifying your feelings and emotions. Ask yourself what it is you're actually feeling. If possible take a few moments to watch the emotion without trying to change it.
- Notice how the people around you affect your feelings.

- Pause for thought before forming a judgement or reaching a decision, particularly when you feel pressured.
- When faced with a problem, look at it from as many different perspectives as possible. What factors are involved? Is it a problem that can be solved, or not? Are you spending too long worrying about it. If it is possible to solve, then how? Who can help you?
- Make a point of asking yourself what the people around you are feeling and why. What might the situation look like from their perspective?
- When listening to someone, give them your full attention. Try not to interrupt. When they've finished, summarise what you've understood back to them to check your understanding - and to show them you want to understand them.
- When helping people to solve problems, ask them questions to help them arrive at their own solution, rather than coming up with your own solution for them. You could ask simple, sympathetic questions like 'have you had to deal with anything like this before?', 'what did you do?' or 'who might be able to help you'?
- When something doesn't work out as planned remember FAIL – it stands for 'First Attempt In Learning'. If we got everything right first time around, there wouldn't be much learning involved. Reflect on what you can learn from the experience.

Accurate thinking

Accurate thinking means being objective and basing your understanding on facts rather than emotions.

How you think about something helps to determine how you feel about it and what you choose to do about it. That makes it essential to think as accurately as you can, particularly when dealing with any sort of problem.

To think accurately you should:
1. separate facts from information
2. separate facts into two groups: relevant and irrelevant, or important and unimportant.

Try and focus your thoughts on the facts that are important.

Inaccurate thinking

Have you ever watched a friend jumping to a false conclusion, worrying about something that's unlikely to happen or reading far too much into someone's chance remark? They get so caught up in the thing, they lose all perspective. This is 'inaccurate thinking', and there are different ways we think like this, including:

- Filtering out the positive to focus on the negative. For example, ignoring three compliments to focus on one minor criticism.
- Personalising - making every problem about you. For example, if something goes wrong at work and you immediately assume people will blame you.
- Awfulising and catastrophising. For example, automatically assuming that every small problem will turn into a major disaster.

- Polarising. For example, seeing everything as either good or bad or right or wrong, with no middle ground.

Task: Develop your ability to think accurately by observing your own thinking patterns and questioning your conclusions.

Imagine you're walking down the road and you spot a colleague from work walking on the other side of the road. You smile and call out to your colleague, but they ignore you and turn the corner.

What thoughts go through your head? Are they more like pattern A or B?

Pattern A thoughts: automatic negative thoughts	**Pattern B thoughts: other interpretations of what happened**
She doesn't like me	They just didn't see me
I've done something wrong	They had something on their mind
	They need glasses

Pattern A thoughts belong to a category called automatic negative thoughts.

Pattern B thoughts are consistent with balanced conclusions and are a good example of accurate thinking.

Think about other scenarios and write down the automatic negative thoughts, and come up with more positive interpretations.

Scenario:	
Automatic negative thoughts	**Other interpretations of what happened**

Realistic optimism

Realistic optimism means seeing things as they are, accurately, then making the best of them to maintain a positive outlook whilst being aware of the difficulties that exist.

People who are optimistic tend to be happier and more able to cope when times get tough.

However, it's also possible to be unrealistically positive if you pretend things are fine when they aren't.

Consider this idea: The things we can change, we should. The things we can't change, we must accept.

Realistic optimism is not about unrealistic wishful thinking and it's certainly not about ignoring problems.

Realistic optimism is about:

- engaging with life positively and constructively
- taking personal responsibility for your choices
- taking a problem solving approach to difficulty
- looking for solutions.

Tips to be a realistic optimist

- **Reframing**
  Reframing is a way of viewing events and experiences in a more positive way. It doesn't change the situation, but it can help you look at it from a different perspective, which can change your understanding.

  You can feel different ways at the same time about a situation, of course. The important thing is to understand things from as many perspectives as possible. That helps you draw balanced conclusions.

Task: Reframing negative thoughts

Over the next week, write down any negative thoughts you have at work. At the end of the week, revisit them and think how you might reframe them in a positive light.

Thought:	Reframe:	Balanced conclusion:
Example: I've worked here so long now, how boring is that!?	I'm one of the most experienced people here, how great is that!?	On balance, I get a real satisfaction from being here

- **Making the best of a difficult situation**
  A difficult situation presents you with two basic options and then a choice.

- **Develop optimism**
  Emotional intelligence and accurate thinking both help to develop realistic optimism.

  At its heart, however, optimism comes from a feeling that:
  - what you're doing is worth it
  - you have the skills that you need
  - you can deal with the problems and difficulties you're going to encounter.

The best way to develop those feelings is to:
- understand your role and it's value – that means talking about what you do with colleagues and clients
- build networks of mutual support
- take every opportunity to learn and develop.

Reminder of key learning points

You behave resiliently when you:

- manage your own thoughts and feelings
- assess a problem before you try to resolve it
- are realistically optimistic
- think accurately about things
- are sensitive to other people's emotions
- are confident in your own ability to solve problems
- are willing to embrace the new in order to grow.

Personal resilience in a nutshell

- Personal resilience is about self-awareness, coping strategies, networks of support and being positive - these are all things that can be developed.
- Personal resilience is underpinned by the ability to manage in-the-moment and long term pressure.
- Managing pressure begins with recognising when pressure is becoming excessive.
- Too much in-the-moment pressure leads people to misread situations and react inappropriately; repeated often enough, in-the-moment pressure can become a health risk.
- Simple techniques exist to relax, become self-aware and regain control of thoughts and feelings.
- Exposure to excessive long-term pressure results in chronic stress and can produce many negative physical, psychological and behavioural effects.

- Key strategies for managing long-term pressure include addressing the sources of pressure, recognising unhelpful thinking, achieving a good work-life balance, respect for personal coping limits, boundary-setting, assertive communication, time-management and building networks of support.
- Focus personal development on emotional intelligence, accurate thinking and realistic optimism to become more resilient.
- Optimism is linked to feeling that what you're doing is worth it, you have the skills you need to do it and are able to deal with difficulty.

Where can I find out more about resilience?

Investigating resilience online

Resilience is an area where practice and research are developing quickly. Internet searches offer an easy way of keeping up to date with trends and approaches. Put any of the questions below into your search engine for some interesting results.

- What is resilience?
- Resilience and stress at work
- What are resilient behaviours/attitudes/skills?
- How can I become more resilient?
- How can I help others become resilient?
- Resilience training UK



Resources from Skills for Care

Greater resilience, better care

This guide is for managers in adult social care services to help them develop the resilience of their staff.
www.skillsforcare.org.uk/resilience

Learn more about stress at work

This booklet explains what good and bad stress is and how you can use stress to your advantage.
www.skillsforcare.org.uk/resilience

Core skills

We've developed resources to help you develop your English, number, digital and employability skills, including resilience.
www.skillsforcare.org.uk/coreskills

Common core principles to support mental health

This guide provides a basis for a general understanding of promoting good mental health and recognising signs of poor mental health.
www.skillsforcare.org.uk/mentalhealth

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Helping prevent facial skin damage beneath personal protective equipment

9 April 2020

Ensure you have been correctly fitted for the equipment that your organisation uses.

Always follow the guidelines for donning and doffing.

It is recommended that you keep your skin clean and well hydrated/moisturised – apply creams at least 30 minutes before applying PPE.

Consider use of a barrier skin wipe/skin protectant if you are likely to be wearing PPE for extended periods. This will not protect your skin from over-tightening but may protect it from increased moisture. Check the barrier product does not build up residue under the mask.

Take time to fit your mask before starting a clinical consultation. Ensure all folds in your mask have been used to optimise the correct fit for you and do not over-tighten. If you feel your mask is digging in, move away from direct patient contact, remove the mask using doffing guidance and allow the skin to recover for approximately five minutes. Replace your mask with a new one ensuring a good fit.

Regularly inspect your skin for signs of redness/soreness.

It is important that you take regular breaks (we recommend every two hours) from wearing a mask to relieve the pressure and reduce moisture build-up. Where possible, rotate in teams where FFP3 can be removed between clinical shifts. This will help allow the skin time to recover.

Stay well hydrated throughout the day.

Caution: Skin protectants and emollients with white soft paraffin are flammable. You are advised not to smoke with them present on your skin.

If at all possible, avoid the use of dressings as they may compromise mask fit, but if you need to use a product underneath your mask to protect the skin, consider the following:

- the product should be as low profile (thin) as possible
- it is preferable that the product has a tapered edge
- you should ensure you mask still fits correctly; **the fit test should be repeated**
- ensure the skin and your mask/visor are clean and thoroughly dry before applying.

Managing damaged skin

If a break occurs in the skin on your face:

- inform your line manager and complete an incident report
- consider the use of an alternative to the mask, such as a hood
- consider the use of a tapered silicone foam or a thin hydrocolloid dressing to protect your skin, but you must ensure a complete fit of your mask
- remember to remove the dressing each time as part of the doffing process.

These products are recommended as first choice, but the decision should be based on your local formulary and availability.

Guidance for TVNs

Skin care

Maintaining well-hydrated skin is key. Remind staff they should do this by drinking plenty of liquid as well as applying simple moisturisers.

When applying moisturisers, it is advised that they are used at least half an hour before the mask is applied to ensure they sink into the skin and do not damage the material of the mask.

Skin protection

Ensure staff understand that damage can occur due to moisture (sweat in this instance) and also friction if the PPE is not properly fitted or correctly tensioned.

A skin barrier product may help in this instance. Select a barrier product that dries quickly and does not leave residue as this may ‘ball’ under the mask and cause further problems.

Caution: all skin protectants and any emollients with white soft paraffin are flammable: advise staff not to smoke with them on their skin.

Selecting a dressing

While there is no real guidance on which dressing is better than any other, there are some generic principles to consider:

Balance the need for stability of the product against potential skin damage. An adhesive product is much better to prevent slippage, and therefore potential leakage, but can cause problems if removed frequently. Therefore, consider use of skin barriers before applying, and using silicone adhesives unless the staff member has a known allergy. Dressings should be removed and replaced at each doffing as they may be contaminated. An adhesive remover may help reduce damage to the skin.

Fit and seals: the thinner the product is, the better. But also consider how much protection this gives and which force it is offering protection against (pressure, shear or friction). A profile-edged product gives a better opportunity of maintaining the seal than one with blunt edges. The individual should be fit-tested with the product in situ.

The best way to relieve pressure is physical removal of the mask. This should be done at least every two hours if possible. The skin should be wiped free of any sweat and allowed to dry.

If staff are cleaning their masks with wipes, they must ensure any residue is dry before reapplying.

Consider the risk of adhesive leeching and sticking to the mask seal if cutting and shaping adhesive products. Where possible, use appropriately sized and shaped products.

Avoid use of polymer gel shaped products such as Aderma™.

Publications approval reference: 001559

COVID-19 waste management standard operating procedure

6 April 2020, Version 1

This document sets out the waste management approach for all healthcare facilities including primary care facilities and testing facilities in England and Wales during the COVID-19 outbreak.

We need to work together across organisations to collectively deliver waste management services during this period of expanded demand.

A simple and pragmatic approach will be implemented to ensure that waste is managed in a safe manner and critical waste disposal resources are not exhausted during the COVID-19 emergency response.

What does this mean for healthcare staff?

The Advisory Committee on Dangerous Pathogens designates waste arising from COVID-19 patients as infectious clinical waste (EWC code 18-01-03*). It must be packaged in UN-approved orange bags in accordance with the safe management of healthcare waste (HTM07-01). The transport categorisation for this waste is Category B. Sharps and pharmaceutically contaminated items should continue to be segregated appropriate containers sent for incineration, these should not enter the orange bag stream.

In response, all hospitals should ensure that:

- All outer **packaging** must be removed and recycled before an item is taken onto any ward or clinical area. *If this is taken into an isolation or higher risk area, then it is likely to become contaminated and therefore must be disposed as infectious clinical waste*.
- All **food waste** must be disposed of in black bags/compostable bags.
- All **confidential waste** must be put into confidential bins.

- **Soiled linen** must be put into alginate bags and then into relevant outer bags (usually white according to local policy).
- Where **medicines** are prepared in a clean area, pharmaceutical waste must be separated into the blue containers as normal
- All **sharps and anatomical** waste must be put into the relevant receptacle with an appropriately coloured lid as per HTM07-01, and these do not need placing in an orange bag (https://www.gov.uk/government/publications/guidance-on-the-safe-management-of-healthcare-waste).
- **All waste that would usually be put in a yellow bag**[1] should be put in a rigid container for the duration of the COVID-19 response.
- Waste **should not** be routinely double bagged. It is estimated the NHS will use 15 million orange bags a month during the COVID-19 response. We must ensure supply is maintained to everyone.
- Once bagged, waste must be put into carts awaiting collection and disposal. Please ensure that all bins are full before releasing from site:
  - **Note:** There may be a shortage of yellow clinical waste carts (large bins). In this circumstance you should use domestic waste carts and tag them with the appropriate clinical waste consignment.
- Disposal of all waste related to possible or confirmed cases should be classified as infectious clinical waste suitable for alternative treatment and transported as category B, unless the waste has other properties that would require it to be incinerated.
- No domestic waste is to be sent directly to landfill from acute hospital settings.
- In summary, infectious clinical waste should be treated like any other infectious clinical waste – that is, as it would be for TB, hepatitis, etc, following national regulation. Healthcare waste is suitable for non-incineration technologies.

Clinical Waste Bags

- To ensure we can maintain the supply of infectious waste bags (Orange Bags), it has been agreed that NHS Supply chain will supply a single size of bag for the

[1] In the NHS we use a very small number of yellow bags. The reasons for temporarily ceasing their use is twofold:

1. To allow to the required increase in production of the orange bags to cope with demand
2. To ensure we don't have a situation where people are using yellow bags instead of orange bags as we don't have enough incineration capacity in the country to cope with the projected upturn in demand if this were to happen. We need to ensure this capacity is maintained for actual incineration only items.

duration of the Covid-19 response. Orange bags will be available only in an 80-litre size (suitable for larger pedal bins). The supply chain order numbers are:

- **MVN493 (5M available per month):** Orange – 711 x 980mm (28 x 38.5 inch) 40 micron, pillow seal, 80L heavy duty – £1.60 ex VAT roll of 25.
- **MVN849 (10M available per month)**: Orange – 711 x 965xmm (28 x 38 inch) 45 micron, pillow seal, 80L heavy duty – carriage in bulk – £2.80 ex VAT roll of 25

(The Devolved nations will have their own codes for ordering)

Faeces and urine

- Non-ambulatory patients – urine and faeces to be put down the sluice/toilet. Where there is no sluice/toilet available, excreta may be gelled and disposed of in the orange bag. If bed bound, urine from catheter taken to sluice/toilet. The use of these granules must be strictly controlled as described in this NHS National Patient Safety Alert; https://www.england.nhs.uk/publication/patient-safety-alert-superabsorbent-polymer-gel-granules/.
- Ambulatory Patients can go to the toilet as normal where safe and feasible to do so.

Confidential waste in isolation wards

- Confidential waste generated in any wards must be disposed of via the existing confidential waste route. Confidential waste bins should be left for 72 hours prior to shredding.

NHS ambulance trusts

- The above principles should be applied across the ambulance sector.
- Patient transport service (PTS) crews should dispose of their food and packaging waste in general domestic waste bins.
- To minimise the risk of infection, staff and volunteers supporting the transport of patients with confirmed or suspected diagnosis of COVID-19 should implement current guidance for the NHS on appropriate and proportionate use of PPE and decontamination of vehicles. The latest guidance for the conveyance of suspected or confirmed COVID-19 patients can be found at https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts.

Community Patients / clinical staff working in people's homes

- Clinical staff working in people's homes are to leave their PPE behind in a bag, this will be stored for 72 hours before being put into their domestic waste stream.
- Community Teams advising relatives caring for patients in their own home are advised to follow the same guidelines. Storing waste, generated by the patient

/relative for 72 hours before adding to the domestic waste stream in a standard black bag.

Working across government agencies

NHS England and NHS Improvement are working closely with the Environment Agency (EA) to ensure clinical waste is processed in line with legislative requirements. We will continue to work with the EA and other critical agencies, such as the Department for Transport (DfT), to ensure waste flows from healthcare premises to the relevant treatment facilities. Updates on Regulatory Position Statements (RPS) and/or relevant transport authorisations will be posted on the collaboration hub.

General advice from the Environment Agency EA

The EA is working closely with NHS England and NHS Improvement and PHE to review options as the incident progresses. Its strategy (alongside managing other wastes) relies on you meeting all the above NHS requirements. It will continue to provide support via its local officers and/or centrally via the National Performance Advisory Group Best Value Group, and link with the below central waste co-ordination function.

- **Pre-acceptance audits:** when waste is swapped between contractors there will be no requirement to produce a new pre-acceptance audit during contingency arrangements.
- **Expiring pre-acceptance audits:** where a pre-acceptance audit has expired or will expire shortly, the EA will allow the existing audit to be extended to the end of July 2020.

Central waste co-ordination function

To support organisations during this time we have established a central waste co-ordination function. This will:

1. Co-ordinate daily operational activity across the supplier base. Supported by the Cabinet Office, we are working with all suppliers to ensure healthcare facilities are serviced no matter who the contract holder is.
2. Co-ordinate weekly cross-government communication, including from DHSC, Cabinet Office and DEFRA, and link in with the devolved nations, the SMDSA and key regulatory authorities, to discuss matters of escalation and resolution.
3. Be a point of escalation for healthcare organisations needing assistance.

The workstream lead is Fiona Daly, National Sustainability and EFM Workforce Lead. Fiona will be the central point for direct reporting across government, ensuring **business continuity plans** are delivered.

The team is supported by four people working across the system. The team's key duties are:

- manage the **national waste co-ordination function**
- co-ordinate operational requirements from trusts/facilities with the suppliers and planning collections
- support the NHS in ensuring the **standard operating procedure** is being applied. Communication of all waste matters to the NHS and back to the logistics teams for divert support for waste collections.

The team can be contacted at england.wastemanagement@nhs.net

Useful links

Hospitals and healthcare facilities:

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Householders who are self-isolating with suspected COVID-19:

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

Community nursing:

https://www.gov.uk/government/publications/covid-19-decontamination-in-non-healthcare-settings

Primary Care:

https://www.england.nhs.uk/coronavirus/publication/managing-coronavirus-covid-19-in-general-practice-sop/

Admission and care of people in care homes

https://www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes

Advice to local authorities on prioritising waste collections:

https://www.gov.uk/government/publications/coronavirus-covid-19-advice-to-local-authorities-on-prioritising-waste-collections

Contracting

Trusts/Health Boards will not be expected to amend their contract with their existing supplier. A reconciliation process is currently being agreed for England across the supplier base. A process will be defined alongside the Cabinet Office, the NHS England and NHS Improvement Commercial team and Deloitte. This will be offered to NHS Wales also. Further guidance will follow.

Government has produced two guidance notes in respect of payments to suppliers and retendering and extensions of contracts:

- https://www.gov.uk/government/publications/procurement-policy-note-0120-responding-to-covid-19
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874178/PPN_02_20_Supplier_Relief_due_to_Covid19.pdf

Trusts should consider this guidance in respect of waste contracts and, as far as possible, use the flexibilities in line with this guidance.

Trusts are advised that there is unlikely to be a stable market to retender contracts during the COVID-19 emergency response and therefore they should carefully consider grounds for extension of existing contracts where these are due to expire imminently. Trusts should work with suppliers and, if appropriate, provide relief against current contractual terms (eg KPIs and service credits) to maintain business and service continuity. Please let us know immediately if you are experiencing any issues.

If you have any queries or questions, then please contact our logistics cell's dedicated waste management team at: england.wastemanagement@nhs.net

Nottingham City Council | Nottinghamshire County Council | NHS

Care About Medicine

Medicines information for staff in a social care setting

Providing Information, Support & Guidance on managing medicines effectively

Special edition March 2020

Coronavirus Contingency - Safe Administration of Medicines from Original Packs in Care Homes

Due to the coronavirus (Covid 19) pandemic, community pharmacies are becoming overwhelmed. As a result, care homes may now receive medicines for residents in their original packs, rather than medications being dispensed in a blister pack/monitored dosage system.

To ensure staff are aware of how to safely administer medicines this way, it is essential that ALL staff who administer medicines have read and understood this information sheet

We recommend this is printed and placed on your medicines trolleys and cabinets

- **How to store the medicines?**

It is best practice if medicines for each individual resident are stored together.

Often care homes use separate containers to store each resident's medicines in. This keeps all the medicines for one resident together. These must then be locked away.

Make sure any medicines that need cold storage are placed in the medicines fridge and any Controlled Drugs (CDs) are locked in the Controlled Drug cupboard and a record made in the CD register.

- **What is the difference between administering medicines from original packs compared to blister packs?**

You may have got into the habit of selecting the medicine from the appropriate section of the blister pack when you were administering from the MDS (monitored dosage system) without fully reading all the important details.

EVERY time you administer medication you MUST read the label very carefully for each medicine and check each detail on the label against the information on the MAR sheet. The details MUST agree before you can administer the medicine.

- **How should medicines be administered?**

To make sure no medicines are forgotten, it is best to administer the medicines in the order they appear on the MAR sheet. If you work down the MAR sheet in a systematic order, you will be less likely to make a mistake.

Be aware there may be more than one MAR chart for each person, remember to double check the medicine label against the MAR sheet paying particular attention to the 6 Rights-i.e. you are giving the right person, the right medicine, at the right dose, at the right time, using the right route and bearing in mind the person has the right to refuse.

- **Where are the particular areas of risk?**

There are many areas of risk with administering medicines. Here are a few of the common ones:

When you administer tablets from a manufacturer's original pack, make sure you take the strip of tablets out of the box, check the back of the strip to make sure the name of the medicine printed on it corresponds with the name of the medicine on the label, pop out the tablet into a medicine pot and then replace the strip back into the box straight away.

You must make sure you only administer one medicine at a time and replace the strip of medicines back into the box immediately. This will reduce the likelihood of you replacing the wrong strip of medicines into the wrong box.

When you pop tablets or capsules out of a manufacturer's original pack, select the tablet in a consecutive order (i.e. use the pack as if it were a day marked pack) and not just randomly. This will ensure you don't get left with all sorts of odd tablets in amongst the empty popped blister strips and will make auditing much easier and will reduce the likelihood of error.

Where medicines have been dispensed by the pharmacy into plain tablet boxes, you must be particularly careful to avoid error.

- **Only administer one medicine at a time.**

Be careful of medicines that have the same name but different strengths e.g. medicines for Parkinson's or epilepsy -often people might be taking a combination of different strengths at different times of day.

- **Will it take longer to administer medicines using original packs?**

Yes, to start with, as you need to get used to checking every single detail on the label against the MAR sheet for each medicine, one point at a time. Like most things, the process will speed up as you get used to doing it. There are no short cuts.

- **How should the administration of medicines be recorded?**

You must record on the MAR sheet whenever you administer a medicine so this should be no different to what you have been doing before. It must be obvious which medicines have been given, when they were given and by whom. The MAR sheet must be an accurate record of all medicines that have been received into the home, those administered and those refused and you must have a record of which medicines have been returned.

- **Do staff need to be trained to administer medicines?**

YES , REMEMBER—Make sure staff are fully trained and have been assessed as competent before they administer medicines.

The information in this newsletter does not cover all aspects of medicines handling.

If you require any help or information please see contact details below.

With thanks to

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CASCAIDr

Ten things that all care home managers should know

Please use this within the care home and pass it on to staff, residents and relatives – it's been composed in order to promote good decision-making and protect against misinformation during the Covid-19 crisis.

1. DNAR and ReSPECT forms

A DNR/DNAR/DNACPR form is something that a **capacitated** person can choose to fill out as an indication that they do not want to be resuscitated, should they cease breathing independently.

Making and recording a decision about CPR in advance and communicating it to those who need to know about it, can help to ensure that as far as is humanly possible, **inappropriate** CPR is avoided.

It is a person's personal **choice** whether they fill out a DNAR form and to do so they must have capacity to understand what they're signing. They should be given the time required and proper, well-informed information, against which to consider the consequences and implications of their decision.

When a medical ***professional*** fills out such a form, it is an indication that their clinical opinion is that it would not **work,** so should not be attempted, usually because the patient is dying from an advanced and irreversible condition. A medical professional should never unilaterally impose that view as a ban on treatment.

In a case where this is the view, and the person lacks capacity to discuss the matter with a medical professional, the person's **family** should be consulted (unless before losing capacity the person stated that this should not happen). Family members should be made aware of the person's condition, their chances of survival and plans for treating them, or not, before such a record is added to the records of any incapacitated person.

So the fact that such forms may have been **issued for thinking about, in the Covid-19 crisis,** is not wrong in *itself* - nor should the mere receipt of such forms convey an expectation that a GP is requiring or expecting them to be completed and signed by or 'for' all residents by care home managers …

Here is a link to the Resuscitation Council's guidance on DNAR/DNACPR processes: https://www.resus.org.uk/faqs/faqs-dnacpr/ and information about **DNARs** and what is known as the **ReSPECT** Process can be found here: https://www.resus.org.uk/respect/?assetdeta3af2d45-c6ff-4793-84c9-61858f65b520=31444

Two other forms on the RH side of that ReSPECT page are worth looking at: the **ambulance** guide and the **clinician's** guide.

A DNAR form is not a **formal Advance Decision**, which *can* be binding on medical professionals to prevent treatment from being administered. The only way to know if those words were included in an apparent Advance Decision is to look: the signed and witnessed document must contain words must make clear that the refusal of the specific treatment is to apply, **even if life is at risk** – which it obviously will be if the person has stopped breathing – but which would also be the case if they needed to be on a ventilator. See https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Advance-Decisions-to-Refuse-Treatment-Guide.pdf

A DNAR form is not legally binding *unless* it is in the form of an advance decision signed by the person themselves, and with the special words required. See here for more guidance on Advance Decisions: https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/

2. Next of Kin's and relatives' rights - and limits to those rights

If the person **lacks** capacity through mental or physical infirmity (e.g. advanced dementia, delirium, a low BMI, hypoxia), their next of kin or wider group of relatives are not final ***decision***-makers on the DNAR issue. Neither is the care home manager.

(NB A person with a **registered Lasting Power of Attorney** over a person's welfare, **may** have been given that power through opting IN to **special wording in section 7 of that document**, if the person being cared for wanted to give a power to refuse life sustaining treatment to the person granted the LPA, for a time in the future when the grantor lost capacity.)

If there is no LPA holder with that power, then people interested in the welfare of the individual, e.g. the family and the person in charge of their care should be consulted before a best interests conclusion is reached **and recorded in advance on a DNAR form –** which conclusion is **still** not binding**.** A person's closest supporters might well want to record their views about what they think the person would have wanted, regarding resuscitation, but that is information for the clinical team at the hospital, not a decision that a paramedic, or the care home manager or a GP **can properly regard as a decision about or justification for refusing treatment or hospitalisation of that person.**

A short profile of the person's condition, needs, capacity when not unwell, their dependency and other information that can be shown to a paramedic or read out to a GP for their input based on what they know of the patient is just as important for good triage, once a person gets to hospital. A photograph with a date stamp on it as to when the person was last enjoying some quality of life, would be helpful.

If a person in the home lacks capacity, and **no family members are available** to be consulted (even on the phone) about best interests balance sheet approach about hospitalisation or treatment that could well be invasive and disproportionate or intolerable to the person, **then an IMCA should be appointed by the council and may need to act quickly**. IMCAs should know about new guidance from the Court of Protection on when an application may need to be made to the Court of Protection for a decision about best interests.

The fact that certain medical treatments (including, where relevant, withholding or withdrawing treatment on best interests grounds) are defined as 'serious' does not require that they should be subject to an application to the Court of Protection. Rather they indicate the need for special care and attention to the decision-making process surrounding them, **including the appointment of an Independent Mental Capacity Advocate in appropriate circumstances.** It may not be necessary to apply to the Court of Protection if everyone agrees about a person's best interests regarding resuscitation or life-saving treatment, but only if decision makers can demonstrate:

- the provisions of the Mental Capacity Act 2005 and relevant guidance in the Code of Practice have been followed; and
- relevant professional guidance has been observed; and
- there is agreement at the end of the decision-making process as to the decision-making capacity of the person and the best interests of the person in question.

In those circumstances, in principle, medical treatment may be provided to, withdrawn from, or withheld in accordance with the agreement, without application to the court, in reliance upon the defence in section 5 Mental Capacity Act 2005. If, however, at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is:

(a) finely balanced, or
(b) there is a difference of medical opinion (e.g. as to the risks or prospects of success), or
(c) a lack of agreement as to a proposed course of action being in the best interests of the person from those with an interest in the person's welfare, or

(d) there is a potential conflict of interest on the part of those involved in the decision-making process

then it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration must always be given as to whether an application to the Court of Protection is required and that should be all that one needs to say to the Hospital, Ambulance Trust or Safeguarding team, if **rationing** scarce resources seems to be what is driving the views of those discussing hospitalisation or treatment: there will be a conflict of interest and a serious one in that situation - unless those opposing hospitalisation or treatment are able to point to the source of their legal authority and a rationale that is not **blanket, or arbitrary**, in its approach to care home residents, their condition or their age.

Where any of the above matters arise and the decision relates to the best interests aspect – to the pros and cons of specific life-sustaining treatment **– as opposed to its scarcity, availability or non-availability, an application to the Court of Protection must be made.** This is an inalienable facet of the individual's rights, guaranteed by the European Convention on Human Rights ('ECHR') and this specifically includes the withdrawal or withholding of clinically assisted nutrition and hydration. **If scarcity or rationing seems to be the issue, judicial review is the right route for challenge.**

The most recent case in which this approach has been used is *Sherwood Forest Hospitals NHS Foundation Trust v H* (https://www.bailii.org/ew/cases/EWCOP/2020/5.html)

The link to the practice guidance from the Court of Protection is found here: https://www.bailii.org/ew/cases/EWCOP/2020/2.html

3. Being clear about hospital visiting during the virus crisis

Relatives can only hope to indicate their view of what would be in the person's best interests if they are acting on a well-informed basis. Nobody in a caring profession would ever want to mislead people's family members as to their legal rights, but care home managers are not likely to be experts in human rights or NHS law, regarding the allocation of scarce resources, even if they are strong on the Mental Capacity Act.

a) When someone's heart and breathing stop because they are dying from an advanced and irreversible condition, CPR will subject them to a vigorous physical intervention. **It may deprive them of a dignified death or prolong the process of dying and, in doing so, prolong or increase suffering.**
b) In the Covid-19 period, people's families need to understand (and may well depend on care home managers for discussion of best interests) that

    i. Hospitals accommodating patients in the UK **are not allowed to impose blanket bans on visiting those patients**. Hospitals are public places and hospital managers can and do have policies, not rules - for visiting - and exceptions must be made before the hospital can be said to be respecting everyone's human rights.

    ii. Some hospitals' policies will set **out** the exceptions in advance, such as for 'end of life' patients, and impose infection control conditions - but even if they do **not**, they are obliged to permit people to make the assertion that one's loved one is an exceptional case and needs to be visited.

https://www.nhs.uk/using-the-nhs/nhs-services/hospitals/visiting-someone-in-hospital/ is a link to the NHS information on hospital visiting.

https://www.bbc.co.uk/news/uk-northern-ireland-52055447 is a link to the position in N. Ireland and is a typical policy described by the media as a ban, which turns out **not** to be a ban, so be warned and be astute! Visiting a relative in hospital is not against the Coronavirus Staying at Home regulations. Those regulations **allow** for providing care or assistance to a vulnerable person. It is inconceivable that someone visiting a seriously ill patient in hospital would be given a fixed penalty notice.

4. Admission to hospital and access to specialist treatment

It is the law in this country that doctors are not allowed to ration treatment, and hospitals are not allowed to refuse **admission**, on the basis of age, disability or the concept of clinical frailty, or the person's likely dependency on hospital care or resources.

Clinicians may, in **extreme circumstances**, **not yet current**, have no option but to allocate access to critical care or specialist equipment, taking into consideration a range of factors informed by their ethical code, such as

a) the **current capacity of the hospital** – capacity in terms of empty beds, sufficient PPE, the date of patients' admission to hospital, the number of staff available to work to support patients if allocated to those beds

b) the person's **individual clinical presentation**, the prospects of benefiting from what could be provided, the likely period over which the person would need to occupy a hospital bed if provided with the treatment, the risks and drawbacks of the treatment in question, the person's wishes and feelings, and if the person lacks capacity, the views of people interested in that person's health and wellbeing.

See links here for the NICE guidance on access to critical care, including the clinical frailty algorithm it recommends doctors could use. https://www.nice.org.uk/guidance/ng159/chapter/1-Admission-to-hospital. Note that the very first page makes it clear that this document is regarded as good guidance for allocation **to critical care *only***, NOT for admission to hospital in the first place.

Furthermore, it is considered by the British Medical Association to be ethically not inappropriate if **the NHS were to become stretched beyond its capacity to treat everyone according to need**, for clinicians to pursue agreed policies for rationing treatment – for instance, withholding or only providing treatment for a limited period, from those not expected to benefit significantly from it or those who have not benefited from it within a certain time, or ordering people in terms of the date of their admission to hospital in the first place. The BMA does not have the authority to do anything more than suggest what those policies might be.

See here for that BMA thinking: https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf

See here too for the Royal College of Physicians' ethical guidance for the Covid-19 period:

https://mcusercontent.com/feeeed3bba7c179fd3a7ef554/files/f5cf180e-c1bf-4e63-8199-4171f30b5026/Ethical_dimensions_of_COVID_19_for_front_line_staff_1_.pdf

It should be noted that in a very recent case, since the virus began, the courts have said this about Human Rights and the rationing of resources:

"In some circumstances, a hospital may have to decide which of two patients, A or B, has a better claim to a bed, ***or a better claim to a bed in a particular unit, even if ceasing to provide in-patient care to one of them will certainly cause extreme distress or will give rise to significant risks to that patient's health or even life.*** *A hospital which in those circumstances determines* ***rationally, and in accordance with a lawful policy, that A's clinical need is greater than B's, or that A would derive greater clinical benefit from the bed than B, is not precluded by Article 3 ECHR from declining to offer in-patient care to B. This is because in-patient care is a scarce resource and, as Auld LJ put it in R v***

North West Lancashire Health Authority ex p. A [2000] 1 WLR 977, at 996, "[i]t is plain… that article 3 was not designed for circumstances… where the challenge is as to a health authority's allocation of finite funds between competing demands". Decisions taken by a health authority on the basis of finite funds are, in my judgment, no different in principle from those taken by a hospital on the basis of finite resources of other kinds. In each case a choice has to be made and, in making it, it is necessary to consider the needs of more than one person.

Analytically, the reason why a decision to require a patient to leave a hospital is unlikely to infringe Article 3 ECHR is because it is based on a prior decision ***not to provide [further] in- patient care.*** *Such a decision engages the state's positive (and limited) obligation* ***to take steps to avoid suffering reaching a level that engages Article 3****, rather than its negative (and absolute) obligation not itself to inflict such suffering. Where the decision to discontinue in-patient care involves the allocation of scarce public resources,* ***the positive duty can only be to take reasonable steps to avoid such suffering****: cf R (Pretty) v Director of Public Prosecutions [2002] 1 AC 800, [13]-[15] (Lord Bingham).* ***It is difficult to conceive of a case in which it could be appropriate for a court to hold a hospital in breach of that duty by deciding, on the basis of an informed clinical assessment and against the background of a desperate need for beds, to discontinue in-patient care in an individual case and, accordingly, to require the patient to leave the hospital.*** *The present is certainly not one.*

Even though the decisions to cease to provide in-patient care to MB and to require her to leave, plainly interfere with MB's right to respect for private and family life, the evidence adduced by the Claimant amply ***demonstrates that the interference was justified in order to protect the rights of others,*** *namely those who, unlike MB,* ***need*** *in-patient treatment. Bearing in mind the broad discretionary area of judgment applicable to decisions of this kind, there is* ***no prospect that MB will establish the contrary****."*

The link to this case (*University College Hospitals Foundation Trust v MB*) is here:
https://www.bailii.org/ew/cases/EWHC/QB/2020/882.html

The judge accepted that a decision by an NHS hospital not to provide in-patient care in an individual case might, in principle, be **challengeable on public law grounds, by judicial review** (NOT the Court of Protection, please note) if the decision were tainted by **improper purpose or had been made in breach of statutory duty or otherwise contrary to law. So that position preserves public law challenges for anyone to raise in the Covid-19 period, for instance on the basis of a blanket policy of non-admission or non-selection of anyone aged over 90, or just based on being disabled intellectually or physically, assuming the property owner is a public body amenable to judicial review, such as hospitals.**

An important difference between this and any other case that might arise in the context of accessing a ventilator or an ICU bed, is that here, the view was very firmly reached that this woman MB did not **NEED any other treatment the hospital could possibly give her**, whereas in a Covid-19 related competition for a ventilator, it could well be different.

So although this case points to the difficulty of challenging a rationing decision of the nature that may be driving all sorts of people not to seek or push for hospitalisation of care home residents, **it must be made clear to patients and their loved ones that it is always going to be possible to use law against blanket, discriminatory or irrational policies** that are contrary to ethical and professional values ("outrageous in their defiance of logic or accepted moral standards" – Lord Diplock in a seminal case on *irrationality*.)

5. The Home's duty of care, regarding standing up for an incapacitated person's rights to be considered for hospital admission - AT the hospital

A care home manager, a paramedic, an ambulance trust or the NHS should not therefore refuse to convey a patient (or acquiesce in someone else's refusal) who otherwise needs to go to hospital, on the grounds of the setting where a person lives, or their age or condition, or diagnosis. Just as anyone living

in their own home with any friend of neighbour or the means to call a cab will take themselves to hospital, people in a care home are entitled to an equal chance to be treated.

It is part of a duty of care in the law of negligence, owed to all in the care home, to call the emergency services and be able to assert a person's basic rights – such as making sure that any advance decision that they have made or any other statement of wishes, or the views of an LPA welfare holder with the special authority over life sustaining treatment - and a profile of that person's recent health and well-being - is passed on to the authorities.

A person who is struggling to breathe and for whom human or nursing or mechanical assistance is beyond the capability of the person's residential or nursing home staff or registration level, **has a right to be considered for NHS treatment of all levels;** it must be part of the duty of care owed to all residents that those looking after them will take reasonably practicable steps to ensure that this occurs, including asking anyone who refuses, to tell them what the source of their authority for that stance *is thought to be*.

6. Hospital Discharge arrangements during the Covid-19 crisis

In the Covid-19 crisis period, anyone who goes to hospital (with Covid-19 symptoms or for something else unrelated) will be discharged as soon as it is possible to discharge them safely **even if they have not been tested to negative status**. See here for the hospital discharge policy which explains the current vision for Discharge to Assess within 2 hours of a person's fitness for safe discharge.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/880288/COVID-19_hospital_discharge_service_requirements.pdf

That document makes clear that the NHS is obliged to fund their follow-on care, unless and until it decides that the person does not qualify for NHS continuing health care.

It is suggested in the document that the local authority will continue to contract for the care of that person if they are already so doing, but that the NHS will fund the care. The person's status as a self-funder, or a person whose assets are above or below the capital threshold, will not be relevant and should not delay discharge. Care homes might therefore wish to consider applying a scale of fees (whether banded or not) that makes no distinction between those who have been publicly funded, or privately funded, up to admission to hospital.

The Adult Social Care Plan issued 15 April 2020 has a section on funding which is the government's commitment to ensuring that sufficient funds are available to support rapid hospital discharge:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879639/covid-19-adult-social-care-action-plan.pdf

"4.3 We expect local authorities to get the funding they have received quickly to the front line. Local authorities should take steps to:

• Protect providers' cashflow, including making payments on plan in advance;

• Monitor the ongoing costs of delivering care, such as higher workforce absence rates caused by self-isolation, sickness and family caring responsibilities; and

• Adjust fees to meet new costs."

On the 18th April, the government doubled the amount of money it had already committed to supporting local authorities through the crisis.

7. Admission and re-admission arrangements

Privately funded care home clients cannot be evicted without regard to the Protection from Eviction legislation because they are residential occupiers, even though they are not **tenants**.

Service users who are publicly funded are also protected as residential licensees, through permission for their occupation having been procured by the public body's contract for their benefit, together with the necessary care.

Any care home contract that provides for less than 28 days' notice may not be ***lawful*** given that it cannot abide by that overriding legal right to protection under the above Act. The Act requires 28 days' notice and due process through the **courts** (ie a possession action) if the person will not leave voluntarily. Some people will lack mental capacity and need a litigation friend, even to defend proceedings.

We think that most care home contracts (whether for privately or publicly funded clients) contain a term providing for shorter notice to be given if the home's management has reason to believe that it cannot meet the person's needs any longer – and that in general the Protection from Eviction legislation is not considered because the council or CCG will still owe a duty to meet a person's needs – and urgently - in any event, whether or not the local authority has adopted the Care Act easements described in section 10 below.

During the Covid-19 crisis, however, **NO possession actions are being heard by the courts**, and all will be 'stayed' (put on ice). This measure will cover all private and social renters, as well as those with mere licenses covered by the Protection from Eviction Act 1977.

An **injunction** can, however, be sought, and the *MB* case referred to above, brought by a hospital, is an example of the use of that solution, and is not dependent on notice having expired, if notice has at least been *given*.

Apart from the possibility of such notice terms being triggered, by genuine concerns about how to isolate people who have not got a negative testing status, nor completed 14 days' isolation from first symptoms, publicly funded residents ought only to arrive or return from hospital **with their needs documented to at least a level that enables preparation of a detailed care plan by the home**.

Care home managers are not automatically obliged to accept, or to accept BACK, people to their homes, for care, where their needs have not been sufficiently documented or recorded as to enable the manager to make a professional decision whether the Home can deliver safe, appropriate care, whilst managing the duty of care to other residents and their own staff. The home is providing care together WITH accommodation, as one integrated and inter-dependent package.

Their registrations with CQC depend on them remaining financially viable and not taking on responsibilities that they cannot deliver upon, for the price that has been agreed, whether in a framework or on the spot at the time the bed is needed. Care home managers are professional people and not public servants – contracting with the council does not make them formal partners of councils and CCGs.

Any Guidance directed to them from government only constitutes advice and requests unless a piece of legislation provides specific authority for a **direction**.

8. Human Rights obligations owed directly by care homes

Care homes **owe human rights**, as a matter of law, to all publicly funded clients, directly, and must in particular discharge the function of providing care together with accommodation in a way that recognises and delivers upon what is required by the **right to life, freedom from inhuman or degrading treatment, the freedom from unjustified deprivation of liberty and the right to respect for private and family life and the person's home.**

The home's **owners** must fund compliance with these obligations in order for the service to be a fit service for purpose, and therefore must be able to justify their decisions regarding the resourcing of managers' day to day functions, so far as staffing, PPE and all other strategic decision-making are concerned.

Section 73 of the Care Act 2014 is where this legal status stems from, and it has not been suspended or modified. It was the position for care homes anyway, under the Human Rights Act 1998, giving them the status of a public body, for legal claims about any breach of human rights.

9. Accessing Personal Protective Equipment, beyond what homes' management have been able to source

All Homes are being assisted to cover PPE shortages by the parallel supply chain that the government has set up, the details of which can be found below.

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe is the link to government guidance on PPE.

Local authorities have been given funding to meet the likely increased costs of meeting needs properly, in the Covid-19 crisis. They are obliged to tell government how they are ensuring that providers get that funding so that the care home market remains viable.

10. Care Act functions

Since April 1st, Councils have been given the option to regard the Care Act duties of assessment, eligibility and review as suspended, but whether they have chosen to do so, is a matter for them.

If they so decide, then they must notify this intention to the DHSC, and put it on their websites. The implications will be for assessment functions and care planning. A care home faced with a decision to reduce an existing client's publicly funded budget is not obliged to meet ONLY the needs that the council might wish that home to meet. They can decline to keep the client/patient if the commissioner will not contract for care that the home can demonstrate is required in order to meet need safely, in professional terms.

Despite the Covid-19 crisis, a care home is still its own-decision maker as to whether it accepts variations of public sector contracts, and if it does not, it is not a criminal or civil law wrong to reject unilateral variation of a contract. The extent of responsibility and risk that care homes choose to agree to accept under the law of contract, is a separate matter to the rights of the member of the public who is owed a duty by a public body, in respect of the meeting of their needs, or who is being provided with services through a public body's commissioning, under a statutory power such as s19 of the Care Act, or under the auspices of **safeguarding**.

Unless or until councils decide to adopt the easements, the Care Act duties and all the principles that underpin a **rational, transparent and sufficient personal budget** continue to apply and amount to a set of rights for the client, upheld through public law.

When a council decides to adopt the Care Act easements it must explain how it is doing that, and there may be a role for providers to play, to help councils through this period – such as Trusted Assessor Status for assessments and reviews.

Here is the guidance for councils as to what they must consider before adopting the easements:

https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities

April 2020

Email: info@cascaidr.org.uk

Website: www.cascaidr.org.uk

Social Media: @CASCAIDr on Facebook and twitter

If you think that this sort of level of guidance is valuable to you and to members of the public, please do distribute it.

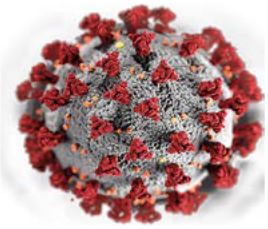
Please also DONATE whatever you can – here's our online donation button:

https://ssl.nochex.com/cascaidr/default.aspx

CASCAIDr functions without any public support: we are unable at present to take on new referrals for ongoing casework, but remain committed to providing a steer through our triage service if you make a referral via our site https://www.cascaidr.org.uk/free-advice/

We aim to offer clear, legally literate guidance to support service users, carers, practitioners and strategic leaders during the outbreak. We aim to survive as a charity so that we can continue to stand up for legally literate social work once the Care Act is brought back into full force!

The Coronavirus



The Coronavirus is a virus that can make people feel unwell.

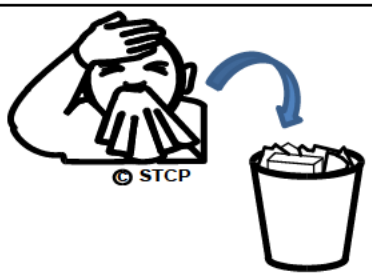
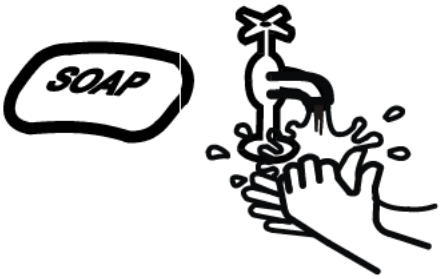
COVID19 or
CORONAVIRUS

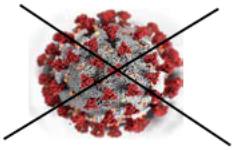
The Coronavirus can also be called "COVID-19".

People who have the Coronavirus may have:

- Sore Throat
- Dry Cough
- A Fever
- Difficulty Breathing

Most people who have the Coronavirus will stay at home to get better.

	Some people who have the Coronavirus will go to the hospital to get better.
	To help stop the spread of germs, people must cough or sneeze in a tissue then put the tissue in a bin.
	To help stop the spread of germs, people must wash their hands with soap and water: • Before eating • After sneezing • After touching your nose or mouth
	We should take our time when we wash our hands. Washing between fingers and all over our hands.
	Use a hand sanitiser if there is no soap.
 	People are not allowed to go to busy places. Lots of shops, events and places are staying closed. You will have to spend more time at home.

	Your family and staff will help you find activities to do at home.
 	Places will be closed to try to stop lots of people catching Coronavirus and let everyone get better. Just like other types of flu, the Coronavirus will go away.
   	It is important that we follow what the Government and NHS ask us to do. If you are worried about Coronavirus you can talk to family or staff who support you. There are people who can help you.

Produced by Speech and Language Therapy

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Covid - 19
16 March 2020

Supporting your employees and business through uncertainty

Practical hints & tips

Presented by
Nikki Hufton & Sian Cattell

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Current situation

- COVID-19 has been declared a pandemic by the World Health Organization and moved from contain to delay phase in the UK.
- It will pose a significant challenge to many organisations as more people become ill and cannot attend work.
- If you are an employer you have certain responsibilities to your workforce as well as keeping the business on the road.

The symptoms too look out for are:

- a high temperature (37.8 degrees and above)
- a new, continuous cough

You do not need to call NHS 111 to go into self-isolation.

If your symptoms worsen during home isolation or are no better after 7 days contact NHS 111 online at 111.nhs.uk.

If you have no internet access, you should call NHS 111.

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Good hygiene practice

Make sure your workplace is clean and hygienic.

Promote regular and thorough hand-washing by everyone.

Provide all employees with an alcohol-based hand rub where possible.

Encouraging people to use and bin tissues.

Hygiene Promotion

CATCH IT

Germs spread easily. Always carry tissues and use them to catch your cough or sneeze.

BIN IT

Germs can live for several hours on tissues. Dispose of your tissue as soon as possible.

KILL IT

Hands can transfer germs to every surface you touch. Clean your hands as soon as you can.

NHS

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Contingency planning

- Assess your level of exposure to business disruption caused by the virus.
- Will you have direct impact to day-to-day operations from suppliers?
- Build a contingency team: a person, or small group of people, to take responsibility for operating and implementing the contingency plan implementation.
- They should meet regularly to review the preparations and ensure they are still fit for purpose. It's important to act early, even if planned contingencies are not then needed.
- NOTE: Having a policy or procedure written down is NOT enough.

Contingency planning

Response Stage	Trigger	Key Actions	Who	Notes
STAGE 1 – GENERAL	None	(everyday hygiene and procedures) None - General reminders for hygiene/spotting symptom - Display handwashing poster - Effective handwashing facilities and soap available - Follow usual absence periods for sickness - Review cleaning routines/frequency		
STAGE 2 – PREVENT	Where in increased risk is present - Increased absence rates of staff - Public health alerts – - Suspected cases of specific illness in workplace or within the community	- Increase hygiene procedure - Communication with key people including key information - Support people self-isolating - Consider flexible working - Consider events and make changes i.e. training and conferences - Daily review of the situation - Who are your key people/areas of the business - What contingency measures can you put into place?		
Stage 3 – Slow infection	Where a significant risk is present - direct case or increased likelihood of cases - Public health advice for restrictions	Consider reducing contact situations: Team meetings - Send staff home with any symptoms - Additional Cleaning including deeper cleans		
Stage 4 Contain	Where specific and/or significant changes or restrictions need to be in place - High levels of sickness - High rates of absence - Significant danger of disease or illness	- Part / full closures of site / - Deep cleans - Reduction or exclusion of visitors		

Travel advice

- Foreign & Commonwealth Office travel advice is constantly under review, so that it reflects the latest assessment of risks to British people.

- In response to coronavirus measures they are advising against all but essential travel to some countries, cities and regions.

- You must check the travel advice to the country you are travelling to

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Chancellors Budget

Statutory Sick Pay (SSP) – New measures to become law in the forthcoming COVID-19 Bill.

- If linked to Coronavirus : Statutory Sick Pay will be made available from day one (instead of from day four).

- The Budget also announced employers with less than 250 employees can claim a refund for COVID-19 related SSP costs (up to two weeks per employee).

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Medical evidence for SSP:

- Employees can currently self-certify for the first seven days employers should use discretion around the need for medical evidence for absence where an employee is advised to self-isolate.

- Govt to introduce a temporary alternative to the current fit note in the coming weeks for the duration of the COVID-19 outbreak.

- Those in self-isolation can obtain a notification via NHS 111 to use as evidence for absence from work.

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Working from home where possible?

What if employees can't work from home?

What if employees need to care for family (children/parents) members?

Communication Strategy

Internal

- Keep emails short and to the point with links to policies or content via links
- Tell colleagues when to expect further communication
- Brief managers well with the most up to date information on your organisations approach

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Questions?

For more support call 0800 567 7003

Get direct guidance by registering as a member through the website.

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Covid - 19
20 March 2020

Supporting your employees and business through uncertainty

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School closures and Key workers-

Health and Social Care workers (including volunteers, support and admin staff, cleaners, supply chain producers and distributors)

Education and Childcare (nursery and teaching staff, social workers)
Key Public services (police, religious staff, charities and workers running frontline services)

Local and National Govt (admin if essential to Covid 19 response, payment of benefits)

Further Key workers- vital jobs for public health and safety

Food (production, distribution, sales and delivery)

Police, MOD, armed forces personnel, fire and rescue, prison and probation staff etc

Transport workers

Key public services related to local and national government admin roles including benefit payments; postal and justice systems, religious staff

Utility Workers, essential financial services, police and support staff

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Social Care Sector -

Wholesale closure of workplaces in the social care sector is not an option.

Maintaining services is key and those working in this sector are now identified as Key workers for child schooling purposes.

Should your staff contract the virus measures would include:

- Controlling the spread after infection.
- Prioritisation of services.
- Cancelling annual leave.
- Increasing pay.
- Use of agency staff.

Social Care Sector -

Wholesale closure of workplaces in the social care sector is not an option.
Maintaining services is key
Should your staff contract the virus measures would include:

- Controlling the spread after infection.
- Prioritisation of services.
- Cancelling annual leave.
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Working from home

- Have a routine
- Find a work space
- Stay in touch
- Get active

Presented by
Nikki Hufton & Sian Cattell

School Closure

- Be open that the kids are with you
- Expect Interruptions
- Let them say hello – Its fun
- Have things in place for key times
- Shorten calls and meeting times

Presented by
Nikki Hufton & Sian Cattell

Essential Employee Crisis Communication

- Be proactive
- Get a team together. ... Virtually
- Act fast—but only say what you know to be true
- Make your communication continuous
- Inform when and through what channels you will communicate
- Use leaders
- Key considerations – health and safety (hse.gov.uk), kindness and compassion and consider the messages could go external .

Marketing in a crisis

- Giving back – free resources
- Socially responsible!
- Don’t wrap it up as community service, if it is to about cash flow
- Use free platforms and take advantage of expertise
- Consumers: • Stopped • Patient •Well off • Live for today
- Essentials • Treats • Postponables • Expendables
- Call 07952 67862 • contact@indigodrumcommunications.com

Source: https://hbr.org/2009/04/how-to-market-in-a-downturn-2

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Questions?

For more support call 0800 567 7003

Get direct guidance by registering as a member through the website.

Working together to improve end of life care

Community Palliative, End of Life and Bereavement Care in the COVID-19 pandemic

A guide to End of Life Care symptom control when a person is dying from COVID19 care for General Practice Teams,
prepared by the Royal College of General Practitioners
and the Association for Palliative Medicine

First Edition March 2020

Adapted from Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland: COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care, Version 2

Collated for General Practice Teams by:
Dr Catherine Millington-Sanders and RCGP COVID-19 End of Life Care Advisory Group

This guidance is produced during the COVID-19 outbreak in order to support the care in the community of patients and those important to them, at the end of their lives or who are unwell as the result of COVID-19 or other life-limiting illnesses.

This document will be updated and adapted as further contributions are received and in line with changing national guidance. The most current version of the guidance document will be available on the public-facing pages of the RCGP COVID-19 Resource Hub and Association for Palliative Medicine website (https://apmonline.org/). Please check that you are referring to the most current version.

Also check COVID government updates: https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response

For national examples of contingency medication list options for symptom control and resources to support carer administration (after considering any safe-guarding risks), please see RCGP COVID-19 Resource Hub - palliative care section.

Index

Supporting RCGP COVID-19 Community Palliative and End of Life Care resource list
https://elearning.rcgp.org.uk/course/view.php?id=373

The management of symptoms related to infection with COVID-19 including care at the end of life in the community

Primary care teams have responsibility to provide or refer for essential palliative and end of life care, both for those with a pre-existing health condition and those who may die as a consequence of infection with COVID-19. It is important to remember that most people infected with COVID-19 virus have mild disease and recover. Of the laboratory confirmed patients, approximately:

- 80% have had mild to moderate disease
- 15% require admission to hospital for severe disease. This population is a concern for GPs in the need to know how these patients will be managed in Primary care after hospitals reaches full capacity, and the burden of workload shifts to Primary Care
- 5% require admission to an intensive care unit and are critically ill.

Some people will become severely unwell in the community due to COVID-19 or due to unrelated illnesses whilst self-isolating due to the outbreak. When analysed by age, the mortality rate due to COVID-19 equates closely to the one-year mortality rate for the population of the same age.

Some terminally ill patients will enter the last stages of life and die in the community. Primary care teams need to be prepared and supported to manage this. Clinicians should have access to local specialist palliative care teams for additional advice and guidance if required. As the pandemic progresses, it is likely that both hospice-based and home-based specialist palliative care services will be difficult to access.

Discussions about care plans

Conversations about preferences and priorities, including advance decisions to refuse treatment, are part of advance care planning for anybody who has a progressive life-limiting illness. In the context of people who have severe COVID-19 disease, honest conversations about preferred place of care, goals of care and treatment escalation planning should be initiated as early as is practicable so that a personalised care plan can be documented and revised as the situation changes. Families and carers should be involved in these discussions as far as possible and in line with the person's wishes.

In the context of COVID-19, the person is likely to have become ill and deteriorate quickly, so the opportunity for discussion may be limited or lost. Families and carers may be shocked by the suddenness of these developments and may themselves be ill or required to self-isolate. As far as possible it remains important to offer these conversations. Equally, it is a person's right to not be forced to have these conversations. Being kept informed helps to reduce anxiety, even in highly uncertain situations and even if the conversations need to be conducted behind PPE or, by telephone or video consult. Primary care may consider opportunistic conversations with its most high-risk patients in advance of them being infected, where capacity allows.

If advance care planning conversations have already been documented, then colleagues involved in the person's care should be made aware of the person's wishes, where possible using shared electronic medical record systems and Electronic Palliative Care Coordination Systems (EPaCCS) so that other colleagues including out of hours and emergency services are able to understand the person's wishes as well as updating family and carers contact details to support their involvement in their care.

Adult Safeguarding

Even in the midst of a pandemic, clinicians should be aware of and follow the Mental Capacity Act 2005 principles:

1. The patient must be assumed to have capacity
2. The patient must be given all possible support to make decisions
3. The patient can make unwise decisions [subject to restrictions for infection control which apply to everyone]
4. Any decision taken about a person without capacity must be in their best interest [Subject to considerations of justice in the use of limited resources]
5. Any decision taken about a person without capacity should be the least restrictive

Any concerns about an adult being harmed or neglected must be escalated through the normal safeguarding adult pathways.

Domestic violence and abuse (DVA), perpetrated by one (or multiple) adult family members against another can be physical, emotional, sexual and/or financial. Risk factors for DVA include social isolation, frail health, and increased dependence on another for care. The COVID-19 pandemic will cause an increase in deaths at home and face-to-face support may be more limited, increasing the risk of abuse not being identified. Good communication will be needed between healthcare teams with safe, timely information recording any concerns about DVA on the patient electronic medical record.

For more information, read the full guidance on Domestic Violence and Abuse in the context of end of life care in the COVID-19 pandemic on the RCGP COVID-19 Resource Hub.

How to use the symptom management flowcharts

These flowcharts relate to the relief of the common symptoms that may arise because of an infection with COVID-19, including how they should be managed if the patient is dying:

Local palliative care guidelines already exist for other symptoms commonly experienced by people with advanced serious illness. The following symptom flow charts take the general approach of:

- correct the correctable
- non-drug and drug approaches

Examples of supportive treatments for correctable causes include:

- antibiotic treatment for a secondary bacterial infection may improve fever, cough, breathlessness and delirium
- optimising treatment of comorbidities such as chronic obstructive airways disease or heart failure may improve cough and breathlessness.

Typical starting dose of drugs are given. However, these may need to be adapted to specific patient circumstances. Some reports are highlighting that for some people dying of COVID-19 the end can be rapid with severe breathlessness. We have a duty to assess and ensure patients, receive appropriate symptom control, to relieve distress without delay. It may be necessary to rapidly titrate symptom relieving drugs by intravenous or subcutaneous injection to relieve distress.

It is important to regularly assess the symptoms of individual patients dying of COVID-19 symptoms and these may vary in severity for each patient. The frequency and dosing must be assessed on an individual basis and adjusted according to their need. For example, severe COVID-19 symptoms, may require higher or more frequent doses, which may include increasing the starting doses or having a low threshold to titrate quickly. Clinicians should access local specialist palliative care teams for advice and guidance if required.

Please note that all routes of administration of drugs should be considered and the choice depends on availability of equipment such as syringe drivers and of staff that are able to administer drugs via different routes. Consider other routes such as buccal, rectal, transdermal. Discuss with the patient's family or carers ways they may administer of medications.

When prescribing medications, as always in end of life care, consider how large a supply may be needed and avoid distress in acute deterioration. Local pharmacy planning measures should be considered to support recovery of unused drugs rather than destroying them, to avoid national shortages. It may also be helpful to work with your local pharmacy teams to enable health care professionals to carry a locked supply drugs for recorded, emergency use in the community.

Management of fever Primary care
COVID-19 Outbreak

Consider accessing local specialist palliative care teams for advice and guidance if required

Fever is when a human's body temperature goes above the normal range of 36–37° Centigrade (98–100° Fahrenheit). It is a common medical sign. Other terms for a fever include pyrexia and controlled hyperthermia. As the body temperature goes up, the person may feel cold until it levels off and stops rising.

Is it fever?

- Significant fever is defined as a body temperature of:
  - 37.5ºC or greater (oral)
  - 37.2ºC or greater (axillary)
  - 37.8ºC or greater (tympanic)
  - 38ºC or greater (rectal)

- Associated signs & symptoms:
  - shivering
  - shaking
  - chills
  - aching muscles and joints
  - other body aches

Non-pharmacological measures

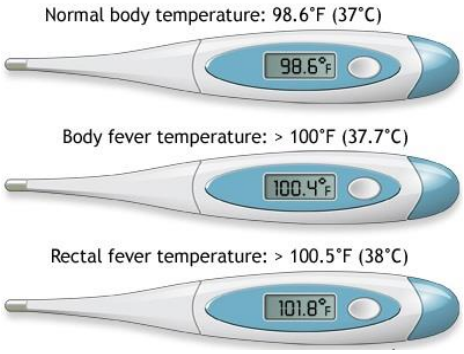
- Reduce room temperature but not to the point of inducing shivering
- Wear loose clothing
- Cooling the face by using a cool flannel or cloth
- Oral fluids
- Cooling the face by using a cool flannel or cloth
- Portable fans are **not** recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent but if self-isolating this may not be so relevant

Pharmacological measures

- Paracetamol 1g PO / PR QDS

It is not advised to use NSAIDs in patients who may recover from COVID-19

- In the dying patient who is not expected to recover from Covid -19 it maybe appropriate to use ibuprofen orally or diclofenac to control fever via a s/c driver



Management of cough Primary care
COVID-19 Outbreak

Consider accessing local specialist palliative care teams for advice and guidance if required

Cough is a protective reflex response to airway irritation and is triggered by stimulation of airway cough receptors by either irritants or by conditions that cause airway distortion.

Cough hygiene

To minimise the risk of cross-transmission:

- Cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping & blowing the nose
- Dispose of used tissues promptly into a closed waste bin
- Clean hands with soap and water, alcohol hand rub or hand wipes after coughing, sneezing, using tissues

Non-pharmacological measures

- Oral fluids
- Honey & lemon in warm water
- Suck cough drops / hard sweets
- Elevate the head when sleeping
- Avoid smoking
- Humid air may help if it is possible to provide this

Pharmacological measures

- Treat underlying causes such as superadded bacterial infection
  or uncontrolled COPD, HF or asthma- this may help symptoms even in the dying person
- Simple linctus 5-10mg PO QDS
  if ineffective
- Codeine linctus 30-60mg PO QDS
  or
- Morphine sulphate immediate release solution 2.5mg PO 4 hourly

If all these measures fail, seek specialist advice to discuss:

- use of sodium cromoglicate 10 mg inhaled 4 times a day (can improve cough in people with lung cancer within 36-48 hours)
- if severe / end of life: morphine sulphate injection 10mg via a syringe driver over 24 hours and 2.5–5mg SC 4 hourly PRN

Management of pain
COVID-19 Outbreak

Consider accessing local specialist palliative care teams for advice and guidance if required

Patients may experience pain due to existing co-morbidities but may also develop pain as a result of excessive coughing or immobility. Such symptoms should be addressed using existing approaches to pain management.

Patient on no analgesics - mild pain

- Step 1:
  - start **regular** paracetamol (usual dose 1g four times a day)
  - dose reduction is advisable in old age, renal impairment, weight <50kg, etc
- Step 2:
  - persistent or worsening pain: stop paracetamol if not helping pain
  - start codeine 30-60mg four times a day **regularly**
- Step 3:
  - maximum paracetamol and codeine, persistent or worsening pain: stop paracetamol if not helping pain
  - stop codeine
  - commence strong opioid (e.g. oral morphine)

****NSAIDS contraindicated in COVID-19****

Commencing strong opioids

- start either an immediate-release (IR) or a modified-release (MR) preparation
- ALWAYS prescribe an immediate-release morphine preparation prn
- starting dose will depend on existing analgesia – calculate dose required
- monitor the patient closely for effectiveness and side effects
- always prescribe laxatives alongside strong opioids
- always prescribe an antiemetic regularly or prn

Suggested starting doses

- opioid-naïve/frail/elderly
  - morphine 2.5-5mg PO IR 4 hourly
- previously using regular weak opioid (e.g. codeine 240mg/24h)
  - morphine 5mg PO IR 4 hourly or MR 20-30mg BD
  - frail/elderly: use lower starting dose of 2.5mg PO IR 4 hourly or MR 10-15mg BD
- eGFR <30
  - seek advice

Titrating oral opioid dose

- if adjusting the dose of opioid, take prn doses into account
- check that the opioid is effective before increasing the dose
- increments should not exceed 33-50% every 24 hours
- titration of the dose of opioid should stop when either the pain is relieved or unacceptable side effects occur
- if pain control achieved on IR consider conversion to MR opioid (same 24-hour total dose)
- seek specialist advice if analgesia titrated 3 times without achieving pain control / 3 or more prn doses per day / total daily dose of oral morphine over 120mg / day unacceptable side effects

When the oral route is not available

- if analgesic requirements are stable - consider transdermal patches (e.g. buprenorphine, fentanyl)
- if analgesic requirements are unstable consider initiating subcutaneous opioids
- seek specialist advice if necessary
- morphine is recommended as the first line strong opioid for subcutaneous use for patients, except for patients who have been taking oral oxycodone or those with severe renal impairment
- if constant pain, prescribe morphine 4 hourly SC injections or as 24-hour continuous infusion via a syringe driver (McKinley T34)
- conversion from oral to SC morphine: oral morphine 5mg ≈ SC morphine 2.5mg
- wide inter-individual variation exists and each patient should be assessed on an individual basis
- prn doses of 1/10 to 1/6 of regular 24-hour opioid dose should be prescribed 2-4 hourly SC prn

If first line medications are unavailable, consider local guidance on contingency 2nd / 3rd line options

Consult your local pharmacy guidelines for guidance. National examples can be found on the RCGP COVID-19 Resource Hub

Minimise stock wastage. If available, consider if a syringe driver is helpful

If subcutaneous administration not possible, consider alternative routes e.g. buccal, rectal, transdermal

Management of breathlessness
COVID-19 Outbreak

Consider accessing local specialist palliative care teams for advice and guidance if required

Breathlessness is the subjective sensation of discomfort with breathing and is a common cause of major suffering in people with acute, advanced and terminal disease. In assessing breathlessness, you may want to consider respiratory rate, observation of breathing, use of accessory muscles, evidence of cyanosis and difficulty in completing sentences. Treatment of underlying causes of dyspnoea should be considered and optimised where possible. Both COVID-19 and non-COVID-19 conditions) ***may*** cause severe breathlessness / distress toward end of life.

Reversible causes

COVID -19 often causes breathlessness in its own right and this should be managed with supportive and symptomatic treatment however for many patients there may be other reversible causes contributing.

- Reversible causes should be identified and treated where possible. This would include treatment of superadded bacterial infection, and adequate management of underlying conditions such as COPD, asthma or heart failure.
- Even in the dying patient symptoms may be improved with treating these conditions and it should be considered

Non-pharmacological measures

- Positioning (various advice depending on position: sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward)
- Relaxation techniques
- Reduce room temperature
- Cooling the face by using a cool flannel or cloth
- Portable fans are <u>not</u> recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent but if someone isolated at home this may not be relevant
- Mindful breathing techniques, distraction and psychological support can all reduce the sensation of breathlessness.

Pharmacological measures

- Opioids may reduce the perception of breathlessness
  - Consider Oramorph 2.5-5mg prn (or equivalent opiate)
  - If needed, consider morphine modified release 5mg bd (titrate up to maximum 30mg daily if solely for breathlessness)
  - Morphine 1.25-2.5mg SC prn if unable to swallow titrated up if needed
  - Midazolam 2.5-5mg SC prn for associated agitation or distress
- Anxiolytics for anxiety
  - lorazepam 0.5mg SL prn
- Consider administration via s/c
- Consider oxygen (no evidence of benefit in the absence of hypoxaemia)
- Consider anti-emetic + laxative for morphine/opiate side

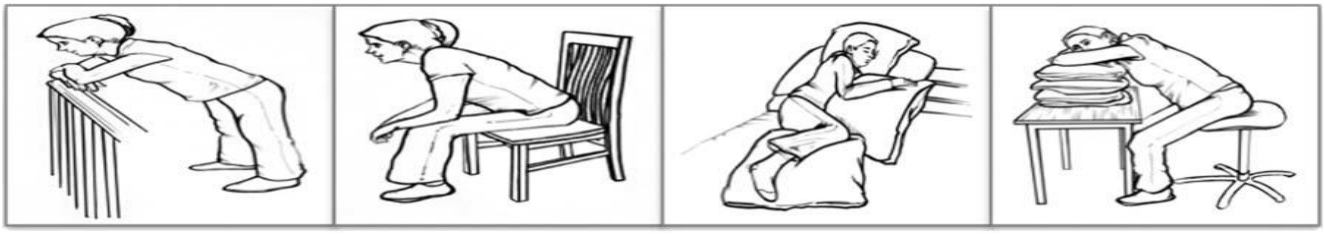
Pharmacological measures – Acute Respiratory Distress Syndrome

Patients can rapidly deteriorate with ARDS COVID-19 symptoms - these can be extremely distressing for the patient and family. **In individual circumstances and depending on the degree of distress, starting doses of medications to help manage breathlessness may need to be increased by up to 50%.** e.g. Morphine (or equivalent opiate), midazolam. If repeating doses, remember subcutaneous medications can take at least 20 minutes to build effect.

o Morphine 2.5-5mg SC prn. Can be titrated to resolution of symptoms and repeated when symptoms begin to recur.

o Midazolam 2.5-5mg SC prn for associated agitation or distress. Can be titrated to resolution of symptoms and repeated when symptoms begin to recur. Higher doses for severe uncontrolled distress at the end of life may be required in patients rapidly dying of COVID-19. IV administration may be indicated - severe cases in extremis

If first line medications are unavailable, consider local guidance on contingency 2nd / 3rd line options
Consult your local pharmacy guidelines for guidance. National examples can be found on the RCGP COVID-19 Resource Hub
Minimise stock wastage. If available, consider if a syringe driver is helpful
If subcutaneous administration not possible, consider alternative routes e.g. buccal, rectal, transdermal



Forward lean 1 | Forward lean 2 | Adapted forward lean for lying | Adapted forward lean for sitting

Management of delirium Primary care
COVID-19 Outbreak

Consider accessing local specialist palliative care teams for advice and guidance if required

Delirium is an acute confusional state that can happen when someone is ill. It is a SUDDEN change over a few hours or days, and tends to vary at different times of day. People may be confused at sometimes and then seem their normal selves at other times. People who become delirious may start behaving in ways that are unusual for them - they may become more agitated than normal or feel more sleepy and withdrawn.

Identify and treat underlying causes

- Identify and manage the possible underlying cause or combination of causes and treat these
- These include:
  - superadded infection,
  - drugs,
  - dehydration
  - constipation
  - urinary retention
  - hypoxia
- The delirium may be a direct symptom of COVID-19 therefore treatment options may be limited

Non-pharmaceutical measures

- Ensure effective communication and reorientation (for example explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium
- Ensure adequate care and supervision from family, friends and carers to help with this
- Ensure that people and those looking after them have adequate access to medical input
- Avoid moving people within and between rooms or care settings where possible and keep stimulation at a minimum
- Ensure adequate lighting
- Sometimes providing reassurance that delirium can be a typical symptom of infection can be helpful

Pharmacological measures: mild to moderate to severe

Haloperidol is generally the drug of choice for both hyper- and hypo-active delirium:

- start with 500 microgram / 24h CSCI or PO/SC at bedtime and q2h prn
- if necessary, increase in **0.5−1mg increments**
- median effective dose 2.5mg/24h (range 250 microgram - 10mg / 24h
- consider a higher starting dose (1.5-3mg PO/SC) when a patient's distress is severe and / or immediate danger to self or others

If the patient remains agitated, it may become necessary to add a benzodiazepine, e.g.

- lorazepam 500 micrograms-1mg PO bd and prn
  or
- midazolam 2.5-5mg SC prn 1-2 hourly

Pharmacological measures: end of life (last days / hours)

Use a combination of levomepromazine and midazolam in a syringe driver
Levomepromazine (helpful for delirium)

- start 25mg SC stat and q1h prn (12.5mg in the elderly)
- if necessary, titrate dose according to response
- maintain with 50-200mg / 24h CSCI
- alternatively, smaller doses given as an SC bolus at bedtime, bd and prn

Midazolam (helpful for anxiety)

- start with 2.5-5mg SC/IV stat and q1h prn
- if necessary, increase progressively to 10mg SC/IV q1h prn
- maintain with 10-60mg / 24h CSCI

If the above is ineffective, seek specialist palliative care advice

If first line medications are unavailable, consider local guidance on contingency 2nd / 3rd line options. National examples can be found on the **RCGP COVID-19 Resource Hub**

Management of this symptom, which is distressing for both relatives and staff (patients are usually unaware of what they are doing at this time) can be troublesome. Through use of the medications above, titrated appropriately, this can usually be managed effectively.

- Prevention of delirium is better than cure, so meticulous adherence to delirium prevention strategies (orientation, prevention of constipation, management of hypoxia, etc) is essential
- Adoption of daily screening, using Single Question in Delirium (SQiD) and / or 4AT rapid test for delirium (https://www.the4at.com/) to detect early and treat cause

Care immediately before and after death

A proportion of people who have severe COVID-19 will die of the infection or complications. This guidance includes a flow chart of what needs to be done and how best to support people in this situation, throughout this period. Bereavement support will be essential particularly for those with existing mental health conditions. In most parts of the country, bereavement services already exist and it will be important to understand your local support options. It is also important to consider the role of compassionate communities and supportive networks within them available. Experience in previous disaster situations tells us that community support and local group initiatives will be most valuable on the path to recovery for bereaved and traumatised.

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times.

Staff should be aware that this guidance is subject to change as developments occur. Check for updates on the RCGP COVID-19 Resource Hub. Additional information can be found here; https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response. Funeral directors and Coroners offices can be contacted for additional support and guidance.

Important considerations for Care immediately before and after Death where COVID-19 is suspected or confirmed

(Information to do with certification apply to England and Wales – information about Scotland and Northern Ireland is in the box at the bottom of the flowchart)

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's family/significant other/s

BEFORE DEATH

Decisions regarding escalation of treatment will be made on a case by case basis

If death is imminent and family wish to stay with their loved one, they should be advised regarding infection risk and should wear full PPE

Consider the patient's spiritual or religious needs; if appropriate, signpost to whatever resources are available in your local area.

VERIFICATION OF DEATH

Inform and support the family and/or next of kin. Consider their spiritual or religious needs and signpost to appropriate resources in your local area.

Appropriately trained professional completes Verification of Death process wearing required PPE and maintaining infection control measures.

Verification of death process should be completed as per local policy/guidelines.

Any equipment used in the Verification of Death process should be either disposed of or fully decontaminated with Chlorclean solution

Emotional/Spiritual/Religious needs of the deceased and their family/significant other/s

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times.

Staff should be aware that this guidance is subject to change as developments occur. Check for updates on the RCGP COVID-19 Resource Hub. Additional information can be found here; https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response. Funeral directors and Coroners offices can be contacted for additional support and guidance.

MEDICAL CERTIFICATE OF CAUSE OF DEATH

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased' s family/significant other/s

Emotional/Spiritual/Religious needs of the deceased and their family/significant other/s

Appropriate Doctor completes Medical Certificate of Cause of Death as soon as possible

↓

Covid-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death. A swab is not necessary if the doctor feels that to the best of their knowledge and belief, Covid-19 is the cause of death.
Covid-19 is notifiable but it is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009.

↓

The body does not need to be seen for cremation paperwork, unless the patient has not seen a doctor in the 28 days before death.

↓

Where next of kin/ or a possible informant are following self-isolation procedures or ill or unavailable, arrangements can be made for the funeral director to act as an informant. Documents should be signed, scanned and sent by secure email and the originals posted or kept safe for collection at a later date, depending on local arrangements. See further section on "Registering the

↓

If referral to HM Coroner is required **for another reason**, notification should take place as soon as soon as possible and is legally required in writing.

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times.

Staff should be aware that this guidance is subject to change as developments occur. Check for updates on the RCGP COVID-19 Resource Hub. Additional information can be found here; https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response. Funeral directors and Coroners offices can be contacted for additional support and guidance.

CARE AFTER DEATH

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's family/significant other/s

If deceased has been tested for covid-19 and no results please treat as high risk.

Full PPE should be worn for performing physical care after death. Information on PPE can be found in the "PPE requirements" table on the final page of this document.

Mementoes/keepsakes e.g. locks of hair, handprints etc. must be offered and obtained during physical care after death by person/s wearing full PPE, as they will not be able to be offered at a later date. They should be placed in a sealed plastic bag and families advised to NOT open for 7 days.

The act of moving a recently deceased patient might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk - a body bag should be used for transferring the body and those handling the body at this point should use full PPE

Registered nurses to complete Notification of Death forms fully including details of COVID-19 status (NEW SECTION) and place in pocket on body bag along with body bag form, ID band with patient demographics placed through loops in body bag zip.

The outer surface of the body bag should be decontaminated (see environmental decontamination https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/wuhan-novel-coronavirus-wn-cov-infection-prevention-and-control-guidance#decon) immediately before leaving the clinical area. This may require at least 2 individuals wearing PPE (check your local PPE guidance), in order to manage this process.

Ensure that anyone involved in moving the body is aware of confirmed or suspected COVID-19

If someone has died in a care setting, the deceased's property should be handled with care as per policy by staff using PPE. Items that can be safely wiped down such as jewellery should be cleaned with Chlorclean and securely bagged before returning to families.
Clothing, blankets etc. should ideally be disposed of or treated as per local policy. If they must be returned to families they should be double bagged and securely tied and families informed of the risks

Consider bereavement support for the family and/or carers of any confirmed or suspected COVID-19 deaths and refer on as appropriate

Emotional/Spiritual/Religious needs of the deceased and their family/significant other/s

NB - ORGAN/TISSUE DONATION IS HIGHLY UNLIKELY TO BE AN OPTION AS PER ANY OTHER ACTIVE SYSTEMIC VIRAL INFECTION

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times.

Staff should be aware that this guidance is subject to change as developments occur. Check for updates on the RCGP COVID-19 Resource Hub. Additional information can be found here; https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response. Funeral directors and Coroners offices can be contacted for additional support and guidance.

Clear and complete documentation

Open. honest and clear communication with colleagues and the deceased' s family/significant other/s

REGISTERING THE DEATH

All deaths must be registered by an informant and it is now expected that this will be done remotely

Where the deceased's next of kin or a possible informant are following self-isolation procedures, ill or unavailable a funeral director can act as an informant on behalf of the family. Where there is no alternative informant available, a member of Bereavement Service/Office staff can register the death as an "occupier".

Wherever possible, the following information is required to be given to the Registrar by whoever is registering the death;

- NHS number
- Date of death
- Full name at death
- Details of any other names that the deceased has been known by
- Maiden name if applicable
- Date of birth
- Place of birth
- Occupation and if deceased retired
- Marital status
- Full Name of spouse/civil partner if applicable
- Spouse/Civil Partner occupation and if retired
- Full address and postcode of deceased
- For statistical information date of birth of spouse and the industry they work/worked in and if they supervised staff

USEFUL CONTACT INFORMATION AND RESOURCES

Public Health England https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response
Public Health Wales. https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/
Health Protection Scotland https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/
HSC Public Health Agency Northern Ireland https://www.publichealth.hscni.net/news/covid-19-coronavirus
Public health declaration of Covid-19 as a notifiable disease https://www.legislation.gov.uk/nisr/2020/23/made
Mental capacity legislation www.legislation.gov.uk/nisr/2019/190/pdfs/nisr_20190190_en.pdf

Emotional/Spiritual/Religious needs of the deceased and their family/significant other/s

Holistic Care - Psychosocial, Spiritual, Religious and Cultural beliefs of patients and families

In these unprecedented times, the spiritual care of our patients will become increasingly important as people grapple with spiritual questions regardless of whether they have a faith or none. As primary care clinicians we need to acknowledge these questions as part of our care and be able to signpost people to where they can receive ongoing support. In some areas, Primary Care Chaplaincy will be vital to support us in these conversations giving an opportunity to consider what makes life meaningful and how to find inner hope and strength during the time of personal and national crisis. Our practices may have links with community faith groups which will help the specific communities in which we work. Although this may be an area of care that we are less familiar with, it is increasingly important we consider it as an integral part of holistic end of life care. The Association of Chaplaincy in General Practice offers useful advice and support http://acgp.co.uk/

It is important that we are able to link with existing compassionate neighbourhood and community initiatives which help people, families and neighbourhoods to support each other, in terms of the practical help of shopping, cooking, cleaning etc and the emotional support of friendship and care. Going into the future, there will be the need for peer support bereavement groups/cafes to help deal with the psychological aftermath of the COVID-19 pandemic. Each GP surgery can offer support simply knowing and being able to advise where to find information about local groups, so that patients and families can be linked with them. Our community connector roles will provide vital links between our patients, the practice and existing community services and supportive networks within our communities.

- National example of GP Surgery Bereavement leaflet - https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2020/03/NHS-Bereavement-Leaflet.pdf
- COVID CRUSE - Grief and Trauma - https://www.cruse.org.uk/coronavirus/trauma
- A collaborative guide to COVID-19 care - https://covid-at-home.info/

Looking after yourself and colleagues

As we sadly anticipate many community deaths from Covid-19 it is important we consider how to provide effective palliative care that meets the physical, social, psychological and spiritual needs of our patients, not just at the end of their lives but at different points along the trajectory of this disease. We will also be providing care and support for the families of our patients in circumstances that will make preparing for death more difficult.

In addition, the uncertainty of the progression of the illness, the pressure that we will be working under and the sheer scale of the pandemic and subsequent deaths will mean that we, as primary care clinicians, will be working in unfamiliar, emotional territory.

In order to care effectively for our patients and their families, we must care for the physical, social, psychological and spiritual needs of our colleagues and ourselves. Firstly, we need to recognise our own vulnerabilities and the effect of our emotions upon our behaviours. It is important to develop within our team safe spaces, psychologically and physically, to talk about these and the effect upon our wellbeing.
We must develop mindful and deliberate compassion towards each other which involves noticing and being present in each other's suffering as well as creating flexible time to cope with suffering, buffering each other from overload as outlined in the GMC document, "Caring for doctors, Caring for patients". https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf

We all will have anxieties, we will feel the burden of risk, we will be faced with suffering and death and at times will be limited in what we are able to do. We will feel tired and overwhelmed. We will not be failing our patients or our teams by feeling these things.

We will need to come alongside each other in our daily teams, or virtually, to identify with others who will be feeling the same. At times we will be able to be steady and calm in the face of the great suffering. At times we will seek this compassion from others. It is a time to show we value each other and confer dignity to each other. We need to be reaching out and establishing these networks of support now. Start by asking someone you work with how they really are.

Resources

Resources for looking after ourselves and each other during this very difficult time.

UK: Support with mental wellbeing, finance, housing and unemployment
https://www.mentalhealth.org.uk/coronavirus

England: NHS Practitioner Health provides https://www.practitionerhealth.nhs.uk/covid-19-workforce-wellbeing

Northern Ireland: www.nidirect.gov.uk

Scotland: section on Mental Wellbeing: https://www.nhsinform.scot/illnesses-and-conditions/infections-and-poisoning/coronavirus-covid-19

Wales
For doctors in training: Professional Support Unit HEIW.ProfessionalSupport@wales.nhs.uk
For all doctors: Health for Health Professionals www.hhpwales.co.uk

RCN – COVID and your mental wellbeing
https://www.rcn.org.uk/get-help/member-support-services/counselling-service/covid-19-and-your-mental-wellbeing

These websites provide professionals with direct links to health, wellbeing and other referral sites for doctors in need.

BMA Wellbeing support services - Open to all doctors whether BMA (British Medical Association) members or not and is staffed by professional telephone counsellors 24 hours a day, 7 days a week. They are all members of the British Association for Counselling and Psychotherapy and are bound by strict codes of confidentiality and ethical practice. You can even choose to remain anonymous when you call.

DocHealth - A self-referral service available to all doctors, UK wide, and aims to provide confidential, specialist-led support for those suffering with stress-related depression or anxiety. The programme will initially run as a 24-month pilot, and aims to complement existing support services such as BMA Counselling and the Doctor Advisor Service. It is a joint venture from the RMBF and BMA. DocHealth is exclusively self-referral, with no report writing unless specifically requested by the doctor using the service. Fees are based on a sliding scale relating to the grade and circumstances of the doctor.

Doctors Support Network - A self-help group for doctors with mental health concerns, including stress, burnout, anxiety, depression, bipolar affective disorder, psychoses and eating disorders. All doctors in the group have been troubled at some stage in their lives. There are regular meetings around the UK, a newsletter and an email forum.

GMC (General Medical Council) online guide 'Your health matters' - Provides the first step in this support, helping to provide timely information for doctors who may for health reasons be involved in the GMC's fitness to practise procedures. The content was written with the help of Practitioner Health Programme, the Doctors' Support Network and the British Medical Association.

Practitioner Performance Advice (formerly NCAS) - Allows you to self refer, if you are returning to work after a period of absence, or you have health problems which may be impacting on your performance, and they will provide expert advice about the steps you can take and where you can go for help.

Royal Medical Benevolent Fund - A UK charity for doctors, medical students and their families. They provide financial support, money advice and information when it is most needed due to age, ill health, disability or bereavement.

Sick Doctors Trust - A proactive service for actively addicted doctors that is structured to provide an early intervention programme. The trust facilitates treatment in appropriate centres, arranges funding for inpatient

treatment and provides advocacy and representation when required. A charitable trust controlled by a board of trustees and staffed by doctors in recovery.

Samaritans - supporting anyone through branches across the UK and Republic of Ireland

Support for doctors - Academy of Medical Royal Colleges - A listing of websites that can offer support

Managing mental health challenges faced by healthcare workers during covid-19 pandemic
BMJ 2020;368:m1211
https://www.bmj.com/content/368/bmj.m1211

COVID-19: Support for Businesses

The government has announced a full range of measures to support businesses, public services and individuals during the coronavirus (Covid-19) pandemic. This document outlines what support is available to businesses and where and how they can access it.

It is important to note that there could be other schemes offering support that are unknown at the current time.

The measures that have been made available to businesses include:

- A Coronavirus Job Retention Scheme where small and large employers will be eligible to apply for a government grant of 80% of workers' salaries up to £2,500 a month. The scheme will be backdated to March 1 and available for at least three months.
- A new Coronavirus Business Interruption Loan Scheme (CBILS) will be delivered by the British Business Bank. It will enable businesses to apply for a loan of up to £5 million, with the government covering up to 80% of any losses with no fees. Businesses can access the first six months of that finance interest free, as government will cover the first six months of interest payments.
- For businesses with fewer than 250 employees, the cost of providing 14 days of Statutory Sick Pay (SSP) per employee will be refunded by the government in full. This will provide two million businesses with up to £2 billion to cover the costs of large-scale sick leave. The online service you'll use to reclaim SSP is not available yet. HMRC will announce when the service is available and guidance will be issued via the gov.uk website.
- Deferral of VAT payments due to coronavirus (Covid-19). If you're a UK VAT registered business and have a VAT payment due between 20 March 2020 and 30 June 2020, you have the option to defer the payment until a later date. You will still need to submit your VAT returns to HMRC on time. You do not need to tell HMRC that you are deferring your VAT payment. If you choose to defer your VAT payment you must pay the VAT due on or before 31 March 2021.
- A dedicated helpline to help businesses and self-employed individuals in financial distress and with outstanding tax liabilities receive support with their tax affairs. Through this, businesses may be able to agree a bespoke Time to Pay arrangement. If you are concerned about being able to pay your tax due to coronavirus, call HMRC's dedicated helpline on 0800 024 1222. Monday to Friday: 8am to 4pm.
- A £10,000 cash grant for the smallest businesses, delivered by local authorities. Small businesses that pay little or no business rates and are eligible for small business rate relief (SBBR) or rural rate relief (RRR) will be contacted by their local authority – you do not need to apply. The funding will be provided to local authorities that are responsible for business rate billing. Guidance for local authorities on the scheme will be provided shortly.
- For further information and updates on these schemes, please visit the business support website.

Here are 5 key steps you can take

1. Get help with your finances

For small and medium sized businesses, the new Coronavirus Business Interruption Loan Scheme is now available for applications. For more information and how to apply, click here.

You can also speak to your bank or lender to discuss options.

The Bank of England's new lending facility for larger firms is also open for applications. Find out more on their website.

2. See what you're entitled to

The government is also making cash grants and additional funding available to certain sectors and smaller businesses.

Find out more about the schemes available, whether you're eligible and how to apply here.

3. Support your staff

Through the Coronavirus Job Retention Scheme, the government will pay salaries (at 80% of current pay up to £2,500 a month) for workers who are no longer working and would otherwise be made redundant.

For businesses with fewer than 250 employees, the cost of providing 2 weeks of Covid-19 related statutory sick pay per employee will be refunded by the government in full. Find out more here.

4. Check guidance on tax

If you are concerned about paying your tax you can talk to HMRC about managing payments.

The government have already postponed upcoming VAT payments through to June, cancelled business rates for many sectors and delayed July's self-assessment tax payments until January 2021. Find out more here.

5. Follow the latest advice

The financial support hub on the gov.uk website will be updated regularly as more information becomes available.

The Prime Minister's daily press conference, live streamed on the @10DowningStreet Twitter feed, will also provide the latest updates on health advice, support for businesses and employees, as well as a range of other issues.

Care Quality Commission (CQC)

The Care Quality Commission have made some changes to the way they operate during the coronavirus outbreak. This includes how they support providers and communicate or receive information.

The CQC have suspended routine inspections to reduce the pressure on health and social care services but will still monitor providers through client feedback and will still visit if there is a suspected risk of harm or abuse. More information can be found here. The CQC have also published the answers to questions adult social care providers have asked during the coronavirus outbreak. Read FAQs.

Further Advice

- The government has published frequently asked questions for businesses and employers. Read FAQs
- Coronavirus Business Bulletins are issued by the Department for Business, Energy and Industrial Strategy and provides information for employers and businesses on coronavirus (Covid-19). Find out more
- The Chartered Institute for Personnel and Development has produced a factsheet, which sets out how employers should respond to the threat from coronavirus. Download factsheet
- HMRC has launched a tax helpline to help businesses concerned about paying their tax due to coronavirus. Deferring VAT and Income Tax payments. Find out more
- Companies House are offering a 3 month extension period for all businesses to file their accounts during Covid-19. Find out more
- The National Council for Voluntary Organisations (NCVO) have guidance and support information for charities during the Covid-19 lockdown. Find out more
- Information from gov.uk on extra protection for businesses with a ban on evictions for commercial tenants who miss rent payments. Find out more
- The Prince's Trust Enterprise Relief Fund will offer grants to 18 to 30-year olds across the UK who are self-employed and/or running their own business. Find out more

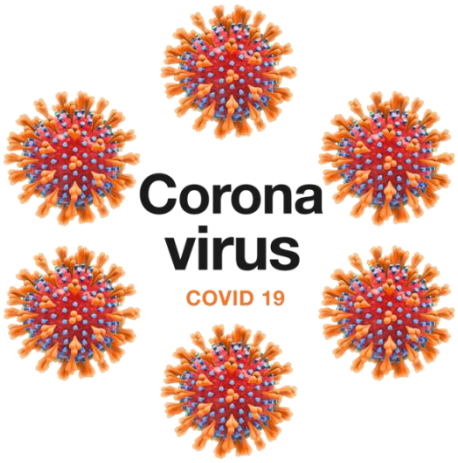
This document is up to date as at 22nd April 2020

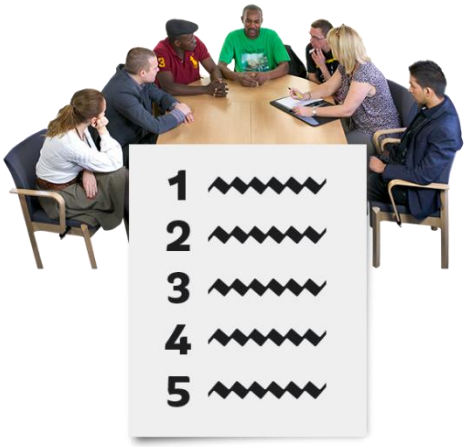
Public Health England

Protecting and improving the nation's health

Coronavirus (COVID-19)

March 2020

	COVID-19 is a new illness. Lots of people call it Coronavirus. It can affect your lungs and your airways.
	Most people who get Coronavirus will not be very ill. Some older people or people who already have health problems may become more ill. You may feel worried about Coronavirus. This is normal. Talk about how you feel with people you can trust.



We have a plan to slow down how fast Coronavirus spreads.

There are things everyone can do to help stop them and other people getting Coronavirus.

1) Keep your hands clean.

Wash your hands lots of times during the day:

✔ use soap and water

✔ use hand sanitiser (gel) if there is no soap and water when you are out

✔ make sure you wash your hands when:

- you come home
- you visit other places
- before you touch food

✘ Do not touch your eyes, nose or mouth

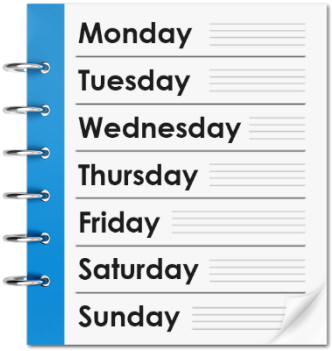
✔ Always cough and sneeze into a tissue.

✔ Then throw the tissue away and wash your hands.

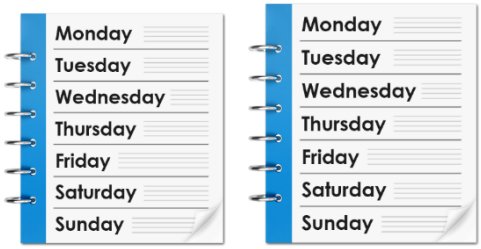
2) Be ready to stay at home

Stay at home and don't meet up with other people for 7 days if you have Coronavirus symptoms. These are:

- a new cough, and you keep coughing or
- a high temperature



After 7 days, if you feel better, you can start your usual routine again.



Stay at home and don't meet up with other people for 14 days if you share your home with someone who has symptoms of Coronavirus.

3) Make a plan

Think about what you will do if you are asked to stay at home.

If you have support from family or paid carers you should make a plan with them.

4) Only use health services when it is important to do so.

If you:

- are staying at home and start to feel much more ill or
- have stayed at home for 7 days and still have symptoms of Coronavirus

then:

- get advice from NHS 111 online
- if you need to speak to someone call 111
- **you should <u>not</u> go to a GP surgery, pharmacy or hospital** as you could pass Coronavirus to others

Only dial 999 or go to Accident and Emergency if there is an emergency.

- **Only get information about Coronavirus from places you can trust**

These places are:

- The UK coronavirus (COVID-19) page
- The NHS coronavirus (COVID-19) page
- NHS 111 online
- If you are planning to travel abroad check the Foreign and Commonwealth Office travel advice page
- Follow Public Health England or The Department of Health and Social Care on Twitter for regular updates

The pictures in this summary are from Photosymbols: https://www.photosymbols.com/

Signposting people in the COVID19 high risk groups to self-management support and information

As a result of the Covid-19 pandemic, there is an important task across the Personalised Care Group to identify practical ways that we can support people staying at home. Supported self-management is of particular importance to people living with long-term conditions, who are at increased risk of severe illness from coronavirus (COVID-19).

Supported self-management approaches such as health coaching, peer support and self-management education help people to build their knowledge, skills and confidence to manage their own health and care. Evidence shows that when people are supported to increase their knowledge, skills and confidence they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions which is more important than ever at this time.

This document has been designed to support healthcare professionals to signpost patients with long-term conditions, identified in the high risk groups, to support and information to self-manage at home.

The main charities for specific conditions have published guidance and information for self-managing during this pandemic including access to helplines and online peer support. There are self-management education programmes available on the nhs apps library some conditions and more generally for maintaining a healthy lifestyle as well as lots of information available on nhs.uk.

This document will be continually updated, so if you have any feedback on how this could be further developed or shared then please contact england.patientactivation@nhs.net.

COPD/ Emphysema/ Bronchitis		
SSM support	**Description**	**How to access**
British Lung Foundation		
British Lung Foundation – Coronavirus advice for people living with COPD	We've Been Researching **Lung** Conditions for 30 Years and Our Aim is to Always Improve Care. We	https://www.blf.org.uk/support-for-you/coronavirus

	Are the Only **UK** Charity Looking After the Nation's **Lungs**. See the Impact of Our Work. Campaigning for Change. 230+ Breathe Easy Groups. Founded in 1984	
Guide to COPD – for more information for patients about living with their condition	Information about what COPD is, the symptoms you might get, and how it's diagnosed and treated. Tips about controlling breathing and how to manage flare-ups, also called exacerbations	https://www.blf.org.uk/support-for-you/copd
Peer Support options for people with COPD over the phone	British Lung Foundation UK helpline	https://www.blf.org.uk/support-for-you/copd
COPD local support groups - which offer people living with COPD a chance to meet and share experiences with others.	F2F groups but may be hosting online?	https://www.blf.org.uk/support-for-you/copd
NHS apps library		
NHS apps library	There are a number of apps available for free on the NHS apps library to support people to self-manage their condition.	my mhealth: myCOPD free in certain areas nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/

Asthma		
SSM support	**Description**	**How to access**
British Lung Foundation		
British Lung Foundation – Coronavirus advice for people living with asthma	Researching Lung Conditions for 30 Years. The only UK charity looking after the nation's lungs.	https://www.blf.org.uk/support-for-you/coronavirus
Guide to asthma – for more information for patients about living with their condition	Asthma is a common, long-term or chronic, disease. It affects about 5 million people in the UK. This information is for adults living with asthma, their family, friends and carers. It describes the common causes of asthma, symptoms, treatment options and tips for managing your asthma. We also have information on asthma in children	https://www.blf.org.uk/support-for-you/asthma
Peer Support options for people with asthma over the phone	British Lung Foundation UK helpline	https://www.blf.org.uk/support-for-you/asthma
Asthma local support groups - which offer people living with asthma a chance to meet and share experiences with others.	F2F groups but may be hosting online?	https://www.blf.org.uk/support-for-you/asthma

Asthma UK		
Asthma UK - coronavirus advice for people with asthma	Asthma UK works to stop asthma attacks and, ultimately, cure asthma by funding world leading research, and supporting people with asthma to reduce their risk	https://www.asthma.org.uk/advice/triggers/coronavirus-covid-19/
A telephone helpline	Speak to an asthma expert nurse on our helpline 0300 222 5800	https://www.asthma.org.uk/advice/resources/helpline/
Self-management information for people living with asthma, including action plan template	Resources have been created using the most trusted evidence and evaluated by healthcare professionals and people with asthma.	https://www.asthma.org.uk/advice/resources/
NHS apps library		
NHS apps library	There are a number of apps available for free on the NHS apps library to support people to self-manage their condition.	https://www.nhs.uk/apps-library/searchapps/?query=asthma

Chronic Kidney Disease		
SSM support	**Description**	**How to access**
Kidney Care UK		
Kidney Care UK – Coronavirus advice for people living with asthma	Kidney Care UK are the UK's leading patent support charity, providing practical, financial and emotional support for	https://www.kidneycareuk.org/news-and-campaigns/coronavirus-advice/

	kidney patients and their families	
Guide to kidney disease – for more information for patients about living with their condition	Whether you're newly diagnosed or a long term kidney patient we have lots of information on the many aspects of kidney health - including dialysis, kidney function, and transplants	https://www.kidneycareuk.org/about-kidney-health/
Peer Support options for people with kidney disease	We can offer you support through our patient grants, holiday grants, counselling service, advocacy service, as well as our funding to improve care services	https://www.kidneycareuk.org/get-support/
Close Facebook group - which offer people living with asthma a chance to meet and share experiences with others.	Our closed Facebook group puts you in touch with others affected by kidney disease, giving you a chance to share experiences and tips on living with kidney related conditions	https://www.kidneycareuk.org/get-support/online-community/
NHS apps library		
NHS apps library	None available.	

Sickle Cell		
SSM support	**Description**	**How to access**
Sickle Cell Society		
Advice from the Sickle Cell Society on Coronavirus and Sickle Cell Disorder	The UK's only national charity to support people living with sickle cell	https://www.sicklecellsociety.org/coronavirus-and-scd/

Peer Support options for people with sickle cell over the phone	The SCS Helpline Service provides confidential information, guidance, and emotional support to individuals and families affected by sickle cell living within the UK	https://www.sicklecellsociety.org/helpline/
Information on support groups, local services and NHS Sickle Cell and Thalassaemia Centres across the UK	NHS Sickle Cell and Thalassaemia Centres, Haemoglobinopathies Coordinating Centres (HCCs) and Support Groups. Support groups play a vital part in delivering care for people living with sickle cell and their families	https://www.sicklecellsociety.org/supportgroups/
NHS apps library		
NHS apps library	None available	

HIV		
SSM support	**Description**	**How to access**
THT		
Advice from the Terrance Higgins Trust on Coronavirus and HIV	The UK's only national charity to support people living with HIV	https://www.tht.org.uk/news/coronavirus-covid-19
Peer Support options for people with HIV over the phone	THT for support, advice and information.	https://www.tht.org.uk/our-services/phone-and-post/tht-direct-helpline

Information about online peer support provided by Terrence Higgins Trust	Information about service in local areas	https://www.tht.org.uk/our-services/services-your-area/support-people-living-hiv
NHS apps library		
NHS apps library	None available	

Cancer		
SSM support	**Description**	**How to access**
Cancer Research UK		
Advice from Cancer Research UK on Coronavirus and Cancer	The world's largest charity dedicated to saving lives through research. Our vision is to bring forward the day when all cancers are cured	https://www.cancerresearchuk.org/about-cancer/cancer-in-general/coronavirus-and-cancer
Peer Support options for people cancer	A nurse helpline is available free of charge	https://www.cancerresearchuk.org/about-cancer/coping/emotionally
A chat group for people experiencing cancer	Chat to others in your cancer community	https://www.cancerresearchuk.org/about-cancer/cancer-chat/home
NHS apps library		
NHS apps library	None available	

Diabetes		
SSM support	**Description**	**How to access**
Diabetes UK		

Coronavirus advice for people living with Diabetes	Updates on coronavirus and diabetes.	https://www.diabetes.org.uk/about_us/news/coronavirus
Twitter @_diabetes101	Twitter account set up by health care professionals to support people with diabetes during Covid19. Offers advice and support and online social activities for people with diabetes to join in while staying at home. Twitter bio reads: "In light of #COVID19 and pressure of NHS teams we have gathered a bunch of HCPs together to signpost PWD to accredited information & boost morale!"	Via twitter, follow @_diabetes101
Guide to Diabetes	Information you need on how you can fit diabetes around your lifestyle, from what to eat to how you can treat and manage your condition effectively.	https://www.diabetes.org.uk/guide-to-diabetes
Peer Support options for people with diabetes	Social media online communities, online support forum, real life stories, bloggers, top tips, videos by and for children with Type 1 Diabetes. Diabetes UK helpline.	https://www.diabetes.org.uk/how_we_help/community https://www.diabetes.org.uk/how_we_help/helpline
NHS apps library		

NHS apps library – Diabetes	There are a number of apps available for free on the NHS apps library to support people to self-manage their condition.	https://www.nhs.uk/apps-library/category/diabetes/
MyDESMOND		
MyDESMOND – for people with Type 2 diabetes, both newly diagnosed and established.	MyDESMOND has been designed to support diabetes self-management through digital means with modern lifestyles at the heart. Primarily developed with mobile-use in mind. Meets NICE requirements.	Contact your local DESMOND coordinator https://www.desmond-project.org.uk/people-with-diabetes/
Bertie Type 1 diabetes education programme	Online self -management education for people with type 1 diabetes	https://www.bertieonline.org.uk/

Mental health		
SSM support	**Description**	**How to access**
Mental Health Foundation		
Looking after your mental health during the coronavirus outbreak	The Mental Health Foundation is part of the national mental health response providing support to address the mental health and psychosocial aspects of the Coronavirus outbreak, alongside colleagues at Public Health England and	https://www.mentalhealth.org.uk/publications/looking-after-your-mental-health-during-coronavirus-outbreak

	the Department of Health and Social Care.	
Your mental health	A range of content designed to give you more information about mental health and to help you to look after your mental health. We have podcasts, videos, inspiring stories and information about getting help if you're struggling.	https://www.mentalhealth.org.uk/your-mental-health
Mind		
Coronavirus and your wellbeing	You might be worried about coronavirus (COVID-19) and how it could affect your life. This may include being asked to stay at home or avoid other people. This might feel difficult or stressful. Mind offers advice on things you can try that could help your wellbeing.	https://www.mind.org.uk/information-support/coronavirus-and-your-wellbeing/
Information and support	When you're living with a mental health problem, or supporting someone who is, having access to the right information – about a condition, treatment options, or practical issues – is vital. This page contains Tips for everyday living, Guides to support and services,	https://www.mind.org.uk/information-support/

	helplines, Elefriends – an online community and more,	
NHS apps library		
NHS apps library - Mental Health	There are a number of apps available for free on the NHS apps library to support people to self-manage their condition.	https://www.nhs.uk/apps-library/category/mental-health/

Chronic liver disease		
SSM support	**Description**	**How to access**
British Liver Trust		
Coronavirus information	For people with a liver condition, or you've had a liver transplant, this answers a number of the most common questions related to the coronavirus outbreak that you may have below.	https://britishlivertrust.org.uk/coronavirus-covid-19-health-advice-for-people-with-liver-disease-and-liver-transplant-patients/
Help and online community	If you are a patient or care for someone with a liver condition, you can contact our Helpline and/or join the British Liver Trust online forum. The British Liver Trust Helpline is staffed by fully qualified liver nurses and provides support to anyone affected by a liver condition.	https://britishlivertrust.org.uk/information-and-support/support-for-you/helpline-and-online-community/
Children's Liver Disease Foundation		

Coronavirus updates	Information and guidance for parents of children and young people with liver conditions during the coronavirus outbreak	https://childliverdisease.org/coronavirus-update-for-parents/
Help and support	Information and support for parents and young people with liver conditions	https://childliverdisease.org/parents/ https://childliverdisease.org/young-people/

Chronic neurological disease		
SSM support	**Description**	**How to access**
Parkinson's UK		
Understanding coronavirus and Parkinson's	Our priority remains supporting people living with Parkinson's. That's why we've gathered the facts and guidance to help answer some of your most common questions about coronavirus and Parkinson's.	https://www.parkinsons.org.uk/news/understanding-coronavirus-and-parkinsons
Support Groups	Get information about Parkinson's and support including a helpline and online community.	https://www.parkinsons.org.uk/information-and-support
Motor Neurone Disease Association		
Coronavirus and MND	We are aware that the situation surrounding the spread of coronavirus may be causing people affected by motor neurone disease (MND) concern. As always we are	https://www.mndassociation.org/mnd-and-coronavirus/

	here to offer advice, support and to signpost to the most appropriate organisation. In this case our advice is directly mirroring that being shared and updated regularly by the NHS and the Government.	
Support and information	Find out about the help and support available. You can also find details on our **contact us** page.	https://www.mndassociation.org/support-and-information/
Alzheimer's Society		
Coronavirus: Information for people affected by dementia	Find out more about the coronavirus and how to protect yourself and others.	https://www.alzheimers.org.uk/coronavirus-covid-19
Get support	If you or someone you know are worried about or affected by dementia, we are here for you. Get advice on a range of topics and find support near you.	https://www.alzheimers.org.uk/get-support
MS Society		
COVID-19 coronavirus and MS treatments	This page gives the latest guidance on coronavirus COVID-19 for people affected by multiple sclerosis	https://www.mssociety.org.uk/about-ms/treatments-and-therapies/disease-modifying-therapies/covid-19-coronavirus-and-ms
MS and coronavirus care and support	We've been talking to lots of people in our community about multiple sclerosis and COVID-19. These are some of the	https://www.mssociety.org.uk/care-and-support/ms-and-coronavirus-care-and-support

	questions that crop up the most.	
Epilepsy Society		
Epilepsy and the Coronavirus (COVID-19) FAQs	Dr Simona Balestrini is the Muir Maxwell Research Fellow at the Epilepsy Society. Here, she has put together an FAQ factsheet for those with epilepsy about the coronavirus (COVID-19).	https://www.epilepsysociety.org.uk/epilepsy-and-coronavirus-covid-19-faqs#.Xnk40WC7JPY
Helpline and other support	Taking care of your overall wellbeing is a vital part of living with epilepsy. For some people, having information or support can help.	https://www.epilepsysociety.org.uk/helpline-and-other-support-1#.Xnk6BWC7JPY

Department of Health & Social Care

Public Health England

Care Quality Commission

NHS

Admission and Care of Residents during COVID-19 Incident in a Care Home

Version 1

Published 2 April 2020

Contents

Introduction

Care homes have a vital role to play in the UK, especially during the response to the COVID-19 pandemic. We want to make sure you and your staff can continue to care for some of the most vulnerable in our society. With your help, we can help keep them safe and cared for.

We want to support Care Home Providers to protect their staff and residents, ensuring that each person is getting the right care in the most appropriate setting for their needs. We know that to do this care homes need to have access to the right knowledge, staff and resources, so they are equipped to deliver care in this challenging time.

We also need care homes to continue to make their full capacity available to support the national effort, both in terms of beds and their skilled care staff**.** Helping to move patients who no longer require acute care into the most appropriate setting will help to save thousands of lives. We thank you for your continued actions to support the implementation of the hospital discharge guidance COVID-19 Hospital Discharge Service Requirements.

In return we will support you and your staff and residents in the following ways:

- We will ensure you have the information and support you need to safely admit and care for patients during the pandemic (see section 2).

- We will ensure a longer-term supply of all aspects of personal protective equipment (PPE) for care homes - and home care providers - so that staff can provide care, as well as providing a national supply disruption line for immediate concerns (see Annex F).

- We have established Capacity Tracker as the single mechanism across the country to report bed vacancies and help manage demand during this incident (see Annex I for further details). This must be kept up to date on a daily basis. This information will not be used to drive any regulatory enforcement activity.

- We will work with commissioners to ensure fair and prompt payment for the existing care commitments and additional care provided during the response to the pandemic, recognising that both PPE and staffing costs are higher than usual.

- We have made NHSMail available for secure communication and transfer of information and this must be used for communication with the NHS.

This guidance is intended for care homes, local health protection teams, local authorities, clinical commissioning groups (CCGs) and registered providers of accommodation for people who need personal or nursing care. This includes registered residential care and nursing homes for people with learning disabilities, mental health and/or other disabilities.

We will also continue to provide domiciliary care providers with the information they need to continue providing care during the COVID-19 pandemic.

1. Admission of residents

The care sector looks after many of the most vulnerable people in our society. In this pandemic, we appreciate that care home providers are first and foremost looking after the people in their care, and doing so while some of their staff are absent due to sickness or isolation requirements. As part of the national effort, the care sector also plays a vital role in accepting patients as they are discharged from hospital – both because recuperation is better in non-acute settings, and because hospitals need to have enough beds to treat acutely sick patients. Residents may also be admitted to a care home from a home setting. Some of these patients may have COVID-19, whether symptomatic or asymptomatic. **All of these patients can be safely cared for in a care home if this guidance is followed.**

If an individual has no COVID-19 symptoms or has tested positive for COVID-19 but is no longer showing symptoms and has completed their isolation period, then care should be provided as normal.

The Hospital Discharge Service and staff will clarify with care homes the COVID-19 status of an individual and any COVID-19 symptoms, during the process of transfer from a hospital to the care home. Tests will primarily be given to:

- all patients in critical care for pneumonia, acute respiratory distress syndrome (ARDS) or flu like illness
- all other patients requiring admission to hospital for pneumonia, ARDS or flu like illness
- where an outbreak has occurred in a residential or care setting, for example long-term care facility or prisons.[1]

Negative tests are not required prior to transfers / admissions into the care home.

Duties and powers under the Mental Capacity Act 2005 still apply during this period. If a person thinks it is more likely than not that the person lacks the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before a decision about their discharge is made. During the emergency period professionals may want to consider a proportionate approach to such assessments to enable timely discharge. The Department of Health and Social Care will shortly be issuing guidance on the use of the MCA and Deprivation of Liberty Safeguards during this

[1] Further guidance on testing can be found online: https://www.gov.uk/government/news/coronavirus-testing.

emergency period. Where the person is assessed to lack the relevant mental capacity and a decision needs to be made then please follow this guidance.

2. Caring for residents, depending on their COVID-19 status

COVID-19 positive cases

If you are caring for a resident who has been discharged from hospital and has tested positive for COVID-19, the discharging hospital will provide you with the following information upon discharge:

- The date and results of any COVID-19 test.
- The date of the onset of symptoms.
- A care plan for discharge from isolation.

Annex D provides further information on the appropriate isolation required for care home residents who have been discharged from hospital following treatment for COVID-19.

Keeping asymptomatic residents safe and monitoring symptoms

Care home providers should follow Social distancing measures for everyone in the care home, wherever possible, and the Shielding guidance for the extremely vulnerable group.

Care homes should implement daily monitoring of COVID-19 symptoms amongst residents and care home staff, as residents with COVID-19 may present with a new continuous cough and/or high temperature. Assess each resident twice daily for the development of a fever (≥37.8°C), cough or shortness of breath. Immediately report residents with fever or respiratory symptoms to NHS 111, as outlined in the section below.

Symptomatic residents

Any resident presenting with symptoms of COVID-19 should be promptly isolated (see Annex C for further detail), and separated in a single room with a separate bathroom, where possible. Contact the NHS 111 COVID-19 service for advice on assessment and testing. If further clinical assessment is advised, contact their GP. If symptoms worsen during isolation or are no better after 7 days, contact their GP for further advice around escalation and to ensure person-centred decision making is followed. For a medical emergency dial 999.

Staff should immediately instigate full infection control measures to care for the resident with symptoms, which will avoid the virus spreading to other residents in the care home and stop staff members becoming infected.

Care home staff should note that people with dementia and cognitive impairment may be less able to report symptoms because of communication difficulties, and therefore staff should be alert to the presence of signs as well as symptoms of the virus. This could include delirium, which people with dementia are more prone to suffer from if they develop an infection.

For people with a learning disability, autism or both we suggest that you read this guidance which has good information about the additional things to do if you are caring for this group of people.

Testing residents

Details of the current testing process are below.[2] As testing capacity increases, the government will aim to offer more comprehensive testing to the sector:

- **Single symptomatic resident:** Testing may be offered following contact with NHS 111 or according to local protocol for swabbing and testing.

- **More than one symptomatic resident:** Inform the Health Protection Team (HPT). They may arrange swabbing for up to 5 initial possible cases to confirm the existence of an outbreak. Testing all cases is not required as this would not change subsequent management of the outbreak.

Continue all strict control measures including isolation, cohorting and infection control measures until results for all residents who were tested are obtained or until the period of isolation has been completed.

3. Reporting of COVID-19 cases

Annex B contains definitions of cases and contacts. Please inform the local Health Protection Team (HPT) of two or more possible or confirmed cases within the care home. The Health Protection Team will advise on further communication to local infection control teams and local authority colleagues and CCGs.

- The HPT will provide advice and support along with local authority partners to help the care home to manage the outbreak.

- Follow the outbreak control measures advised by the HPT.

- The outbreak can be declared over once no new cases have occurred in the 14 days since the appearance of symptoms in the most recent case.

[2] Further guidance on testing can be found online: https://www.gov.uk/government/news/coronavirus-testing.

4. Providing care after death

The infection control precautions described in this document continue to apply whilst an individual who has died remains in the care home. This is due to the ongoing risk of infectious transmission via contact, although the risk is usually lower than for those living.

Further information can be found here.

5. Advice for staff

The personal protective equipment (PPE) that must be worn when caring for possible or confirmed COVID-19 patients, is described in Annex F.

Care home staff who come into contact with a COVID-19 patient while not wearing PPE can remain at work. This is because in most instances this will be a short-lived exposure, unlike exposure in a household setting that is ongoing. These are guiding principles and there should be an individual risk assessment based on staff circumstances, for example staff who are vulnerable should be carefully assessed when assigning duties, and where a possible or confirmed COVID-19 case is present in a care home, efforts should be made to cohort staff caring for that person. Further guidance can be found here.

For staff who have COVID-19 symptoms, they should:

- Not attend work if they develop symptoms.
- Notify their line manager immediately.
- Self-isolate for 7 days, following the guidance for household isolation.
- Care home capacity will be monitored via the capacity tracker and this data will be shared with Local Resilience Forums via the daily national Situation Reports to support capacity planning and response. However, where providers consider there to be imminent risks to the continuity of care, such as the potential closure of a service, they should raise this with the local authority without delay.

6. Supporting existing residents that may require hospital care

If you think one of your residents may need to be transferred to hospital for urgent and essential treatment, consider the following checklist:

If a resident shows symptoms of COVID-19:

- Assess the appropriateness of hospitalisation: consult the resident's Advance Care Plan/Treatment Escalation Plan and discuss with the resident and/or their family

member(s) or Lasting Power of Attorney as appropriate following usual practice to determine if hospitalisation is the best course of action for the resident.

- If hospitalisation is required:
  - Follow Infection Prevention and Control guidelines for patient transport (section 6.3).
  - Inform the receiving healthcare facility that the incoming patient has COVID-19 symptoms.
- If hospitalisation is not required, follow infection prevention and control, and isolation procedures and consult the resident's GP for advice on clinical management / end of life care as appropriate – see Annex C.

If a resident requires support with general health needs:

- Consult the resident's Advance Care Plan.
- Consult the resident's GP and community healthcare staff to seek advice.
- Alternatively, contact NHS 111 for clinical advice.

Postpone routine non-essential medical and other appointments.

- Review and postpone all non-essential appointments (medical and non-medical) that would involve residents visiting the hospital or other health care facilities.
- If medical advice is needed to manage routine care, consider arranging this remotely via a phone call with the GP or named clinician.

7. National support available to implement this guidance

To support implementation, NHS England and Improvement, in collaboration with other national organisations, will be running webinars to build on this guidance and provide Care Homes and their partner organisations with the opportunity to ask questions. This will be supported by a Frequently Asked Questions, which will be regularly updated. If you have any immediate questions on this guidance, please email ENGLAND.bettercaresupport@nhs.net.

For support to use the Capacity Tracker, NECS has set up a Contact Centre to support those providers who are being required to register and update their information daily. The number is 0191 691 3729 and operates between 8am and 8pm, 7 days a week. Outside of these hours, or for more general guidance, providers can email necsu.capacitytracker@nhs.net.

ANNEXES

Annex A: COVID-19 symptoms and higher risk groups

Symptoms of COVID-19 (Coronavirus) are[3] recent onset of:

a. new continuous cough and/or

b. high temperature

Persons at higher risk of COVID-19 in a care home setting

The following individuals are at an increased risk of severe illness from coronavirus (COVID-19). Care home providers should be stringent in following Social distancing measures for everyone in the care home and the shielding guidance for those in extremely vulnerable groups.

a. Anyone who falls under the category of extremely vulnerable should follow the Shielding guidance to protect these individuals**.**

b. Anyone aged 70 years or older (regardless of medical conditions) should follow social distancing guidance for the clinically vulnerable.

c. Anyone aged under 70 years with an underlying health condition – for most this will align with eligibility for the flu jab on medical grounds – should follow social distancing guidance for the clinically vulnerable.

[3] Symptoms may be more nuanced in older people with co-morbidities in care homes who may present with Influenza Like Illness (ILI), respiratory illness, new onset confusion, reduced alertness, reduced mobility, or diarrhoea and sometimes do not develop fever. This may be true for COVID-19, so such changes should alert staff to the possibility of new COVID infection.

Annex B: Definitions of COVID-19 cases and contacts

- **Possible case of COVID-19 in the care home:** Any resident (or staff) with symptoms of COVID-19 (high temperature or new continuous cough), or new onset of influenza like illness or worsening shortness of breath.

- **Confirmed case of COVID-19:** Any resident (or staff) with laboratory confirmed diagnosis of COVID-19.

- **Infectious case:** Anyone with the above symptoms is an infectious case for a period of 7 days from the onset of symptoms.

- **Resident contacts: Resident contacts are defined as residents that:**

    - Live in the same unit / floor as the infectious case (e.g. share the same communal areas).

      or

    - Have spent more than 15 minutes within 2 metres of an infectious case.

- **Staff contacts:** Staff contacts are care home staff that have provided care within 2 metres to a possible or confirmed case of COVID-19 for more than 15 minutes.

- **Outbreak:** Two or more cases which meet the case definition of possible or confirmed case as above, within a 14-day period among either residents or staff in the care home.

Annex C: Isolation of COVID-19 symptomatic patients

Isolation of residents

a. **Single case - Isolation of a symptomatic resident:** All symptomatic residents should be immediately isolated for 14 days from onset of symptoms.[4]

b. **More than one case - Cohorting of all symptomatic residents:**

- Symptomatic residents should ideally be isolated in single occupancy rooms.
- Where this is not practical, cohort symptomatic residents together in multi-occupancy rooms. Residents with suspected COVID-19 should be cohorted only with other residents with suspected COVID-19. Residents with suspected COVID-19 should not be cohorted with residents with confirmed COVID-19.
- Do not cohort suspected or confirmed patients next to immunocompromised residents.
- When transferring symptomatic residents between rooms, the resident should wear a surgical face mask.
- Clearly sign the rooms by placing IPC signs, indicating droplet and contact precautions, at the entrance of the room.
- Staff caring for symptomatic patients should also be cohorted away from other care home residents and other staff, where possible/practical. If possible, staff should only work with either symptomatic or asymptomatic residents. Where possible, staff who have had confirmed COVID-19 and recovered should care for COVID-19 patients. Such staff must continue to follow the infection control precautions, including PPE as outlined in this document.

Isolation and cohorting of contacts:

Careful risk assessment of the duration and nature of contact should be carried out, to put in place measures such as isolation and cohorting of exposed and unexposed residents. Please refer to the definition of contacts in Annex B. There are broadly three types of isolation measures:

- **Isolation of contacts individually in single rooms for 14 days after last exposure to a possible or confirmed case:** This should be the preferred option where possible.

[4] The 7 days isolation period usually applies but care home residents are a particularly vulnerable group and their immune response may differ from younger normally healthier individuals. Therefore, a 14 day period of isolation is recommended for residents in care homes.

These contacts should be carefully monitored for any symptoms of COVID-19 during the 14-day period as described earlier.

- **Cohorting of contacts within one unit rather than individually:** Consider this option if isolation in single rooms is not possible due to shortage of single rooms when large numbers of exposed contacts are involved.

- **Protective cohorting of unexposed residents:** Residents who have not had any exposure to the symptomatic case can be cohorted separately in another unit within the home away from the cases and exposed contacts.

- Extremely clinically vulnerable residents should be in a single room and **not share bathrooms with other residents**.

Annex D: Receiving residents being discharged from hospital

Hospitals around the country need as many beds as possible to support and treat an increasing number of COVID-19 cases. This means the NHS will seek to discharge more patients into care homes for the recovery period (see Table 1).

During the COVID-19 response it will not be possible for care homes to visit a potential resident in hospital to assess their care needs. A Discharge to Assess (D2A) model is in place to streamline the discharge process and the assessment of care needs will be undertaken by hospital discharge teams, in collaboration with Trusted Assessors.

Table 1: Care needs of residents being discharged from hospital (see plain text below)

Upon discharge, patient/resident has...	**What care is required upon discharge?**	**What care is required upon first sign of symptoms?**
No symptoms of COVID-19	Provide care as normal	Provide care in isolation if symptoms occur within 14 days of discharge from hospital • Resident does not leave room (including for meals) **for 14 days** after onset of symptoms or positive test • Staff wear protective equipment & place in clinical waste after use Consult resident's GP to consider if re-hospitalisation is required
Tested positive for COVID-19 ✓ No longer showing symptoms ✓ Completed isolation period	Provide care as normal	N/A
Tested positive for COVID-19 ✓ No longer showing symptoms ⚠ Not yet completed isolation	Provide care in isolation • Resident does not leave room (including for meals) **for 14 days** after onset of symptoms or positive test • Staff wear protective equipment & place in clinical waste after use	N/A

Table 1 plain text.

Upon discharge, care homes should follow the guidance below.

If a resident has no symptoms of COVID-19

- **What care is required upon discharge?** The care home should provide care as normal.
- **What care is required upon first sign of symptoms?** Provide care in isolation if symptoms occur within 14 days of discharge from hospital.[5]
    - Resident does not leave room (including for meals) for 14 days after onset of symptoms or positive test.
    - Staff wear protective equipment & place in clinical waste after use.
    - Consult resident's GP to consider if re-hospitalisation is required.

If the resident has tested positive for COVID-19, is no longer showing symptoms and has completed an isolation period:

- **What care is required upon discharge?** The care home should provide care as normal.
- **What care is required upon first sign of symptoms?** N/A.

If the resident has tested positive for COVID-19, is no longer showing symptoms but has not yet completed isolation.

- **What care is required upon discharge?** Provide care in isolation.
    - Resident does not leave room (including for meals) for 14 days after onset of symptoms or positive test.
    - Staff wear protective equipment & place in clinical waste after use.
- **What care is required upon first sign of symptoms?** N/A.

[5] The 7 days isolation period usually applies but care home residents are a particularly vulnerable group and their immune response may differ from younger normally healthier individuals. Therefore, a 14 day period of isolation is recommended for residents in care homes.

Annex E: Infection Prevention and Control (IPC) Measures

Care homes are not expected to have dedicated isolation facilities for people living in the home but should implement isolation precautions when someone in the home displays symptoms of COVID-19 in the same way that they would operate if an individual had influenza or diarrhoea and vomiting, following the following precautions:

- If isolation is needed, a resident's own room can be used. Ideally the room should be a single bedroom with en-suite facilities. Where this is not available, a dedicated bathroom near to the person's bedroom should be identified for their use only.

- Protective Personal Equipment (PPE) should be used when within 2 metres of a resident with possible or confirmed COVID-19. Guidance on PPE can be accessed on gov.uk. Display signage to prevent unnecessary entry into the isolation room. Confidentiality must be maintained.

- Room door(s) should be kept closed where possible and safe to do so. Where this is not possible ensure the bed is moved to the furthest safe point in the room to try and achieve a 2 metres distance to the open door as part of a risk assessment.

- All necessary procedures and care should be carried out within the resident's room. Only essential staff (wearing PPE) should enter the resident's room (see Annex F).

- Entry and exit from the room should be minimised during care, specifically when these care procedures produce aerosols or respiratory droplets (this is further explained in Annex F).

- Ensure adequate appropriate supplies of PPE and cleaning materials are available for all staff in the care home.

- All staff, including domestic cleaners, must be trained and understand how to use PPE appropriate to their role to limit the spread of COVID-19.

- Dedicate specific medical equipment (e.g. thermometers, blood pressure cuff, pulse oximeter, etc.) for the use of care home staff for residents with possible or confirmed COVID-19. Clean and disinfect equipment before re-use with another patient.

- Restrict sharing of personal devices (mobility devices, books, electronic gadgets) with other residents.

Annex F: Personal Protective Equipment (PPE)

PPE supplies and availability

Supplies of personal protective equipment to the care sector is fundamental for the good care of individuals with suspected symptoms of COVID-19. No wholesaler has been asked to prioritise NHS provision over the care sector nor should they be doing so. The rationale underlying all PPE distribution and utilisation should be based on clinical risk. Managers of care homes should ensure all staff are familiar with and use the PPE recommended by PHE to keep staff and patients safe and to assure essential flows of equipment.

As part of the free distribution of fluid repellent facemasks from the pandemic flu stock, every care home and home care provider has received at least 300 facemasks.

We are working rapidly with wholesalers to ensure a longer-term supply of all aspects of personal protective equipment, including gloves, aprons, facemasks and hand sanitiser. For future PPE requirements, care providers should order PPE from their usual suppliers.

Social care distributor details:

- Careshop
  Email: coronavirus@careshop.co.uk

- Blueleaf Care
  Tel: 03300 552288
  Email: emergencystock@blueleafcare.com

- Delivernet
  Tel: 01756 70 60 50
  Email: kevin.newhouse@delivernet.co.uk

- Countrywide Healthcare
  Tel: 01226 719090
  Email: enquiries@countrywidehealthcare.co.uk

If care providers have immediate concerns overs their supply of PPE, please contact:

The National Supply Disruption line
Tel: 0800 915 9964
Email: supplydisruptionservice@nhsbsa.nhs.uk

In the future, if a care provider is unable to get PPE from their normal supplier, the supplier will be asked to report this to the National Supply Disruption Response (NSDR) team (as above), who can advise on alternative suppliers.

Hand Hygiene

- Washing hands with soap and water for at least 20 seconds is essential before and after all contact with the person being cared for, removal of protective clothing and cleaning of equipment and the environment.
- Wash hands with soap and water. Alcohol-based hand rub (ABHR) can be used if hands are not visibly dirty or soiled.
- Promote hand hygiene ensuring that everyone, including staff, service users and visitors, have access to hand washing facilities.
- Provide alcohol-based hand rub in prominent places, where possible.
- Any visitors should wash their hands on arrival into the home, often during their stay, and upon leaving.

Respiratory and Cough Hygiene – 'Catch it, bin it, kill it'

- Disposable single use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose. Used tissue should be disposed of promptly in the nearest foot operated waste bin. Hands should be cleaned with soap and water if possible, after coughing or sneezing, using tissues or after contact with respiratory secretions and/or contaminated objects.
- Encourage individuals to keep hands away from eyes, mouth and nose. Some people may need assistance with containment of respiratory secretions, those who are immobile will need a container at hand for immediate disposal of the tissue such as a bag.

More information on the use of PPE can be found on gov.uk, including a reference table of when PPE should be used in community settings.

Annex G: Decontamination and cleaning processes for care homes with possible or confirmed cases of COVID-19

Domestic staff should be advised to clean the isolation room(s) after all other unaffected areas of the facility have been cleaned. Ideally, isolation room cleaning should be undertaken by staff who are also providing care in the isolation room.

The person responsible for undertaking the cleaning with detergent and disinfectant should be familiar with these processes and procedures:

a. **In preparation**

- Collect any cleaning equipment and waste bags required before entering the room.
- Any cloths and mop heads used must be disposed of as single use items.
- Before entering the room, perform hand hygiene then put on a FRSM, disposable plastic apron and gloves.

b. **On entering the room**

- Keep the door closed with windows open to improve airflow and ventilation whilst using detergent and disinfection products.
- Bag any disposable items that have been used for the care of the patient as clinical waste.

c. **Cleaning process**

- Use disposable cloths/paper roll/disposable mop heads, to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings in the room, <u>following one of the 2 options below</u>:
  - Use either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.)

    or
  - A neutral purpose detergent followed by disinfection (1000 ppm av.cl.).
- Follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants.
- Any cloths and mop heads used must be disposed of as single use items.

Cleaning and disinfection of reusable equipment

- Clean and disinfect any reusable non-invasive care equipment, such as blood pressure monitors, digital thermometers, glucometers, that are in the room prior to their removal.
- Clean all reusable equipment systematically from the top or furthest away point.

Carpeted flooring and soft furnishings

- For carpeted floors/items that cannot withstand chlorine-releasing agents, consult the manufacturer's instructions for a suitable alternative to use following, or combined with, detergent cleaning.

d. **On leaving the room**

- Discard detergent/disinfectant solutions safely at disposal point.
- Dispose of all waste as clinical waste.
- Clean, dry and store re-usable parts of cleaning equipment, such as mop handles.
- Remove and discard PPE as clinical waste as per local policy.
- Perform hand hygiene.

e. **Staff Uniforms**

Uniforms should be transported home in a disposable plastic bag.

Uniforms should be laundered:

- separately from other household linen,
- in a load not more than half the machine capacity,
- at the maximum temperature the fabric can tolerate, then ironed or tumble dried.

f. **Safe Management of Linen**

Please refer to guidance here.

Any towels or other laundry used by the individual should be treated as infectious and placed in an alginate bag then a secondary clear bag. This should then be removed from the isolation room and placed directly into the laundry hamper/bag. Take the laundry hamper as close to the point of use as possible, but do not take it inside the isolation room.

When handling linen do not:

- Rinse, shake or sort linen on removal from beds.
- Place used/infectious linen on the floor or any other surface e.g. table top.
- Re-handle used/infectious linen when bagged.
- Overfill laundry receptacles; or
- Place inappropriate items in the laundry receptacle.

Laundry must be tagged with the care area and date, and stored in a designated, safe lockable area whilst awaiting uplift or laundering.

This should be laundered in line with local policy for infectious linen.

g. **Waste**

Care homes that provide nursing or medical care are considered to produce healthcare waste and should comply with Health Technical Memorandum.

07-01: Safe management of healthcare waste.

All consumable waste items that have been in contact with the individual, including used tissues, should be put in a plastic rubbish bag, double bagged and tied. This should be put in a secure location awaiting uplift in line with local policies for contaminated waste.

Waste such as urine or faeces from individuals with possible or confirmed COVID-19 does not require special treatment and can be discharged into the sewage system. If able, the individual can use their en-suite WC.

Communal facilities should not be used. Care homes should have well-established processes for waste management.

Annex H: Communications

- Display signs to inform of the outbreak and infection control measures, examples can be found here.
- Provide 'warn and inform' letters to residents, visitors and staff if there is a suspected case of COVID-19 in the home.
- Although the HPT will provide public health advice in response to an outbreak (including potential closure to new admissions), the care home management has the final responsibility to communicate information, including to staff and visitors and to implement infection control recommendations and any advice on closure to admissions from the HPT. The care home has the primary responsibility for the safety of its staff and residents.

Considerations for visitors and non-essential staff

- Family and friends should be advised not to visit care homes, except next of kin in exceptional situations such as end of life. Follow the social distancing guidance.
- Visitors should be limited to one at a time to preserve physical distancing.
- Visitors should be reminded to wash their hands for 20 seconds on entering and leaving the home and catch coughs and sneezes in tissues.
- Visitors to minimise contact with other residents and staff (less than 15 minutes / 2 metres etc.)
- Alternatives to in-person visiting should be explored, including the use of telephones or video, or the use of plastic or glass barriers between residents and visitors.
- Visitors should visit the resident in their own room directly upon arrival and leave immediately after the visit.
- Cancel all gatherings and plan alternative arrangements for communal activities which incorporate social distancing.

Support for care home staff

- Review sick leave policies and occupational health support for care home staff and support unwell staff to stay at home as per Public Health England (PHE) guidance. Support for employers is available here.

- Staff who have a symptomatic household member must stay at home and not leave the house for 14 days. The 14-day period starts from the day when the first person in the house became ill. If the staff member develops symptoms during this period, they can return to work 7 days after their symptoms started and they are no longer symptomatic. Further guidance is available here.

- Staff who fall into the clinically vulnerable group should not provide direct care to symptomatic residents.

- Ensure staff are provided with adequate training and support to continue providing care to all residents.

- All care homes should have a business continuity policy in place including a plan for surge capacity for staffing, including volunteers.

Annex I: Use of Capacity Tracker to support effective discharge planning and continue care outside of hospitals

Summary

- On 19 March, HM Government issued COVID-19 Hospital Discharge Service Requirements.
- As part of current discharge planning it is vital to understand the vacancies in community settings.
- Accurate and timely data is essential for effective management of the response to the COVID-19 pandemic both locally and nationally.
- Rapid system-wide adoption of Capacity Tracker from the 1st April 2020 is required. Comprehensive support for registration and operation is available.
- Any information gathered will not be used to drive any regulatory enforcement activity. Our intention is for this information to be used to support collective planning across the health and social care sector and swiftly resolve issues wherever possible, whether through local or national actions.

What is the role of providers?

- The priority for the duration of the COVID-19 incident is that all providers input data into Capacity Tracker to inform one national and local picture.
- All care homes, all hospices (including children's hospices) and all providers of inpatient community rehabilitation and end of life care MUST input the information specified into Capacity Tracker by 1st April 2020.
- Providers who currently submit information through other systems similar to Capacity Tracker need only to use Capacity Tracker for the duration of the level 4 emergency COVID-19 response.

What is Capacity Tracker?

Capacity Tracker is managed by the NHS North of England Commissioning Support (NECS) and provides the opportunity to easily track occupancy and vacancies to support system-wide bed and discharge planning. It is an established and robust system that has been successfully supporting the tracking of care home vacancies across a large proportion of England for some time.

More than 7,800 care homes are already registered and setup on Capacity Tracker. However, the COVID-19 situation has resulted in the need to quickly extend its use to the remaining care homes as well as all hospices plus all providers of inpatient rehabilitation and end of life care.

What information should be inputted?

To support current discharge planning in response to COVID-19, Capacity Tracker will track care home vacancies and bed capacity in all hospices (including children's hospices) and providers of inpatient community rehabilitation and end of life care. Critically, Capacity Tracker will now also start to collect basic information from care homes on workforce and business continuity issues.

How will the NHS and wider health & social care system use the information?

This essential information will be included in daily national Situation Reports to support capacity planning and response. It will also be used by localities to understand their capacity and pressures across the care sector, again to support care providers, system-wide discharge planning and system resilience. It is vital to maintain resilience across the care sector. To do this local councils and the NHS need to understand the pressures as they change so that support can be provided quickly and where it is most needed. A key element in extending the data capture for care homes is to be able to support any care home that is showing signs of difficulties before it is too late.

How often do providers need to update Capacity Tracker?

To support reliable real time discharge planning when using Capacity Tracker it must be updated **as close to real time as practicable** – e.g. as and when any occupancy, or care home status changes and at least once per day if there has been no change.

What do providers need to do now?

If you don't use Capacity Tracker already you need to register as soon as possible and be fully submitting the required information by 1st April. NECS will provide support to help you with this, through a contact centre, online guides and short videos to help you understand what you need to do.

The Resource Centre in Capacity Tracker also contains up to date guidance and information to support you. You will also receive emails containing essential guidance and resources to help you safely care for your residents/patients. Information received will improve the understanding of the support you and colleagues in the care sector may need.

Please register via Capacity Tracker website at: https://carehomes.necsu.nhs.uk/. Short videos to help you register are available on this website under the 'Help Videos' menu and further videos will be available once you've registered and logged in.

What is the role of Local Authorities (LAs)?

- Local authorities play the central role in ensuring that the local social care market overall works, and a key role in arranging discharge for many people.

- NHS staff are expected to work with and through local authorities in operationalising the Capacity Tracker tool.

- We are asking all partners to populate and use Capacity Tracker because we know that, when this is combined with local knowledge and expertise, key partners across the health and social care system are able to manage the system more effectively, ensure timely and appropriate hospital discharges and make best use of vital care home provision. Where possible if care homes register with an NHSmail email addresses no verification is required – making the process more straightforward. Registration with another type of email will require verification.

- LAs, and in particular their Brokerage Teams, have a key role to play. They should request the required level of access from NECS directly via necsu.capacitytracker@nhs.net and LAs should also identify System Champions and send their name and email address to NHS NECS via necsu.capacitytracker@nhs.net as soon as practicable. LAs are also asked to provide any support they can to care homes and all parties should be aware of the support available via the Capacity Tracker website (https://carehomes.necsu.nhs.uk/).

What is the role of CCGs?

- CCGs will also play a crucial role similar to LAs supporting the rapid implementation of Capacity Tracker across their locality and helping LA counterparts as required.

- It is vital that CCGs ensure all providers in their local area are submitting data to Capacity Tracker, and that they also support/facilitate use of Capacity Tracker.

- **CCGs must take the responsibility to each nominate a group of Capacity Tracker System Champions** (more than one person is required to cover in the case of absence) who will oversee the rapid implementation of Capacity Tracker in their locality.

- These System Champions are crucial because, before providers can submit data, they need to approve their access to Capacity Tracker. System Champions also have more reporting functionality for oversight across the locality. A key role is to ask care

homes, community rehabilitation bed providers and hospices to have a person register as an approver – so they can approve other colleagues as users quickly. The call centre can support any approver / registering issues. Also, registration with NHSmail email addresses will mean no verification is required and is more straightforward, and should be encouraged where possible.

- Name(s) and email address of System Champions which must be notified to NHS NECS via necsu.capacitytracker@nhs.net as soon as practicable.

Adult Social Care Directorate

www.gov.uk/dhsc

Dementia and COVID 19[i]

This short paper attempts to summarise some of the key issues around people with dementia and their carers in relation to COVID 19 (Coronavirus). While there is ample general advice about COVID-19 and its management (www.england.nhs.uk/coronavirus/), the following ten key points have been devised which reflect clinical advice and specific information about dementia. It may be helpful to clinicians and planners.

There are an estimated 675,000 people with dementia in England, the majority of whom are over 65 and have comorbid health conditions, making them particularly vulnerable to develop severe symptoms and develop complications. They are supported by a similar number of carers, most of whom are older people themselves. A quarter of people in acute hospitals and three quarters of residents of care homes have dementia.

Key factors -

- People with dementia are much more prone to develop **delirium** (a confusional state) if they develop an infection – being aware that a person may have dementia will alert staff to this increased risk.
- Going into **hospital** is frightening enough and particularly so for someone with dementia – staff involved in screening and treatment should be aware if a person has dementia and be prepared to take extra time while assessing and treating them. Avoiding unnecessary hospital admissions is important.
- Some people with dementia may have difficulty understanding **complex instructions** about self-isolation or handwashing – keeping information accessible and repeatable is key.
- People with dementia may lack awareness of and be less able to report symptoms because of **communication difficulties** – people should be alert to the presence of signs as well as symptoms of the virus ("look beyond words").
- People with dementia may have **swallowing difficulties** which could put them at increased risk of developing chest infections and dehydration – a swallowing assessment may be helpful.

Specific support -

- Volunteer community groups, with appropriate expertise, could be positively encouraged to **provide support** for carers and people with dementia, particularly those living alone.
- People with dementia in their own homes may already feel isolated and if they need to further self-isolate, additional assistance and support may be needed to mitigate the practical and **emotional impact of separation** – care plans reflecting this are important, including updated **Lasting Power of Attorney** documentation and advance directives.
- **Support in the community** is key – Dementia Connect. (https://www.alzheimers.org.uk/dementiaconnect) and Dementia UK (https://www.dementiauk.org/) are examples of where bespoke advice is available.
- There will be an **additional burden on carers**, many of whom are in high risk group themselves and may become ill and unable to care - if services can help plan so that friends/relatives/volunteers keep daily phone or other contact this should reduce the need for emergency calls on the NHS and social care.
- Relatives and friends not being allowed to see a person in a care home could have a detrimental effect on residents with dementia – use of **technology** may help improve communication between families both at home and in care homes.

[i] This guidance is equally applicable to anyone with cognitive impairment resulting from conditions which affect the brain.

Department of Health & Social Care

The Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) During the Coronavirus (COVID-19) Pandemic

Published 09 April 2020

Guidance for Hospitals, Care Homes and Supervisory Bodies [v0.1]

Summary of key points:

- This guidance is only valid during the COVID-19 pandemic and applies to those caring for adults who lack the relevant mental capacity to consent to their care and treatment. The guidance applies until withdrawn by the Department. During the pandemic, the principles of the MCA and the safeguards provided by DoLS still apply.

- Decision makers in hospitals and care homes, and those acting for supervisory bodies will need to take a proportionate approach to all applications, including those made before and during the pandemic. Any decisions must be taken specifically for each person and not for groups of people.

- Where life-saving treatment is being provided, including for the treatment of COVID-19, then the person will not be deprived of liberty as long as the treatment is the same as would normally be given to any person without a mental disorder. The DoLS will therefore not apply.

- It may be necessary, for a number of reasons, to change the usual care and treatment arrangements of somebody who lacks the relevant mental capacity to consent to such changes.

- In most cases, changes to a person's care or treatment in these scenarios will not constitute a new deprivation of liberty, and a DoLS authorisation will not be required. Care and treatment should continue to be provided in the person's best interests.

- In many scenarios created or affected by the pandemic, decision makers in hospitals and care homes will need to decide:

    (a) If new arrangements constitute a 'deprivation of liberty' (most will not).

    (b) If the new measures do amount to a deprivation of liberty, whether a new DoLS authorisation may be required (in many cases it will not be).

- This guidance, particularly the flow chart at Annex A, will help decision makers to make these decisions quickly and safely, whilst keeping the person at the centre of the process.

- If a new authorisation is required, decision makers should follow their usual DoLS processes, including those for urgent authorisations. There is a shortened Urgent Authorisation form at Annex B which can be used during this emergency period.

- Supervisory bodies who consider DoLS applications and arrange assessments should continue to prioritise DoLS cases using standard prioritisation processes first.

- DoLS assessors should not visit care homes or hospitals unless a face-to-face visit is essential. Previous assessments can also be considered as relevant evidence to help inform the new assessments.

Use of the MCA and DoLS due to COVID-19

1. During the pandemic, the principles of the MCA and the safeguards provided by DoLS still apply. This emergency guidance is for all decision-makers in England and Wales who are caring for, or treating, a person who lacks the relevant mental capacity. It applies to all cases during the pandemic. It applies until withdrawn by the Department for Health and Social Care ('the Department'). The content of this guidance should not become the new norm beyond the pandemic.

2. During the pandemic, it may be necessary to change a person's usual care and treatment arrangements to, for example:

    - provide treatment to prevent deterioration when they have or are suspected to have contracted COVID-19,

    - move them to a new hospital or care home to better utilise resources, including beds, for those infected or affected by COVID-19, and

    - protect them from becoming infected with COVID-19, including support for them to self-isolate or to be isolated for their own protection.

3. New arrangements may be more restrictive than they were, for the person, before the pandemic. It is important than any decision made under the MCA is made in relation to that individual; MCA decisions cannot be made in relation to groups of people.

4. All decision makers are responsible for implementing the emerging government public health advice (https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance). Care and treatment arrangements may need to be adjusted to implement that advice. The government has also issued specific advice for social care providers during the pandemic (https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance).

5. When making decisions during the pandemic, about the care and treatment of people who lack the relevant mental capacity, staff should seek consent on all aspects of care and treatment to which the person can consent.

Best Interest Decisions

6. If the person lacks capacity to provide consent, the decision maker should where necessary make a **best interests** decision under the MCA regarding the care or

treatment that needs to be provided. When doing so, they should consider all relevant circumstances, and in particular:

- whether it is likely that the person could regain capacity and if so whether the decision can wait,
- ensuring participation if reasonably practicable,
- the person's past and present wishes and feelings, and beliefs and values that would be likely to influence their decision,
- the views of the person's family members and those interested in the person's welfare, if it is practicable and appropriate to do so.

7. **In many cases it will be sufficient to make a best interests decision in order to provide the necessary care and treatment and put in place the necessary arrangements, for a person who lacks the relevant mental capacity to consent to the arrangements during this emergency period.**

8. Decision makers should consider whether a person has made a valid and applicable advance decision to refuse the specific treatment in question. If they have made such a decision, then relevant treatment, including for COVID-19 cannot be provided. Likewise, if the person has a donee appointed under a personal welfare lasting power of attorney or a court appointed deputy with a specific authority in relation to the proposed treatment, who is refusing consent to that treatment, then that treatment cannot be provided. Anyone with such authority must act in the person's best interests when making decisions about such treatment. If staff are not in agreement with the attorney's or deputy's determination of the person's best interests, then unless the dispute cannot be resolved through other means, consideration should be given to an application to the Court of Protection.

Delivering life-saving treatment - application of the Ferreira judgment

9. Where life-saving treatment is being provided in care homes or hospitals, including for the treatment of COVID-19, then this will not amount to a deprivation of liberty, as long as the treatment is the same as would normally be given to any patient without a mental disorder. This includes treatment to prevent the deterioration of a person with COVID-19. During the pandemic, it is likely that such life-saving treatment will be delivered in care homes as well as hospitals, and it is therefore reasonable to apply this principle in both care homes and

hospitals. **The DoLS process will therefore not apply to the vast majority of patients who need life-saving treatment who lack the mental capacity to consent to that treatment, including treatment to prevent the deterioration of a person with COVID-19.**

10. This means that, for example, a person who is unconscious, semi-conscious or with acute delirium, and needs life-saving treatment (for COVID-19 infection or anything else) is highly unlikely to be deprived of liberty. They must be treated based on a best interests decision. (The exception to this is people described at para 8.)

11. If additional measures are being put in place for a person who lacks the relevant mental capacity when they are receiving life-saving treatment, for example to stop them from leaving the place of treatment, then the "acid test" set out in Cheshire West (set out below) should be considered. If the acid test is not met then the person is not deprived of their liberty and the DoLS will not be necessary.

Depriving a person of their liberty

12. In cases where the Ferreira judgment does not apply decision-makers must determine if someone is, or will be, 'deprived of their liberty' as a result of the arrangements for their care and treatment. If this is the case, then legal authorisation is required. For adults residing in a care home or hospital this would usually be provided by the DoLS. If the person is residing in any other settings, then an application to the Court of Protection should be considered.

13. Decision-makers should always consider less restrictive options for that person. They should avoid depriving someone of their liberty unless it is absolutely necessary and proportionate to prevent serious harm to the person. In most cases, a best interests decision will be appropriate and the person will not need to be deprived of the liberty.

14. **The Cheshire West ruling stated that a person who lacks the relevant mental capacity to make decisions about their care or treatment is deprived of their liberty if, as a result of additional restrictions placed upon them because of their mental disorder, they are:**

    - **not free to leave the accommodation, and**
    - **under continuous supervision and control.**

This is known as the acid test. Subsequently, the Court of Appeal has commented that "not free to leave" means not free to leave that accommodation permanently (https://www.familylawweek.co.uk/site.aspx?i=ed182592).

15. If the proposed arrangements meet the acid test, then decision makers must determine how to proceed. The starting point should always be to consider whether the restrictions can be minimised or ended, so that the person will not be deprived of liberty. If this is not possible then the key principles to consider are:

    (a) Does the person already have a DoLS authorisation, or for cases outside of a care home or hospital does the person have a Court Order? If so, then will the current authorisation cover the new arrangements? If so, **in many cases changes to the person's arrangements for their care or treatment during this period will not constitute a new deprivation of liberty and the current authorisation will cover the new arrangements,** but it may be appropriate to carry out a review.

    (b) Are the proposed arrangements more restrictive than the current authorisation? If so, a review should be carried out.

    (c) If the current authorisation does not cover the new arrangements, then a referral for a new authorisation should be made to the supervisory body to replace the existing authorisation. Alternatively, a referral to the Court of Protection may be required.

16. In many cases, where a person has a DoLS authorisation or Court Order then decision-makers will be able to put in place new arrangements to protect the person within the parameters of the authorisation or Order. Decision-makers should avoid putting more restrictive measure in place for a person unless absolutely necessary to prevent harm to that person. DoLS cannot be used if the arrangements are purely to prevent harm to others.

Hospitals and care homes

17. As stated above, most changes to arrangements around a person's care or treatment linked to the pandemic (examples at para 2), will not constitute a deprivation of liberty and a best interest decision would be the reasonable course of action.

18. In some cases, a new authorisation may be needed. In such cases, an urgent authorisation can come into effect **instantly** when the application is completed

and lasts for up to a maximum of seven days, which can be extended for a further seven days if required.

19. During the pandemic, only the shortened form at Annex B is needed to grant an urgent authorisation and request an extension to that urgent authorisation, from the supervisory body. This should be submitted as soon as is practically possible after the deprivation of liberty has been identified and started. This guidance makes no changes to the process for a standard authorisation, which should be followed as usual, when required.

20. Any authorisation in force (urgent or standard) is still applicable if the person moves within the same setting e.g. a change of ward. If the person moves to a totally different setting a new authorisation may be needed.

21. The Department recognised the additional pressure the pandemic will put in the DoLS system. Fundamentally, it is the Department's view that as long as providers can demonstrate that they are providing good quality care and/ treatment for individuals, and they are following the principles of the MCA and Code of Practice, then they have done everything that can be reasonably expected in the circumstances to protect the person's human rights.

22. Where the person is receiving end of life care, decision makers should use their professional judgement as to whether DoLS assessments are appropriate and can add any value to the person's care or treatment.

Any other setting

23. The same framework for determining best interest decisions and depriving a person of their liberty set out in the guidance above should be applied when considering the arrangements for care or treatment for a person who lacks the relevant capacity in other settings such as supported living.

24. If the arrangements do amount to a deprivation of liberty, then a referral should in most cases be made to the Court of Protection. The Court has issued their own guidance for this emergency period and will continue to update it as needed (https://www.judiciary.uk/you-and-the-judiciary/going-to-court/family-law-courts/court-of-protection-guidance-covid-19/).

Supervisory bodies (local authorities in England and local health boards in Wales)

25. The Department recognises that supervisory body staff may need to be deployed elsewhere to deal with other urgent front-line adult social care matters during the pandemic. Supervisory bodies are well practised in prioritising DoLS applications and have been using prioritisation methods to do so since 2014. During the pandemic, supervisory bodies will need to take a proportionate approach to all DoLS applications including existing applications and new applications including those generated because of the pandemic.

26. To carry out a DoLS assessments and reviews, remote techniques should be used as far as possible, such as telephone or videocalls where appropriate to do so, the person's communication needs should be taken into consideration. Views should also be sought from those who are concerned for the person's welfare.

27. Where appropriate and relevant, current assessments can be made by taking into account evidence taken from previous assessments of the person. The assessor undertaking the current assessment must make a judgement on whether the evidence from the prior assessment is still relevant and valid to inform their current assessment. If this information is used to support the current assessment or review this should be noted and referenced. Alternatively, if the assessment was carried out within the last 12 months, this can be relied upon without the need for a further assessment.

28. Where the person is receiving end of life care, supervisory bodies should use their professional judgement as to whether an authorisation is necessary and can add any value to the person's care.

Emergency Public Health Powers

29. The Coronavirus Act 2020 gives Public Health Officers power to impose proportionate requirements (including screening and isolation), on a person suspected or confirmed to be infected with COVID-19.

30. If it is suspected or confirmed that a person who lacks the relevant mental capacity has become infected with COVID-19, it may be necessary to restrict their movements. In the first instance, those caring for the person should explore the use of the MCA as far as possible if they suspect a person has contracted COVID-19. The following principles provide a guide for which legislation is likely to be most appropriate:

(a) The person's past and present wishes and feelings, and the views of family and those involved in the person's care should always be considered.

(b) If the measures are in the person's best interests then a best interest decision should be made under the MCA.

(c) If the person has a DoLS authorisation in place, then the authorisation may provide the legal basis for any restrictive arrangements in place around the measures taken. Testing and treatment should then be delivered following a best interest decision.

(d) If the reasons for the isolation are purely to prevent harm to others or the maintenance of public health, then PHO powers should be used.

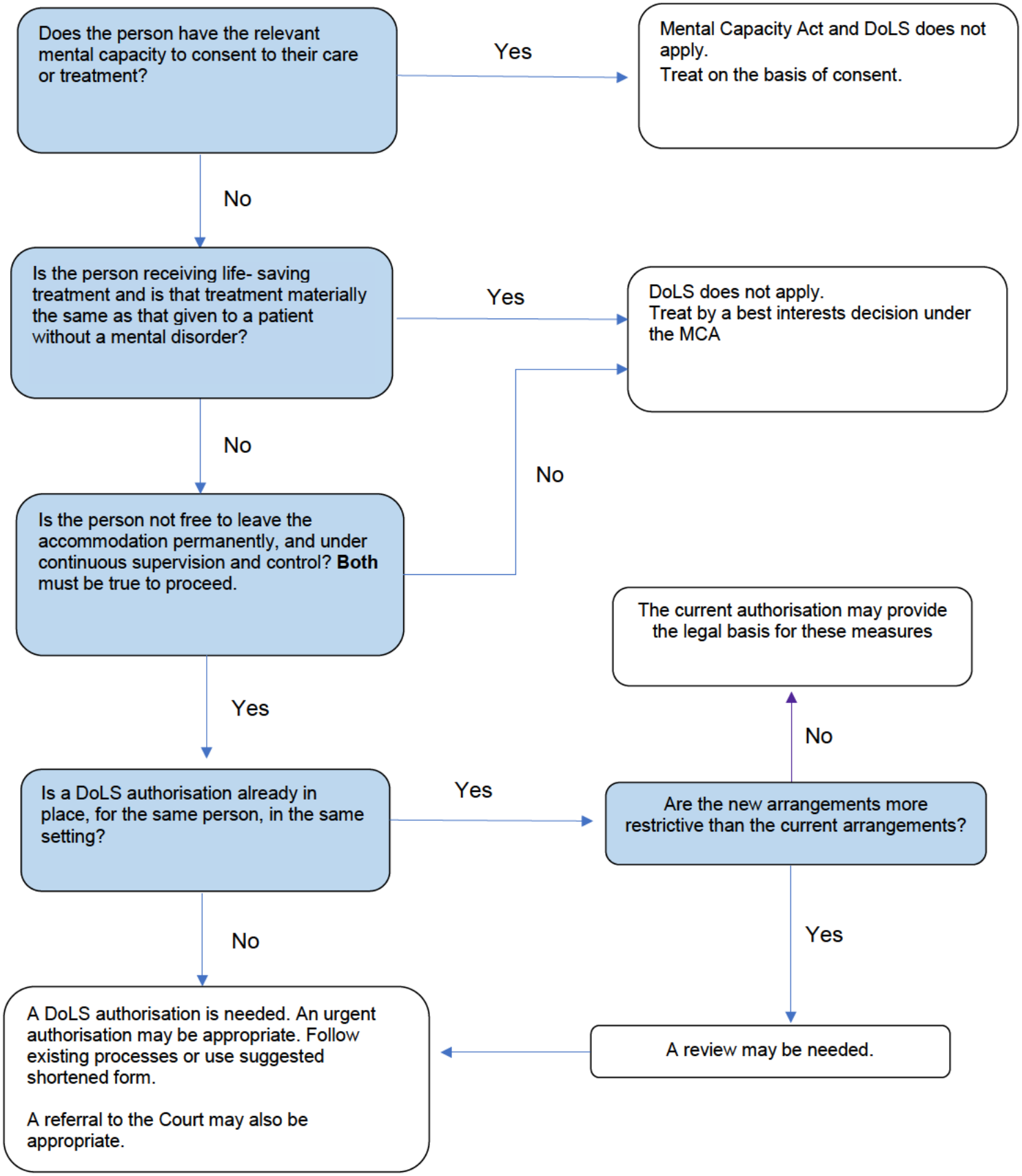
(e) If the person's relevant capacity fluctuates, the PHO powers may be more appropriate.

31. If the public health powers are more appropriate, then decision makers should contact their local health protection teams (https://www.gov.uk/guidance/contacts-phe-health-protection-teams).

Next steps:

32. The Department will monitor responses to this guidance and update it if needed. To offer feedback for potential updates to the guidance, please email lps.cop@dhsc.gov.uk. We are considering the publication of this guidance in other formats.

Annex A: Decision-making flow chart for decision makers in hospitals and care home



Published to GOV.UK in pdf format only.

Care and Transformation/Social Care Oversight

www.gov.uk/dhsc

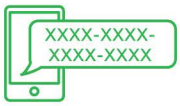
HM Government

NHS

Essential workers (England & Scotland)

How to book a coronavirus test

IMPORTANT: Don't delay — tests are most effective within 3 days of symptoms.



1

Have you received:
a text with a 16-digit code and link from UK_Gov
OR
An email with an invitation to order a home test kit?

NO, I HAVE NOT RECEIVED ANYTHING →

YES, I HAVE RECEIVED A TEXT ↓

YES, I HAVE RECEIVED AN EMAIL ↓

2

Go to ***gov.uk/coronavirus***

Enter your name, employer and mobile number to apply for a test.

Choose one of the testing methods in Step 3

3

REGIONAL TESTING SITE

Enter the invitation code and your details to book an appointment from the times shown.

You will receive an email confirming your appointment and a QR code to bring with you to the testing site.

OR

HOME TESTING KIT

Additional checks are required for sending home testing kits, such as a check on your work email address or other contact details.

If these details can't be checked, please book a regional test site visit instead.

Please note that there will be a limited number of home testing kits initially, with more becoming available over time.

4

Take your test following the instructions you are sent.

If you are using a regional testing site please remember to bring your QR code and a form of photo identification with you.

If you are using a home testing kit, please remember to register your kit online otherwise you will not receive your results.

You should receive your results within 72 hours.

For more information go to **gov.uk/coronavirus** or call the contact centre at **0300 303 2713**

v. 23 April 2020

HM Government

NHS

Coronavirus National Testing Programme
Frequently Asked Questions for Employers of Essential Workers

This document covers the most commonly questions asked by employers who are supporting their employees who have coronavirus-like symptoms. If you have questions that aren't covered in this document or in the accompanying Employer Referral Portal Guide, please email the National Testing Programme Team opshub@dhsc.gov.uk

Currently, this testing offer applies in England and Scotland only. We are working closely with the Devolved Administrations on the approach to testing, and this includes working with them on appropriate solutions for booking into their testing sites. Decisions about eligibility for testing are made by the Devolved Administrations.

1. Can I get staff in my organisation tested?

The National Testing Programme has expanded capacity to test even more essential workers who are self-isolating due to having coronavirus symptoms or because a member of their household has symptoms.

The full list of eligible workers can be found here: www.gov.uk/coronavirus-get-tested
Devolved Administrations operate their own eligibility criteria.

2. Who can get a test?

If you are an employer of eligible essential workers (see list above), then you can offer tests to the following:

- Any self-isolating members of staff who have coronavirus symptoms
- Member of staff does not have symptoms but members of their household do, they can get tested.

3. How do I offer the test to my employees?

A new employer referral portal is now available to make the process as easy as possible. Employers can upload spreadsheets containing the details of essential workers who need to be tested into the secure employer referral portal. The system will generate invitations to the essential workers via SMS and email. Essential workers can then log into the system and book an appointment directly.

A user guide has been issued to all eligible employers giving step by step directions on how to use the system. Employers should email portalservicedesk@dhsc.gov.uk to be given access to the employer referral portal.

The portal also has a self-referral function for employees to self-register, which will take some of the administration burden off employers. Please refer to the accompanying guidance for further information. This system currently operates in England and Scotland only.

4. What kinds of tests are offered?

The test confirms if an individual currently *has* the virus. There are two options for individuals to get tested that will be available via the new website:

- Driving to a regional test site OR
- employees requesting a home test kit which will be delivered to their home

Where members of the household require testing, **up to three** can attend a regional test site with the essential worker. The total of four, reflects the maximum number of occupants that can be safely tested in a single vehicle.

If the essential worker is registering a test on behalf of a member of their household, that employee does not have to attend the test site with the household member. As long as that symptomatic individual's name has been booked as the person who needs the test, it will be their name on the list at the test site.

The maximum number of home test kits an essential worker can order is five.

5. How many employees can access testing?

Please refer all your employees who are self-isolating because they or their household member(s) have coronavirus symptoms for testing via the employer referral portal.

Please note that regional test centres that operate the drive-through function have a limit of four people per car.

6. If an employee has tested negative, can they come back to work straight away?

Employees with negative results should only return to work if they feel well enough to do so. If everyone with symptoms who was tested in their household receive a negative result, the employee can return to work immediately, providing they are well enough, and have not had a fever for 48 hours.

If a household member tests positive, but the worker tests negative, the worker can return to work on day eight from the start of their symptoms if they feel well enough and have not had a fever for 48 hours.

If the worker does not have symptoms but a household member tests positive, the worker should continue to self-isolate in line with national guidance

Employees should discuss their return to work with their employer, following the steps outlined in Flowchart describing return to work following a SARS-CoV-2 test.

If, after returning to work, they later develop symptoms they should follow national guidance and self-isolate.

7. **Will I be told if a member of staff has tested positive for coronavirus?**

The programme **does not return the results to an employer.** It is the individual's responsibility to discuss their test result with their employer as part of their return to work conversation.

We will not agree to release data to employers on individual's test results or an individual's engagement with the test programme.

Information on the management of personal data is available here Privacy Information

8. **Can contractors and part time staff be tested?**

Yes. Contractors and part time staff can be tested.

9. **I have eligible employees based in Scotland/Wales but they live closer to test sites in England OR my employees travel into England for work. Can they use a test site closer to home/near work/in another nation?**

Where essential workers are based in one nation, if they are able to safely access a test site in another then they may do so, as long as they meet the eligibility requirements for that test site. However, we would discourage anyone from travelling an excessive distance to do so, particularly if they are feeling very unwell.

10. **How does the self-referral portal work? As an employer of essential workers, can I just direct my staff there instead of uploading their details myself?**

Yes you can direct your eligible employees to the self-referral portal https://self-referral.test-for-coronavirus.service.gov.uk/ They can book a test for themselves or for members of their household who have coronavirus symptoms. Employees will be able to book tests at regional test sites or order home test kits.

11. **What other support is available for my employees?**

There is a Coronavirus Testing Call Centre for employees who have been referred or booked a test themselves, which is contacted on 0300 303 2713. Lines are open open daily 08:00 – 20:00. This call centre does not offer medical advice. If your employee is unwell, they should call NHS 111 and in a medical emergency, dial 999.

Draft Provider Costs Application Form – Covid-19

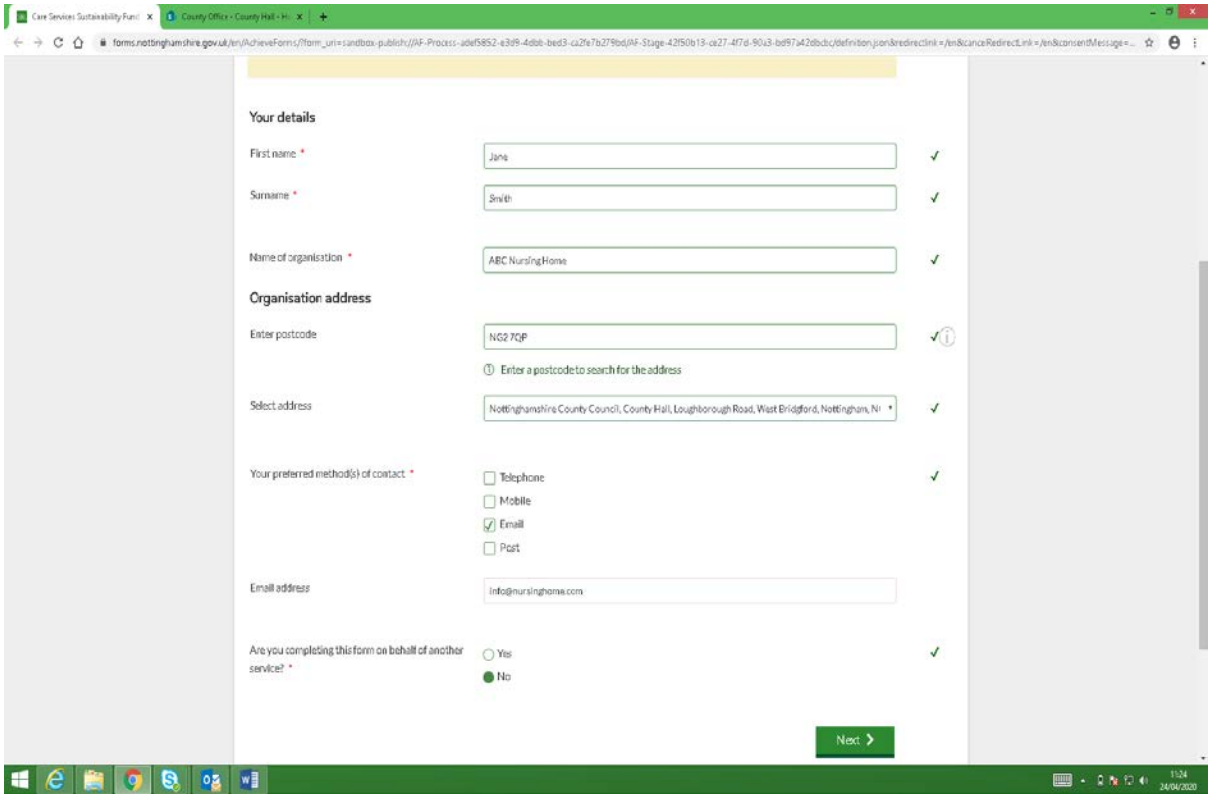
Please see below for the first draft screen shots of the proposed application form for claiming Covid-19 related increased expenditure. This form will not be used for loss of income due to Covid-19, to which separate communications will be issued in due course.

Screen 2 will have a subsequent question to establish what part of the service is utilised by those either self-funding or funded in part or entirely by Nottinghamshire County Council.

You may consider it inappropriate to make a claim, once the form is made available, where your organisation as a whole has not incurred any net loss due to the Covid-19 crisis, for example, the increased costs in one part are offset by the decreased costs in another.

Each section of the form will be supported by guidance as to what evidence will be required and what costs can be included and what might be excluded.

Screen 1:



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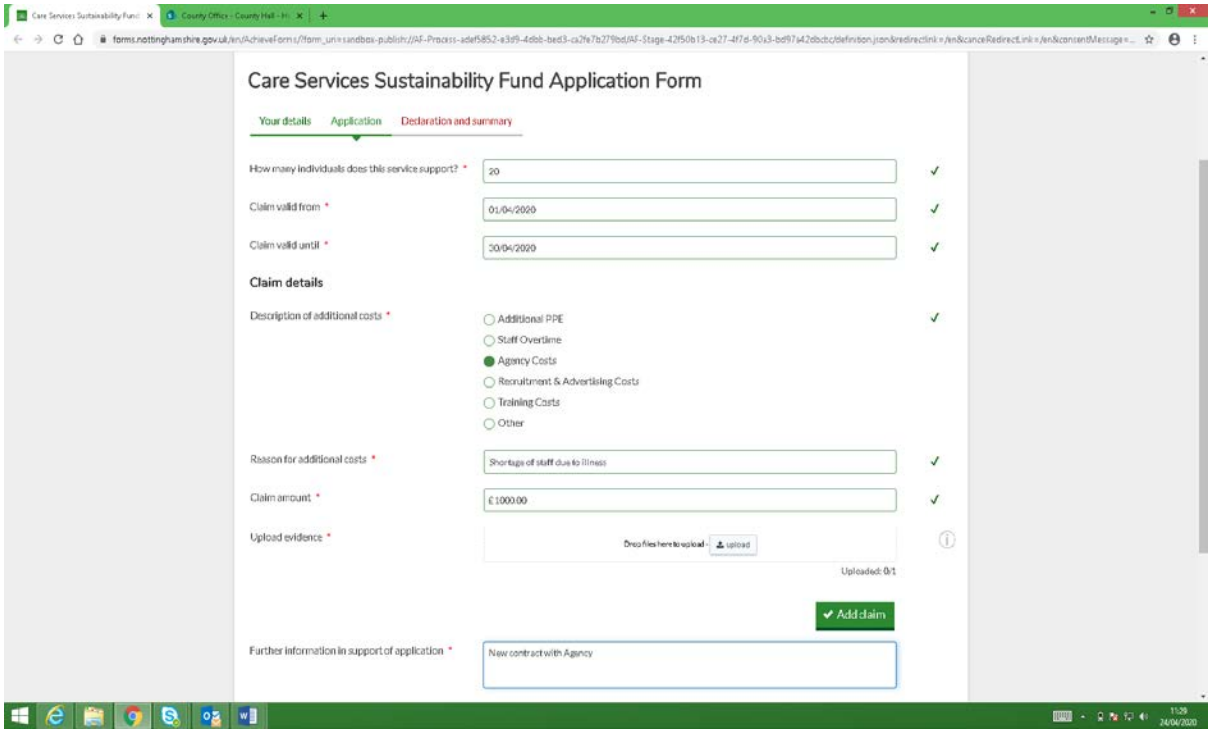
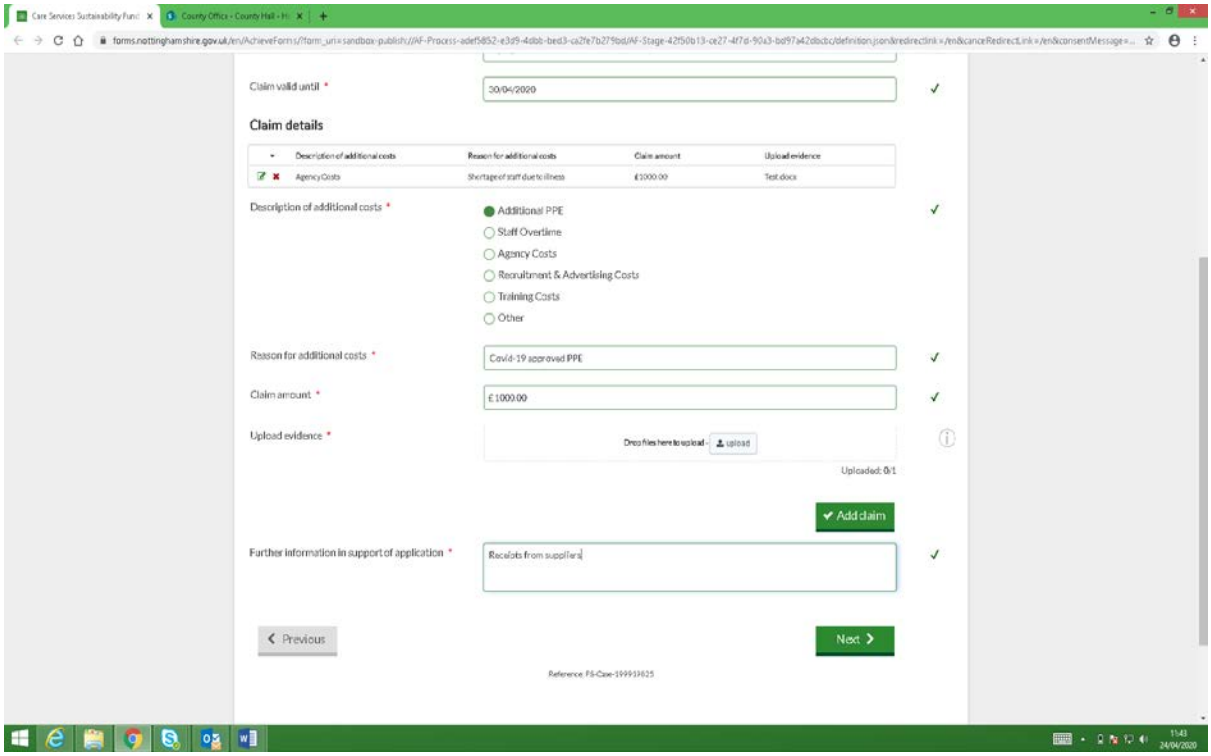


Screen 2 (continued - for additional costs):



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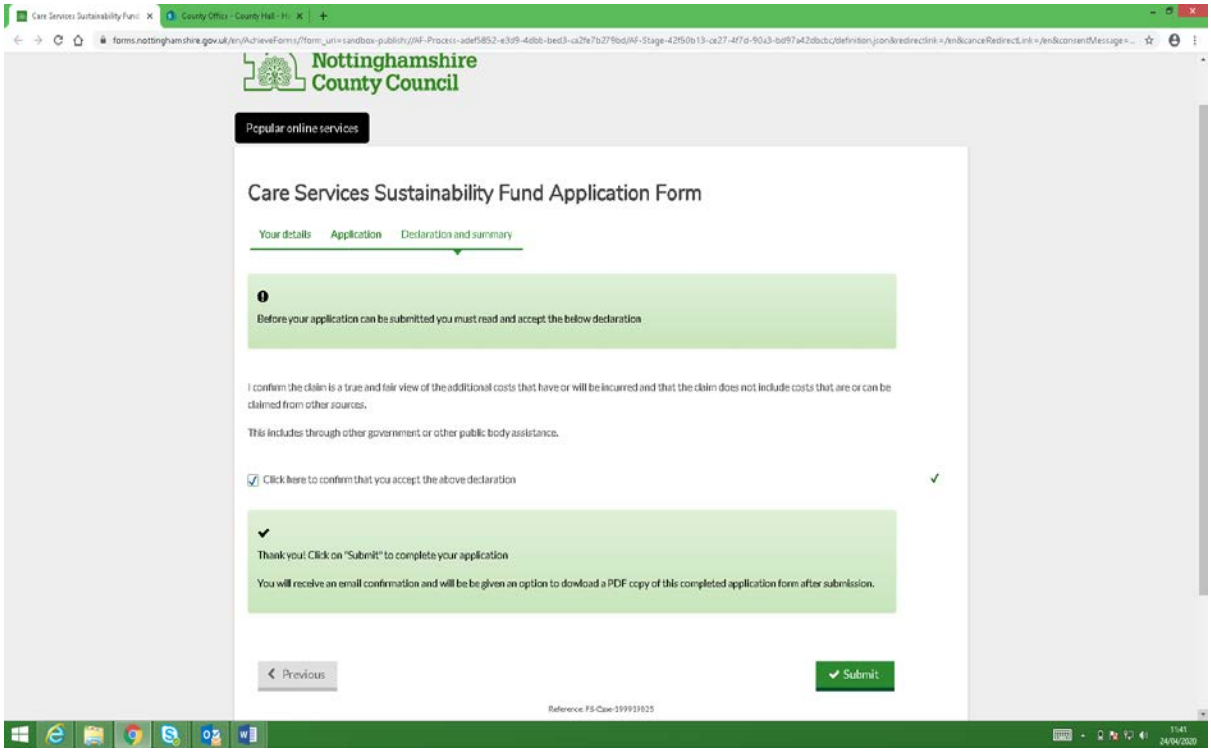
Nottinghamshire County Council
Popular online services
Care Services Sustainability Fund Application Form
Your details
Application
Declaration and summary
Before your application can be submitted you must read and accept the below declaration
I confirm the claim is a true and fair view of the additional costs that have or will be incurred and that the claim does not include costs that are or can be claimed from other sources.
This includes through other government or other public body assistance.
Click here to confirm that you accept the above declaration
Thank you! Click on "Submit" to complete your application
You will receive an email confirmation and will be be given an option to dowload a PDF copy of this completed application form after submission.
Previous
Submit

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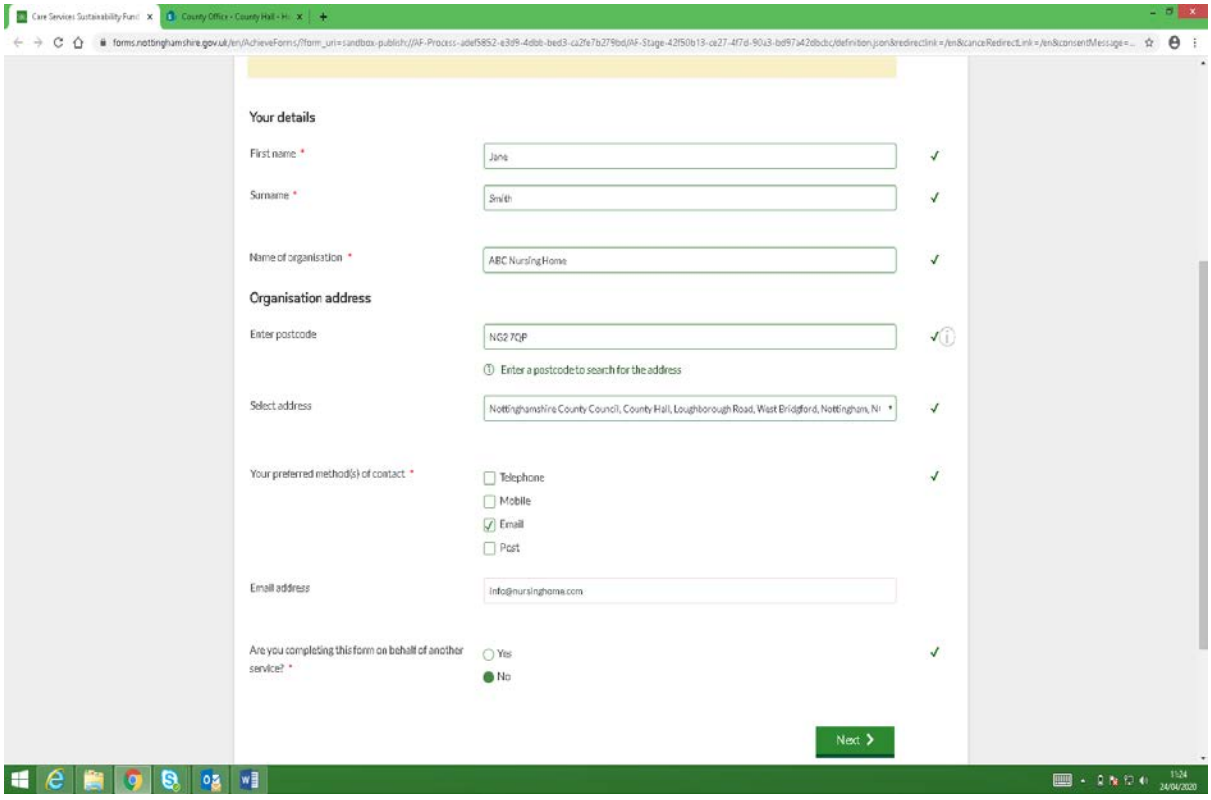

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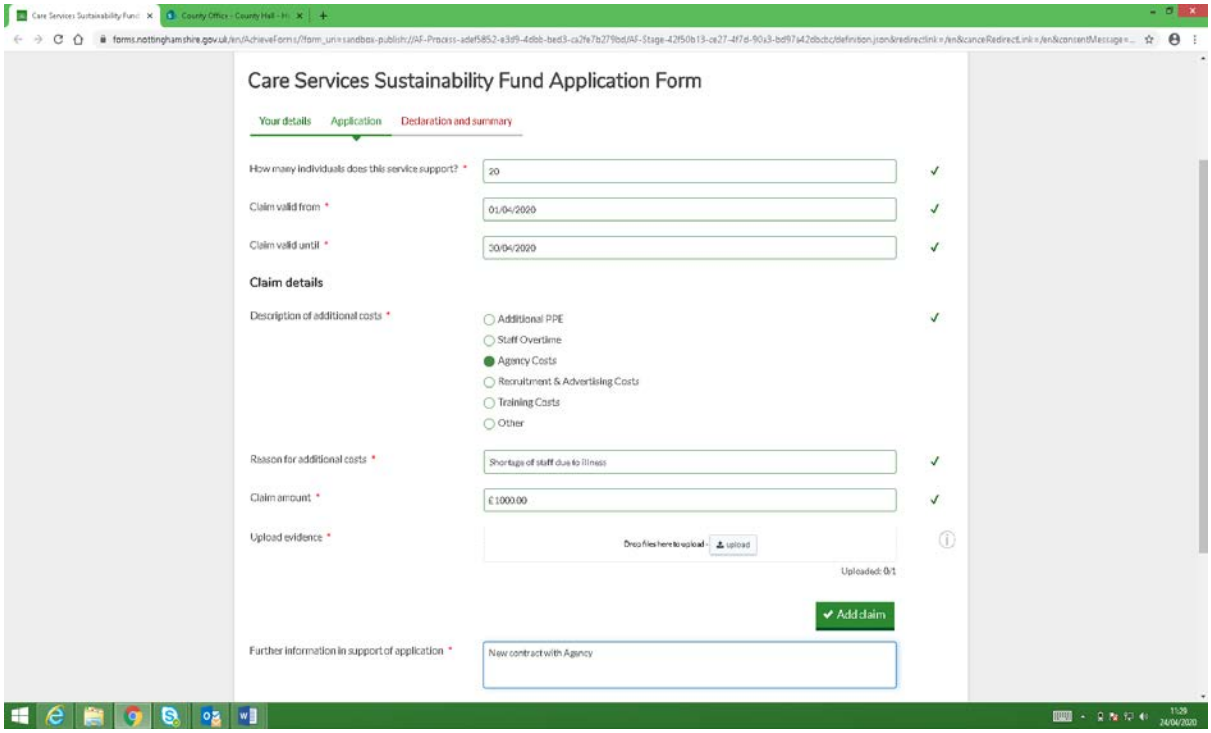

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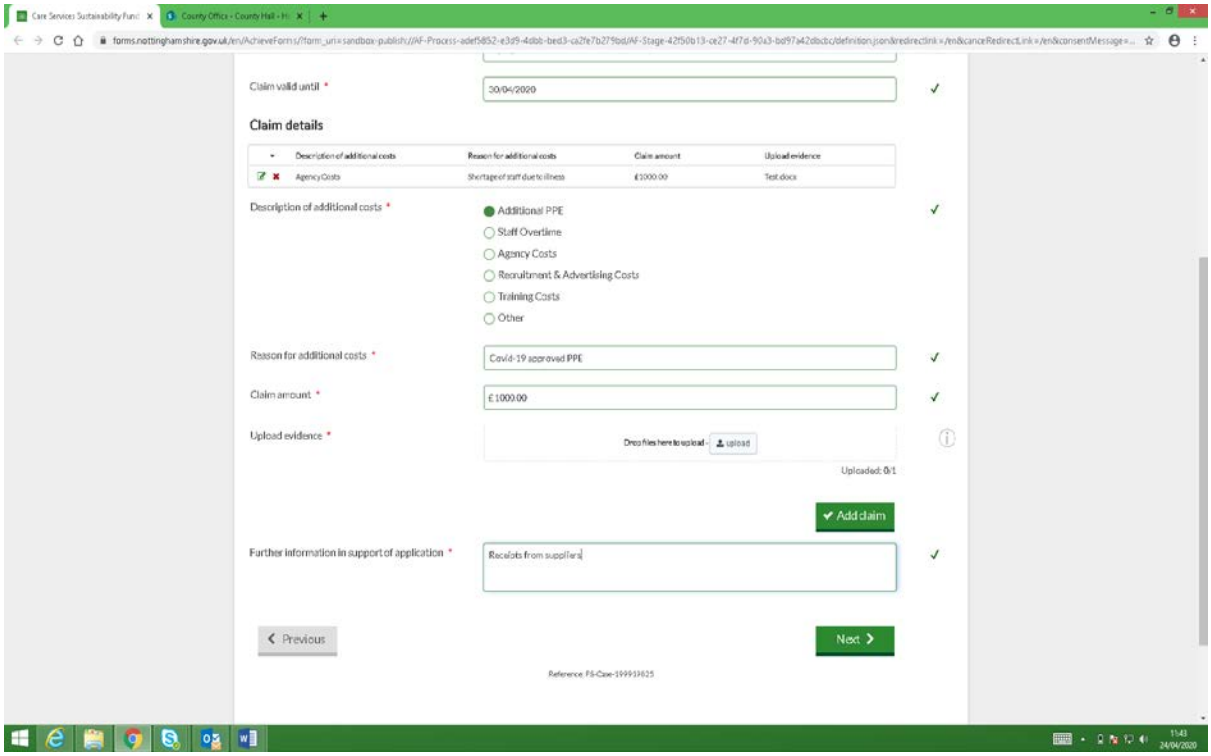

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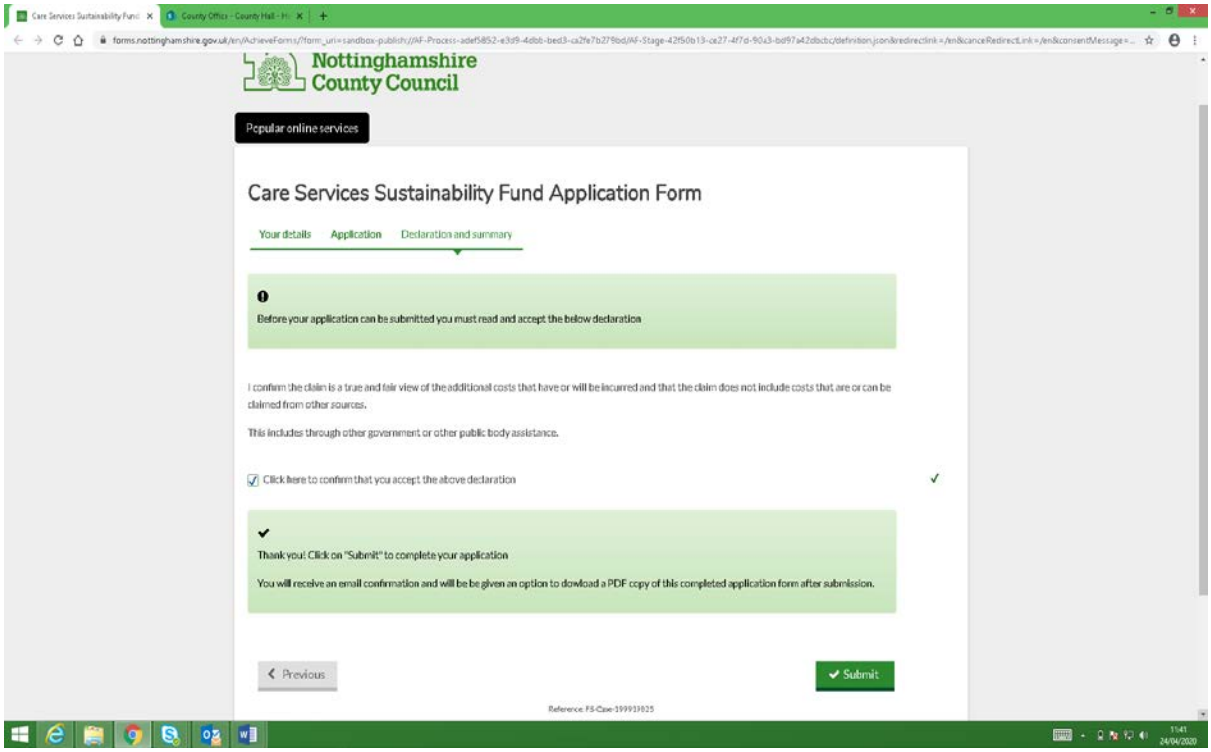
Nottinghamshire County Council
Popular online services
Care Services Sustainability Fund Application Form
Your details
Application
Declaration and summary
Before your application can be submitted you must read and accept the below declaration
I confirm the claim is a true and fair view of the additional costs that have or will be incurred and that the claim does not include costs that are or can be claimed from other sources.
This includes through other government or other public body assistance.
Click here to confirm that you accept the above declaration
Thank you! Click on "Submit" to complete your application
You will receive an email confirmation and will be be given an option to dowload a PDF copy of this completed application form after submission.
Previous
Submit

Market Leading People Practitioners
0800 567 7003
www.precisehr.co.uk

Q&A - Furlough Leave

What does furlough mean?

"Furlough" is an American term and has no prior meaning in UK employment law. In the US, it means to allow or force someone to be absent temporarily from work.

In this scenario, it means anyone asked to stop working during the coronavirus pandemic but who has not been made redundant.

What is the Coronavirus Jobs Retention Scheme (CJRS)?

Under the CJRS, employers can contact HMRC for a grant to cover 80% of the "wage costs" of "furloughed" workers up to a total of £2,500 per month. Employers can top up the remaining 20%, but there is no obligation to do so. The scheme will cover the cost of wages backdated to 1 March 2020 and will be open initially for 3 months. The Chancellor said in his announcement on 20 March 2020 that there will be no limit on funding available for the scheme.

Importantly, the Government statement said that "changing the status of employees remains subject to existing employment law and, depending on the employment contract, may be subject to negotiation."

What steps must employers take to put employees on furlough leave?

1. Decide which employees will be designated as furloughed workers.

2. Give notice to those designated as furloughed workers, preferably in writing. We have drafted a template letter for this purpose. Email sam@precisehr.co.uk for a copy.

3. Do employee representatives or trade unions need to be consulted?

    • Varying the contracts of 20 or more employees to reduce pay to 80% with the intention to dismiss if consent is not achieved would mean under section 188 of TULRCA these employees would be classed as dismissed by reason of redundancy. There would be a duty to inform and consult appropriate employee representatives.

    • We believe that it is not necessary to go down this route in these circumstances, though.

4. Exercise a contractual right to lay off. If necessary, vary contracts to introduce one.

    • Employees are likely to agree furlough leave on 80% pay but agreement is not necessary to unilaterally vary the contract.

5. Provide information to HMRC about the furloughed employees through the new online portal.

Further guidance is expected from HMRC as to what information is required.

What is the process for accessing funds?

The government has said that money will be claimed via HMRC and that they are setting up a portal to enable companies to do so.

How should we select the employees to be furloughed?

The CJRS involves "furloughing" designated workers who would otherwise have been "laid off" during this crisis. It is important that no discriminatory or otherwise proscribed reason is used for designating an employee as furloughed.

Otherwise, there is no set procedure that needs to be followed.

What is covered by the cap of £2,500 per month?

It is not clear as to whether the reimbursement is intended to cover anything other than the employee's basic salary. However, the official guidance uses the words "all employment costs" which could suggest that pensions and other additional benefits may be included.

We are currently awaiting further information and guidance on this specific point.

When it comes to furlough leave, what do we do about individuals with irregular earnings in regard to calculating salary? Should the salary calculations for furlough include overtime &commission, if so on what reference period (12 weeks/52 weeks etc.)?

At the moment, further information is required as to what 'pay' is defined as under the CJRS. For example, is it 80% of gross or net pay and is the employer going to have to pay income tax?

In other employment law areas, a week's pay is defined by reference periods, which often is over a 12 week period.

Do we have to pay back any of the money that will be paid by the government? Wil this be via tax at a later date?

There is currently no information from the government or HMRC about any repayments. However, this seems unlikely.

Is it possible to make a claim under the CJRS if a furloughed worker is still working?

If the employee is still doing work for the company that furloughed them, then this will not count.

Would it be a breach of trust and confidence to lay staff off?

If there is an express contractual right to lay off, as long as this right is not exercised in any discriminatory or malicious way, this would not be a breach of trust and confidence.

Furthermore, case law establishes that there is no implied term as to how long an employer can keep an employee on lay off.

Can you tell me if an individual can undertake any other employment while furloughed e.g. a temporary position stocking shelves in the supermarket?

This might be possible as the only details currently released are that an individual cannot undertake any work for an employer that has furloughed them.

To be laid off, though, an employee must be "available for work."

The position is not certain however and it is expected that the government will elaborate on the rules regarding working elsewhere.

What about employees who are sick or self-isolating?

To be laid off, an employee must be "available for work."

If they are off sick before the period of furlough leave, they will not be available for work.

They are likely to be eligible for statutory sick pay (SSP), however this would usually be at a lower rate than furlough pay.

If an employee becomes sick whilst on furlough leave, this is only likely to become an issue if the employer asks them to return.

If they are self-isolating, in these circumstances we would expect them to be included in the scheme.

What about employees on e.g. maternity leave?

There would be no change to the status of employees on maternity or paternity leave.

Will we have to pay redundancy payments?

Furloughed workers are not redundant so in short, no.

However, if an employer exercises an express or implied right to lay off an employee, in certain circumstances, the employee becomes entitled to claim a statutory redundancy payment. The same applies to short-time working, the definition of which arguably applies here (if the employee will receive less than 50% of their pay, which is possible given the cap).

The employee must have been laid off or kept on short-time working (or a combination of both) for at least: four or more consecutive weeks; or a total of six weeks in any period of 13 weeks.

If an employer provides a contractually guaranteed rate of pay, an employee cannot be laid off for the purposes of claiming a redundancy payment under the statutory scheme. Whether this applies will depend on the contract.

How do we best consult staff when they are all at home?

We suggest where possible that you contact staff via telephone or if possible, by video conferencing. Alternatively, you could look to contact by email.

Is an organisation obligated to make up the difference between the 80% of wages that will be met by the government?

An employer could choose to fund the differences between this payment and your salary but does not have to.

Will there be a breach of trust and confidence if an organisation does not 'top up' the extra 20% under the CJRS is made by an employer?

Unlikely, given that you will have laid people off under an express contractual right to do so.

Can an employee be forced by their employer to take furlough leave?

If a contractual clause exists which permits the employer to either lay off, or bring in short time working, an employer can insist on furlough leave without consent.

Is it possible for an employee to ask their employer that they be placed on furlough leave?

Yes, but there is no obligation for an employer to agree to do this.

If employees are placed on furlough leave, can there be a rotation of furlough leave between members of staff?

It is not clear as to whether this will be permitted but we see no reason why not.

As business needs may change, it would appear sensible for rotation to be allowed but we do not yet know.

Can we furlough workers, and then take them back on if needed?

Yes, they will remain employees and the employer can end the period of lay off when needed.

If instead of furlough leave an employer wants to make somebody redundant, will this be deemed unfair?

If an employer wants to undertake a redundancy exercise, then they can do so.

The question then becomes whether the redundancy exercise has been fair. The CJRS is designed however to keep people in employment and to discourage redundancies. There is also a financial disincentive in making an employee redundant as it would also mean paying notice and any applicable redundancy payment.

Whether the redundancy would be fair would depend on the outcome of consultation. If the employee would rather be furloughed, a dismissal may well be unfair.

What if we've already made staff redundant?

The government announcement talked about staff being brought back into the workforce. So it would seem possible to re-employ staff and then furlough them.

Will all businesses regardless of size will be able to furlough their employees?

There is no indication that there will be any restriction by size of business; to the contrary.

What should we do about any employees who are still working but object to other colleagues receiving 80% of pay on furlough leave?

It is expected that you may have to deal with grievances being raised on this point, but there is nothing to prevent you from looking to resolve any issues informally should they arise.

However, there is no right for employees to insist on being placed on furlough leave.

What is the position in regard to individuals such as agency staff and zero-hour workers under the CJRS?

Whilst there is no explicit confirmation, it is expected that the CJRS will be applicable to all employees.

Will annual leave continue to accrue for furloughed workers?

Annual leave will continue to accrue if an employee is furloughed because they will remain employed as opposed to being made redundant.

It would require specific laws to enable furlough leave, to be classed as annual leave.

To manage this, you could agree with people that they take annual leave instead of furlough leave, but there may be little incentive to do so for many employees.

What about the National Minimum Wage (NMW)?

The NMW is a prescribed minimum hourly rate of pay which employers must legally pay to most of their workers. As furloughed employees won't be working, the NMW will not apply.

Will employees who have moved back home (to other countries) still be eligible to be put into this scheme, if they are still technically employees?

If someone has moved back home, it is hard to see how they could be said to be available for work.

If they are furloughed, there would appear to be no restriction on their location during such a period.

What happens to staff that started after the 28th Feb or started in February but added on payroll in March, will they still be entitled to the 80%?

The scheme is backdated until 1 March 2020 and appears to be available for employees, with no restriction on start date. We await further guidance, however.

When they were technically added to payroll will probably be a non-issue

Subject: FW: UPDATE IPC contact details have temporarily changed

Importance: High

From: IPC (NHS MANSFIELD AND ASHFIELD CCG) <MACCG.IPC@nhs.net>
Sent: 30 March 2020 10:14
Subject: UPDATE IPC contact details have temporarily changed
Importance: High

Dear Manager

It has come to our attention that the email address we had been given for PHE was incorrect. Please see amended details below.

Kind regards

IPC Team

From: IPC (NHS MANSFIELD AND ASHFIELD CCG)
Sent: 25 March 2020 10:09
Subject: UPDATE IPC contact details have temporarily changed
Importance: High

Dear Manager

The Infection Prevention & Control (IPC)Team are now working full time on the CCG's Covid-19 incident response and urgent IPC work only. Please use new email contact details below, the usual landline numbers are no longer in use.

If you need to report an outbreak for non-respiratory symptoms or are concerned about a resident with a healthcare associated infection please email MACCG.IPC@nhs.net and a member of the team will call you back during office hours. During evenings and weekends to report an outbreak or gain urgent advice contact PHE on 0344 2254524.

If you are wanting to report a suspected case of COVID-19 in any residents, please notify PHE on 0344 2254524 or email PHE.CRC.eastmidlands@nhs.net

If you have any other COVID-19 query, please contact the Incident Control Centre on 0115 8831111 or email on nnestccg.nottsincidents@nhs.net Phone lines operate 8am to 8pm 7 days per week.

Kind Regards

Infection Prevention and Control Team
NHS Mansfield and Ashfield Clinical Commissioning Group

Birch House
Ransom Wood Business Park
Southwell Road West
Mansfield
Nottinghamshire
NG21 0HJ

maccg.ipc@nhs.net

****

This message may contain confidential information. If you are not the intended recipient please inform the
sender that you have received the message in error before deleting it.
Please do not disclose, copy or distribute information in this e-mail or take any action in relation to its contents. To do so is strictly prohibited and may be unlawful. Thank you for your co-operation.

NHSmail is the secure email and directory service available for all NHS staff in England and Scotland. NHSmail is approved for exchanging patient data and other sensitive information with NHSmail and other accredited email services.

For more information and to find out how you can switch,
https://portal.nhs.net/help/joiningnhsmail

The following message has been applied automatically, to promote news and information from Nottinghamshire County Council about events and services:

Nottinghamshire County Council is committed to protecting your privacy and ensuring all personal information is kept confidential and safe – for more details see https://www.nottinghamshire.gov.uk/global-content/privacy

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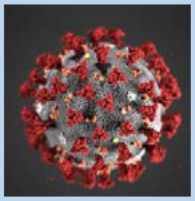
Emails and any attachments from Nottinghamshire County Council are confidential. If you are not the intended recipient, please notify the sender immediately by replying to the email, and then delete it without making copies or using it in any other way. Senders and recipients of email should be aware that, under the Data Protection Act 2018 and the Freedom of Information Act 2000, the contents may have to be disclosed in response to a request.

Although any attachments to the message will have been checked for viruses before transmission, you are urged to carry out your own virus check before opening attachments, since the County Council accepts no responsibility for loss or damage caused by software viruses.

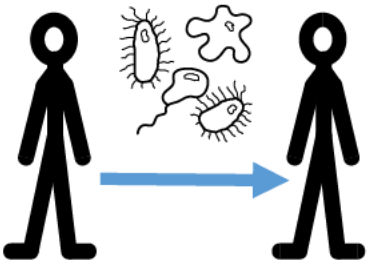
You can view our privacy notice at: https://www.nottinghamshire.gov.uk/global-content/privacy

Nottinghamshire County Council Legal Disclaimer.



Washing your hands

Lots of people are **getting poorly** at the moment because of a new illness called **coronavirus**

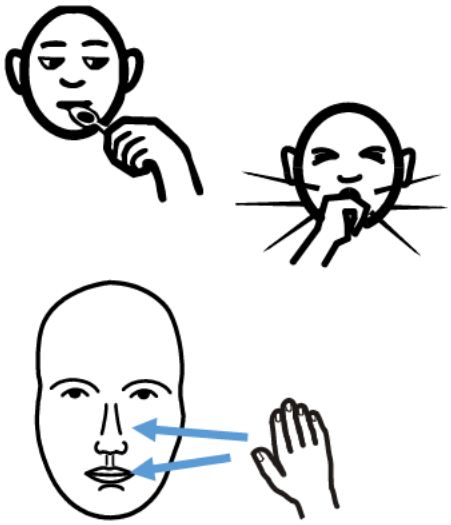


The virus is passed from **person to person** by **germs**

To **help stop** the spread of **germs**, people **must wash** their hands with **soap and water:**

We must **take our time** when we **wash our hands**.

Washing between **fingers** and **all over** our hands.



We should wash our hands

- **Before eating**
- **After sneezing or coughing**
- After **touching your nose** or **mouth**

Department of Health & Social Care

Home Delivery Programme Pilot

Pillar 2 National C19 testing programme

17/04/2020

Home Delivery Programme Pilot: Purpose

The National Testing Programme provides COVID-19 tests to frontline workers or symptomatic members of their household to support the NHS and other employers of frontline workers in maximising its workforce capacity during this unprecedented time.

Why is the Government rolling out Home Testing for COVID-19?

The Secretary of State has been clear that he wants 100,000 frontline workers to be tested for COVID-19 per day by 30 April. An important element of this will be rolling out Home Testing, which the evidence suggests is safe, effective and convenient for those needing to self isolate.

The aim of the Home Delivery Pilots is to demonstrate the end-to-end process for the delivery and collection of multiple types of test kit from frontline workers home. These pilots are aimed to gradually ramp up in terms of volume of tests handled.

The following slides overleaf will explain all of the steps required for the frontline worker during this process as well as answering template and testing FAQs.

Eligibility

Who is eligible for testing?

It is critical that only eligible individuals are sent for COVID-19 testing. This is to ensure efficacy of the test itself, and to ensure that all tests are being used to help get frontline workers who are isolating back to work

Home testing is in particular targeted (but not exclusively) at frontline workers who cannot access a drive through test site for example due to lack of access to transport or remote locations.

Self-isolating because frontline worker is symptomatic

In this instance the keyworker is the only eligible person in their household to receive a COVID-19 test. No other members of their household are eligible.

Self-isolating because an adult (over 18) in their household is symptomatic, but the frontline worker is not

In this instance only the adult household member(s) of the keyworker is eligible to receive a COVID-19 test. It is that household member(s) whose data must be collected. The frontline worker will not receive a test. If more than one household member is symptomatic, but not the keyworker, then all household members should be tested.

Self-isolating because a child (age 5-18) in their household member is symptomatic, but the frontline worker is not

In this instance, only the under 18 household member of the keyworker is eligible to receive a COVID-19 test. Because the household member is under 18 a parent or guardian must perform the test on the under 18 year old. Children under 5 are currently not eligible to be tested.

Self-isolating for other reasons

If the keyworker is self-isolating for other reasons and is not themselves symptomatic, they are not eligible to be tested

High Level pilot process

The summary process is shown below. Further step by step guidance is shown overleaf:

- frontline workers are nominated by their employers. Employers complete a manual booking form. A digital solution is being developed.
- As part of this we require the following information of the frontline worker:
  - First Name
  - Surname
  - National Insurance Number
  - Email Address
- The frontline worker will receive their invitation and instructions by email. Instructions on how to take their sample will be in their test kit
- Following the order of the home test kit, Amazon will deliver the test kit the following day
- This is a self-administered test, following which the Royal Mail courier service will collect the test kit from the Subject's home
- Test results will be delivered (estimated as 48-72 hours) by email direct to the person(s) who has undertaken a test from the test lab

GDPR and Data Protection

- The DHSC privacy statement can be found here and contains any information you may need in relation to GDPR considerations: https://www.gov.uk/government/publications/coronavirus-covid-19-testing-privacy-information/testing-for-coronavirus-privacy-information
- We expect employers to check with their employee's that they are happy for the employer to share their information with the DHSC before sending this information to us.
- For the Home Test pilot, this information will be shared with:
  - Deloitte (for collating and sending to NHS Digital).
  - NHS digital for uploading onto the portal
- Once the individual has uploaded their address details into the NHS digital portal, this information will be shared with:
  - Amazon who will arrange for the home delivery of the test
  - Royal Mail who will arrange to pick up the test

Step-by-Step pilot process

Step 1: The submission template contains the required fields to be populated for each frontline worker put forward for home testing. The template is password encrypted and passwords cannot be shared on the same mode as the template.

Step 2: The designated organisation lead must provide their email address in order to be granted permission to upload to the Home Testing Folder on ShareFile.

Step 3: Once you have access to the Home Testing template. The frontline worker is required to provide the following details:

- First name;
- Last name;
- National Insurance number (The frontline worker's national insurance number must be provided as it is the only unique identifier for the system to send an invitation link) and;
- Email address (The frontline worker's email address is required for the invitations, instructions and test results to be sent to. This can be your work or personal but an email that the frontline worker can access from place of self-isolation)

***ALL fields must be completed.**

Step 4: Ensure the frontline worker's national insurance number is filled out in the correct format:

- There should be two prefix letters, six digits and one suffix letter. The example used is typically QQ123456C.
- Neither of the first two letters can be D, F, I, Q, U or V.
- There should not be any special characters. ?, !, & . are not allowed
- There should not be any blank or unknown entries
- All in uppercase

Step-by-Step pilot process

Step 5: Once the template has been populated, the designated organisation lead will upload the submission to ShareFile. All submissions must be uploaded to the **ShareFile Home Testing** folder no later than **2pm** on a daily basis. Please change the date for each **daily submission** (should you have more) into the title of the spreadsheet, and ensure that **'insert name of organisation-Home testing dd/mm/yy'** is in the title of the template.

Step 6: We will submit your details on the same day that you upload your submission and you will receive an email from NHS X at 8am the following day. The email will contain an invitation to an online portal which will allow the frontline worker to order the required number of kits for themselves and/ or their family member(s).
5 kits can be ordered per household however, test kits should only be ordered for people who are presenting Coronavirus symptoms and are self-isolating. Please note, the kits must **not** be used on children under the age of 5 (please refer to the FAQ's at the end of the pack for further information).

Step 7: Following the order of the home test kit(s), Amazon will deliver the test kit(s) within 24 hours.

Step 8: As soon as you receive your test kit, and before using your test kit, please visit the link that will be included in your email invitation to register your kit and schedule your courier collection service with Royal Mail. The Royal Mail collection of the swab **must** be scheduled to pickup between 0800-1600 the day after Amazon delivery.

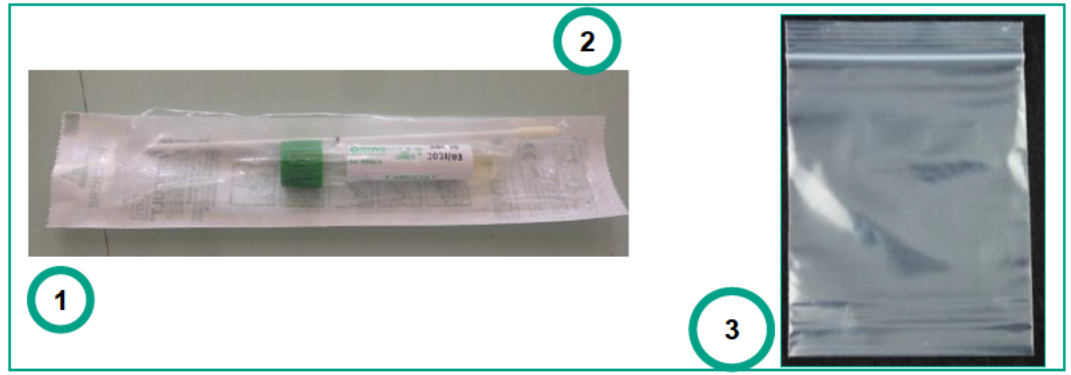
Step 9: On the day of the delivery you should carry-out the self-administered test. Please take your sample after 9pm the day before your collection or before 7am on your scheduled collection day. All details of how to take the test are included in the Instructions enclosed in your test kit. **The slide overleaf will give you an indication of the tools that will be included in your delivery.**

Step-by-Step pilot process

- **Testing Kit will include:**
  1. One Swab
  2. Plastic Vial (inc media)
  3. Plastic Bag

- **Sample Return Packaging:**
  4. Super Absorbent Sheet
  5. 95kPa Pouch
  6. Rigid Outer Box
  7. Tamper Evident Security Seal

- **Kit Peripherals:**
  8. 4 x Barcodes



Step-by-Step pilot process

Step 10: Once you have used the test kit, use the packaging included in the kit to seal the package and attach the enclosed return label. All Packaging Instructions are enclosed in your test kit.

Step 11: Royal Mail will collect the swab from your home at the time you scheduled between 0800-1600. ALL household samples must be ready at the same time and you MUST wait at home for your collection. In order to observe the social distancing rules in place, when the courier arrives they will knock on the door and then move at least 2 meters away. When they have moved away, please open your door, place the packaged test kit outside your door, and close the door. The courier will collect the package, return it quickly and efficiently back to the laboratory.

Step 12: The frontline worker will receive an email with the test results within 48-72 hours of Royal Mail picking up the sample. The results will be sent to the email address the frontline worker provided in the application.

Template Completion FAQs

Template Completion FAQs

01

What information do I need to provide on the spreadsheet? – Please ensure that the following fields are completed on the template:

- First name;
- Last name;
- National Insurance number; and
- Email address (work or personal but an email that the frontline worker can access from place of self -isolation).

02

Who's details am I submitting? – The details of the frontline worker. The frontline worker is responsible for ordering the number of kits required for themselves and/ or their family members.

03

How should I fill out my national insurance number? – National Insurance numbers should be filled out as follows:

- Two prefix letters, six digits and one suffix letter. The example used is typically QQ123456C.
- Neither of the first two letters can be D, F, I, Q, U or V
- There are no special characters. ?, !, & . These are not allowed
- There should be no entries as "unknown"
- They should all be uppercase / capital letters

04

Why do I need to submit my national insurance number and email address? –

- The frontline worker's national insurance number must be provided as it is the only unique identifier for the system to send an invitation link.
- The frontline worker's email address is required for the invitations, instructions and test results to be sent to.

05

When is the deadline for submissions? - all submissions must be uploaded to the ShareFile Home Testing folder no later than **2pm** on a daily basis.

06

In what format should I upload the submission? - Please change the date for each daily submission (should you have more) into the title of the spreadsheet, and ensure that '**[Organisation Name]-Home testing [dd/mm/yy]'** is in the title of the template.

Testing FAQs

Testing FAQs

01

What is the purpose of being tested? –
Getting tested is important to understand if you, or a member of your household, have COVID-19, so that you will know what steps to take to look after yourself, protect others and know if you are fit and well to return to work isolation).

02

How often can we submit our admissions to SharePoint? –
Daily until there is a digital solution.

03

Is this service available 7 days a week and can we submit over the weekend? –
Yes.

04

What is the expected capacity in the next week ahead? –
The aim is to get to 30,000 tests per day over the next few weeks.

05

Can the test be performed on Children? –
The test cannot be performed on children under the age of 5 as they have smaller nostrils a standard swab is inappropriate as it will not easily fit without causing discomfort. Over 5's- Under 12's: Should not be swabbing themselves and should have the swab administered by a parent/guardian regardless of the testing setting.
Over 12's – Under 18's: May elect to swab themselves under parental guidance or be swabbed by their parent or guardian or have an administered swab taken

06

When will a frontline worker receive their email invitation? –
After we have submitted your details you will receive an email invitation from NHS X at 8am the following day.

Testing FAQs

07

When can a frontline worker place my order? –
Once you receive your email invitation and instructions the ordering portal will be open from 0800-1600 every day. If you haven't placed your order you will receive another reminder the following day.

08

How many kits can a frontline worker order for one household? –
5 kits can be ordered per household if required. Test Kits should only be ordered for people who are presenting Coronavirus symptoms and are self-isolating

09

When would the delivery of the kit happen? -
frontline workers will be notified when the portal is open to order kits. Once the frontline worker has placed their order, Amazon will drop off their test kit(s) within 24 hours if orders are made before 13:30.

10

When will the collection of the swab happen?
In the email invitation the frontline worker will need to schedule a time slot for the Royal mail courier to pick the test up from the frontline worker's house for the day after they have received the kit. They must be at their home when collection happens. The Royal Mail collection of the swab must be scheduled to pickup between 0800-1600 the day after Amazon delivery. ALL household samples must be ready at the same time.

11

Is Home Testing for COVID-19 safe/effective?
International peer-reviewed evidence suggests that self swabbing is just as effective at securing a valid sample as clinician-administered testing.

12

While self-swabbing might work for NHS workers, what about for other non-health frontline workers, will they be skilled enough to do it? -
Evidence suggests that those with no clinical background or training should be completely able to secure an effective sample.

Testing FAQs

13

What will the test tell me? –
The test will confirm if an individual who is showing symptoms of the disease actually has it. It will not confirm whether they have had it and have now recovered.

14

How long do results take to come back?
The frontline worker will receive an email with the test results within 48-72 hours of Royal Mail picking up the sample. The results will be sent to the email address the frontline worker provided in the application. This can be a work or personal email address that the frontline worker can access from place of self –isolation.

15

Will Amazon have access to my health data / results?
No. Amazon's only role is to use their world class logistics system to help deliver the tests to peoples' homes. They will not have access to any health or results data as part of this.

Dear Provider

Financial Support for Social Care Providers during COVID-19 Pandemic

The County Council values the relationship that it has with its external partners and when the Covid-19 pandemic began we very we very quickly developed 'financial principles' for working with our partners. One of the things we did was to agree to pay commissioned hours irrespective of what was delivered. This gave providers reassurance about what their income would be to enable them to concentrate on providing their services to local people during these very challenging times.

In addition to this we asked providers how we can best support them further in addition to the supply of local Personal Protective Equipment (ppe) and recruiting additional staff that will be available to work in social care. Some of that feedback has told us that you would benefit from being reimbursed for additional costs by way of a claim to the Council.

To discuss this further and to listen to your suggestions we would like to invite you to attend a virtual meeting to discuss the above on **Thursday 23rd April from 2 – 4pm.**

The meeting will be held through Microsoft Teams. Please see below details of how you can access the meeting: -

- If you are accessing this from a Smart phone or tablet you will need to download the Microsoft Teams App **before** the meeting from the App Store at no cost. Once you have downloaded the app you will then be able to enter the meeting via the invitation in your calendar, as a guest.

- If you are accessing this from your PC or laptop and have Microsoft Teams installed, you can accept the invitation through your app. If you do not have Microsoft Teams, we will invite you to join through using your email address and you can accept the invitation that will be sent to you and you will be able to join as a guest in your web browser.

Further information on how to access and use this application can be found on this link:

https://docs.microsoft.com/en-us/MicrosoftTeams/tutorial-meetings-in-teams?tutorial-step=4

Places will be limited to 50 people and allocated on a first come, first served basis. However, should we be oversubscribed a further event will be organised for early next week. The meeting will be recorded, so that the pertinent points can be shared as appropriate.

To join the meeting on Thursday 23rd April at 2pm, please email claire.poole@nottscc.gov.uk with your name, organisation, job title and the email address that you would like to use to join the meeting.

Places will be limited to one per organisation.

The first 50 acceptances will be notified, a link will be sent along with information relating to the meeting and the protocol for participating.

We very much look forward to hearing from you and joining the meeting on Thursday.

Kind regards

Cherry Dunk and Clare Gilbert.

Publications approval reference: 001559

Version 1, 23 April 2020

Department of Health & Social Care

NHS

Novel coronavirus (COVID-19) standard operating procedure

Running a medicines re-use scheme in a care home or hospice setting

This guidance is correct at the time of publishing. However, it is subject to updates so please use the hyperlinks to confirm you are accessing the most up-to-date information.

NHS England and NHS Improvement

Contents

1. Purpose

This standard operating procedure (SOP) supports timely access to essential prescribed medicines during the COVID-19 pandemic for patients who are being cared for in a care home[1] or hospice setting.[2] In England, care homes can offer nursing and personal care or personal care only. The latter may not employ any registered nurses. This guidance is applicable in England and for use during the COVID-19 pandemic only.[3]

Care homes and hospices in Northern Ireland, Scotland and Wales should refer to guidance and SOPs produced by the governing bodies and regulators in their devolved administration.

2. Background

COVID-19

Public Health England has issued guidance on managing COVID-19 in a residential care setting.

Managing medicines

NICE has issued good practice for managing medicines in care homes. The guidance promotes safe and effective use of medicines in care homes by advising on processes for prescribing (including remote prescribing), handling and administering medicines. It also recommends how medicines (including controlled drugs) should be received, stored and disposed of within a care home setting. That guidance includes a recommendation that care home providers must ensure that medicines prescribed for a resident are not used by another resident.

Although this remains good practice, this new Standard Operating Procedure is designed to help providers manage situations where, during the COVID-19 pandemic, the best interest of patients mean that it is not appropriate to follow this recommendation.

Recycling/re-use of unused medicines

The Human Medicines Regulations 2012[4] are the legislation that underpins the dispensing and supply of medicines, supplemented in the case of controlled drugs by the

[1] The Care Standards Act 2000 defines a 'care home' as accommodation that provides nursing or personal care.
[2] Hospice care aims to improve the quality of life and wellbeing of adults and children with a life-limiting or terminal condition. It helps people live as fully and as well as they can to the end of their lives, however long that may be.
[3] The up-to-date status of the COVID 19 pandemic is confirmed at https://www.gov.uk/coronavirus
[4] http://www.legislation.gov.uk/uksi/2012/1916/contents/made

Misuse of Drugs Regulations 2001. Part 12 of the Human Medicines Regulations 2012 limits the supply of prescription-only medicines (POMs) to supply in accordance with a prescription of an authorised prescriber, subject to various exceptions including supply under a patient group direction (PGD).

Provided that a supply is, in fact, in accordance with the prescription, for the specific purposes of Part 12 of the Human Medicines Regulations 2012, it will generally not be relevant how that medicine is sourced.

Accordingly, if at each stage of the supply chain the legal requirements relevant to that stage have been adhered to, the possibility exists that providers may have in their possession medicines that they are lawfully entitled to have in their possession for one purpose which they may be able to use for another purpose. This new guidance is to support making appropriate use of that recognised possibility in care homes and hospices.

When a patient is prescribed a medicine, once the final supply of the medicine is completed and it is in the patient's safe keeping, it is their property (although not their exclusive responsibility). If the medicine is still in the safe custody of the care home or hospice care provider, whether or not the final supply to the patient has been completed is the subject of differing legal views. Some would say that it becomes the patient's property as early as when it leaves the pharmacy.

This guidance does not seek to resolve these complex legal issues. Rather, it presents an agreed line through them, in the current very unusual circumstances, and that agreed line is strictly for the limited purposes which the guidance addresses.

Under usual circumstances, the re-use or recycling of another patient's medicine is not recommended by the Department of Health and Social Care (DHSC) as the quality of any medicine that has left the pharmacy cannot be guaranteed. Any unused medicines would normally be disposed of by returning them to a contracted external company or community pharmacy.

However, there are increasing concerns about the pressure that could be placed on the medicines supply chain during the peak of the COVID-19 pandemic. A medicines re-use scheme for care homes and hospices could potentially ease some of that pressure in the coming weeks.

Medicines re-use schemes already operate successfully in NHS hospitals across the UK. In addition, hospices and care homes generally have good procedures in place to store

medicines in an appropriate way. We can therefore be more confident of the quality of any unused medicines in these settings.

Due to the current unprecedented impact of COVID-19, DHSC and NHS England and NHS improvement are recommending a relaxation of previous recommendations and the NICE recommended good practice guidance to accommodate re-use of medicines, under very specific circumstances and only in a crisis situation as outlined.

First and foremost, the quality, integrity and safety of medicines are paramount and the best way to assure this is for pharmacies to supply medicines obtained through the regulated supply chain, appropriately labelled for individual patients.

However, in the unprecedented COVID-19 situation, DHSC and NHS England and NHS Improvement recognises that the re-use of medicines may be appropriate in certain circumstances. It is recommended that medicines should only be re-used in accordance with a medicines re-use scheme, set out in a SOP.

This SOP has been developed to support care home and hospice providers. It offers a framework to run a safe and effective medicines re-use scheme that is in the best interest of patients.

3. Medicines re-use scheme SOP for care homes and hospices

When would this apply?

This is time limited and would only apply during this period of emergency. i.e. during the COVID-19 pandemic.

What might constitute a crisis?

Each individual care home or hospice must carry out a risk assessment on an individual medicine basis.

Three key indicators should inform the risk assessment and the subsequent decision:

- No other stocks of the medicine are available in an appropriate timeframe (as informed by the supplying pharmacy) and there is an immediate patient need for the medicine.
- No suitable alternatives for an individual patient are available in a timely manner i.e. a new prescription cannot be issued, and the medicine(s) supplied against it in the conventional manner quickly enough.
- The benefits of using a medicine that is no longer needed by the person for whom it was originally prescribed or bought, outweigh any risks for an individual patient receiving that unused medicine.

Is a medicine suitable for re-use?

The medicine must be checked against the criteria in Tables 1 to 3 (see below) by a registered healthcare professional.[5]

Where no registered healthcare professional is on site (eg in a care home that only offers personal care and has no registered nurses on site), registered healthcare professionals (eg pharmacists, pharmacy technicians, general practitioners, community nurses) from other local organisations, such as clinical commissioning groups, general practices or community settings, can perform that check (this may be done virtually) and confirm that the medicine is suitable for re-use.

All medicines no longer needed by the person for whom they were originally prescribed and intended for re-use must be under the supervision of a registered healthcare

[5] A healthcare professional should be registered with one of the UK's professional regulatory bodies regulated by the Professional Standards Authority.

professional and appropriate records should be kept, including details of the registered healthcare professional who performed the check on suitability for reuse.

If the medicine suitable for re-use is a controlled drug, then it must remain in the control (possession) of an organisation authorised to do so. Further information from the Home Office can be found here. Appropriate records (e.g. controlled drugs register) **must** be maintained in respect of controlled drugs.

This SOP applies to medicines that have been supplied to patients while in a care home or a hospice, have not been removed from that setting (other than for short periods e.g. an outpatient appointment) and have been stored in accordance with good practice guidance on storing medicines in a managed setting. It applies to all medicines, including liquid medicines, injections (analgesics, insulin), creams and inhalers, that are in sealed or blister packs and when the criteria in Table 1 are met.

Providers should also consider, in the case of medicines that they have had difficulty accessing, whether the normal assumption of allowing patients to keep their own supplies of medicines for self-administration is appropriate, or whether other storage arrangements would better facilitate their re-use, if that patient no longer needs them.

Re-use should only be within a single care home/hospice setting; medicines identified for re-use should not be transferred to another care home or hospice, even those within the same parent organisation.

Tables 1 to 3 below provide supporting prompts to assist the registered healthcare professional with their decision making. It is advised that medicines for re-use are pro-actively assessed prior to them being needed in an emergency situation.

Table 1: Criteria to be considered before the medicine can be reused

	Yes	No	Notes
Is the medicine in an unopened pack or blister that has not been tampered with?			In an unopened, unadulterated and sealed pack (including sub-pack) or blister strip. If any doses have already been used, the remainder of that blister strip should be destroyed. If the contents (including blister strips and sealed individual units such as ampoules) are completely intact, then as long as they match the description on the packaging

			they were retrieved from (including check of batch numbers) they can be considered for re-use.
Is it in date?			Medicines should be in date. If expired, they will need to be returned to a pharmacy to be safely destroyed.
Has it been stored in line with the manufacturer's instructions, including any need for refrigeration?			Any medication that requires refrigeration, or that has a reduced shelf-life once removed from refrigerated storage, should be destroyed if it has not stored appropriately. Medicines left in unsuitable conditions (eg direct sunlight, near radiators) or where appropriate storage cannot be confirmed, should be destroyed.
Is the medicine a licensed medicine that has either been prescribed by a registered healthcare professional with prescribing rights or bought 'over the counter'?			For some medicines, 'homely remedies' are an option in care homes and should be considered in line with guidance: https://www.sps.nhs.uk/articles/rmoc-guidance-homely-remedies/

If the answer to all of the above questions is **yes,** then the risk of reuse may be judged to be minimal. If the answer to **any question** is **no** then the medicine should not be re-used. If doubt remains, discuss with appropriate registered healthcare professionals and local networks to get a wider perspective on the decision.

Table 2: Minimise risk of cross-contamination

	Yes	No	Notes
Is the medicine from a patient with a diagnosis of COVID-19 or showing symptoms of COVID-19?			Ensure that adequate infection prevention and control precautions have been taken. Medicine that has been retrieved from a patient infected with COVID-19 should be sealed (double bagged) and quarantined for three days. A do not process before date should be fixed to the bag before the bag is stored safely and away from any other medicines.

Table 3: Ensuring permission is obtained and patients, families and/or carers are fully involved

	Yes	No	Notes
If a medicine is thought to be suitable for re-use, permission should, if possible, be obtained for re-use from the patient for whom it was prescribed or (if the patient lacks capacity) from a person with power of attorney, or (if the patient has died) from their next of kin.			If the patient has become responsible for the safe keeping of the medicine, it is the property of the patient (although not their exclusive responsibility), but if the medicine is still in the safe custody of the care home or hospice care provider, whether the final supply to the patient has been completed is the subject of differing legal views. Reflecting this uncertainty, if possible, ensure the patient or their next of kin agrees for the medicine to be reused. **See Annex B.**

To ensure re-use of medicines is an option that can be used as flexibly as possible we suggest that care homes and hospices proactively seek written permission from all patients for:

- their medicines (if no longer needed) to be made available for other patients and/or
- them to receive a re-used medicine, provided they are deemed safe for re-use.

Further information to inform discussions is available in Annex B.

Once a decision has been made to re-use a medicine, then the following processes (summarised in the flow chart in Section 4 of this SOP) should be followed:

All medicines

1. A log should be maintained of re-used stock. The log should include the generic drug name, batch number, strength, formulation, expiry date quantity and details of the registered healthcare professional who assessed the medicine, as a minimum. When the stock is re-used, the quantity used should be entered. An example log returns sheet is given in Annex B.

2. Any medicines that might be re-used should be placed in a sealed container and marked as 'patient returns', to make it clear that the stock should only be re-used when stock cannot be obtained from the legitimate supply chain. The additional obligations in respect of storage of controlled drugs must be adhered to.
3. Once a medicine has been assessed as being suitable for re-use, the usual processes and governance, as recommended by NICE guideline SC1: Managing medicines in care homes, apply.

4. Any re-used medicine would need to be administered according to the direction of a relevant prescriber[6] and recorded by care home or hospice staff in the relevant administration chart.

5. Unless the product is being supplied under a PGD or a patient specific direction, a new prescription must be obtained prior to supply to the new patient. If it is for a controlled drug, the extra requirements in relation to controlled drugs prescriptions must be satisfied. New remote prescriptions should be scanned and emailed before the first dose is given, and a copy of the prescription kept with the patient's records in line with current processes.

6. The administration chart (paper or electronic) should be updated by the care home or hospice, in line with the direction from the prescriber (in most cases this would be the prescription). The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used. The prescriber does not need to sign the MAR chart.

Controlled drugs

7. Any stock of medication Schedule 2 or 3 controlled drugs should only be retained if it can be stored securely with controlled and limited access (in line with safe

[6] This can be a verbal direction initially with a written prescription to follow either by email or hard copy

storage requirements for controlled drugs). Lawful possession of such drugs is generally predicated on a prescription or direction being in place, so continuity of prescriptions is important for these particular products, having regard to the normal timeframes for safe disposal of these products where they are no longer needed.

8. Any Schedule 2 controlled drugs must be entered into a separate section of the controlled drugs register and then an entry made when they are re-used, as is usual practice.

Records

9. All records (CD register entries and returned medicines stock, risk assessments) must be kept in line with legislation.

Prescribers

10. When medicines are out of stock and there is an immediate need for them, an alternative preparation should be prescribed and dispensed, as is usual practice where possible.

11. Where stock is not available, the supplying pharmacy will contact the care home or hospice to establish whether a medicines re-use scheme is in place and stock of the required medicine is available in the home.

12. Re-used medicines may be administered to residents in a care home or hospice under the direction of a prescriber, and in line with this SOP, where an appropriate medicines re-use scheme is in operation.

13. In this situation, the direction would normally be in the form of a prescription. If a prescription is issued remotely, it should be scanned and emailed to the care home by the prescriber (for known medicines shortages) or the community pharmacy as appropriate in each individual case.

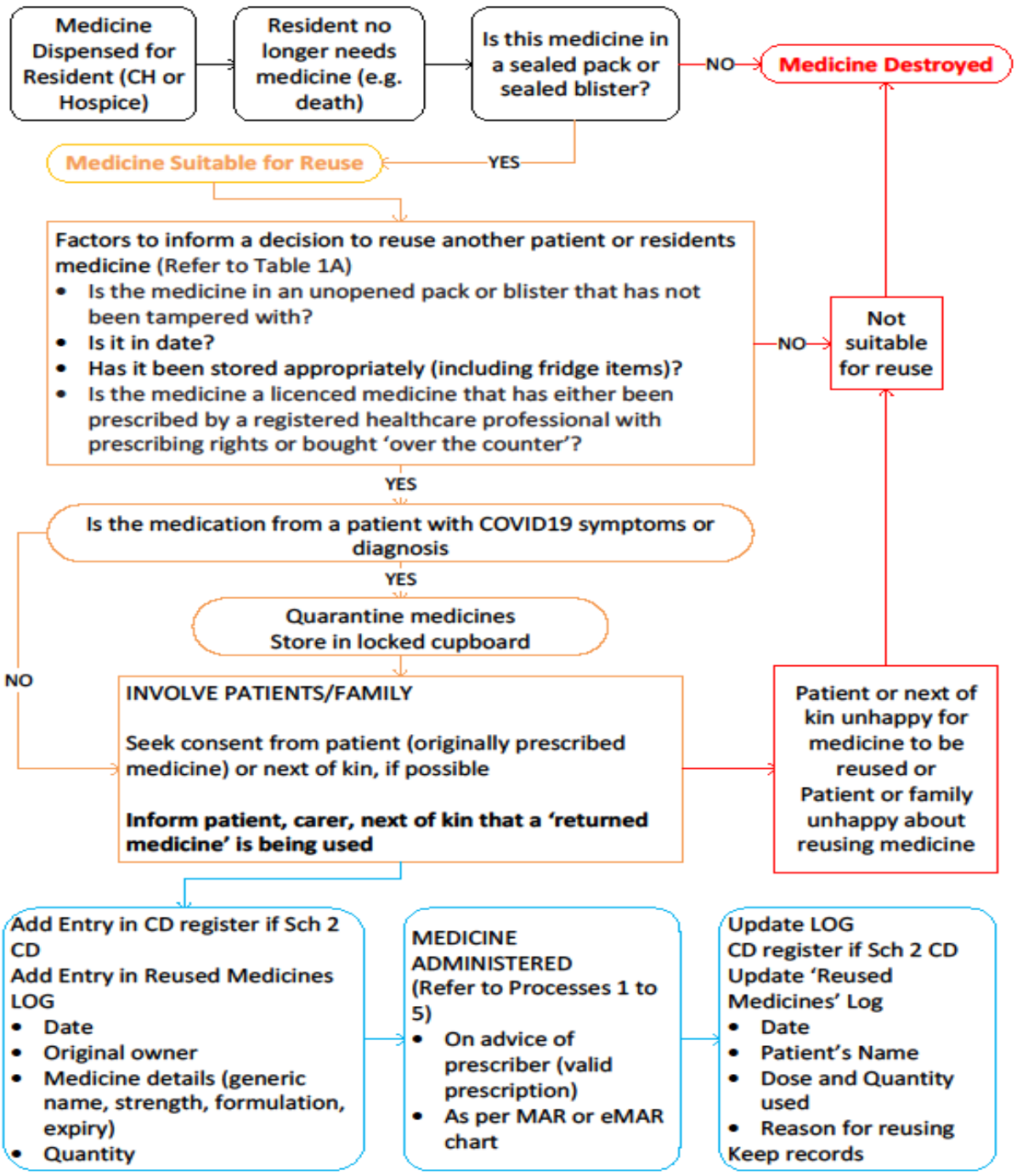
Community pharmacy

14. When medicines are out of stock and there is an immediate need for them, an alternative preparation should be prescribed and dispensed, as is usual practice where possible.

15. Where there is no suitable alternative or a prescription cannot be written for the alternative medicine (eg out of hours), the community pharmacy team should ask the care home or hospice whether they run a medicines re-use scheme and whether they have any stock of the required medicine.

16. If stock of a re-used medicine is available in the care home or hospice, the community pharmacy team must share a copy of the prescription for that medicine with the home and update the corresponding MAR chart as necessary. The supply of the medicine by the care home or hospice will need to be in accordance with that prescription. They cannot rely on a report of its contents.

4. Medicines re-use pathway



Pharmacovigilence
- Report all adverse events and problems to CCG, COVID19 Trimverate
- Report clinical adverse via Yellow Card Scheme (note that medicine was reused)
- Log all errors via NRLS or equivalent

Personal Protective Equipment quick reference guide for Nottinghamshire County Council Colleagues during the COVID-19 Pandemic

Version: 2
Date: 13/04/2020

This guidance is based on current government advice and will be updated and reissued in line with any national changes.

This guide is intended to assist you to assess if PPE is required. It is essential that stocks of PPE are conserved and used appropriately in accordance with national recommendations. It is important for other service users and colleagues that we only use PPE when it is genuinely needed.

Before considering whether PPE is needed you should decide whether the contact needs to take place face-to-face or could be delayed and if it needs to take place do so electronically where possible e.g. by phone or email

Four key factors should guide the assessment of whether PPE is appropriate or not and which PPE would be appropriate if required. These are:

- Whether the citizen **does or does not** have COVID-19 (suspected or confirmed) or is self-isolating because a member of their family/household is symptomatic
- Whether the colleague is having **close personal contact** such as **providing direct care** for an individual
- Whether you will be able to reliably maintain 2m distance from the service user and any other people in the household
- Whether there is someone in the household who is shielding as they are in an extremely vulnerable group

Direct care can include services such as support with continence, washing and bathing, changing and assistance moving. It does not include cleaning, cooking or delivery of meals to a person's home.

Conducting a risk assessment prior to entering a setting where care or support will be delivered is crucial in order to ascertain if PPE is required and ensure PPE is worn upon entering the setting to minimise exposure risk. PPE should be considered as part of a risk assessment for all direct patient/resident care (not just patients with suspected or confirmed COVID-19) at a time when there is sustained community transmission of COVID-19, **as is currently occurring in the UK**, and the likelihood of any patient having coronavirus infection is raised.

Symptoms which indicate COVID-19 include:

- **A high temperature** – this means feeling hot to touch on the chest or back
- **A new, continuous cough** – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours

Table 1: PPE required when delivering care to a citizen who has suspected or confirmed COVID-19, are self-isolating because a member of their household is symptomatic, **or they or a member of their household is shielding.**

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES – Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Recommended PPE for primary, outpatient, community and social care by setting, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Any setting	Performing an aerosol generating procedure[2] on a possible or confirmed case[3]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✓ single use[4]	✓ single use[4]
Primary care, ambulatory care, and other non emergency outpatient and other clinical settings e.g. optometry, dental, maternity, mental health	Direct patient care – possible or confirmed case(s)[3] (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
	Working in reception/communal area with possible or confirmed case(s)[3] and unable to maintain 2 metres social distance[6]	✗	✗	✗	✗	✓ sessional use[5]	✗	✗
Individuals own home (current place of residence)	Direct care to any member of the household where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ risk assess single or sessional use[4,5,8]
	Direct care or visit to any individuals in the extremely vulnerable group or where a member of the household is within the extremely vulnerable group undergoing shielding[9]	✓ single use[4]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✗
	Home birth where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✓ single use[4]	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
Community and social care, care home, mental health inpatients and other overnight care facilities e.g. learning disability, hospices, prison healthcare	Facility with possible or confirmed case(s)[3] – and direct resident care (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ sessional use[5]	✗	risk assess sessional use[5,8]
Any setting	Collection of nasopharyngeal swab(s)	✓ single use[4]	✓ single or sessional use[4,5]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]

Table 2

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. The list of aerosol generating procedures (AGPs) is included in section 8.1 at: www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe. (Note APGs are undergoing a further review at present)
3. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
4. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. Non clinical staff should maintain 2m social distancing, through marking out a controlled distance; sessional use should always be risk assessed and considered where there are high rates of community cases.
7. Initial risk assessment should take place by phone prior to entering the premises or at 2 metres social distance on entering; where the health or social care worker assesses that an individual is symptomatic with suspected/confirmed cases appropriate PPE should be put on prior to providing care.
8. Risk assessed use refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids.
9. For explanation of shielding and definition of extremely vulnerable groups see guidance: 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

Table 2: PPE required when delivering care to a citizen without symptoms of COVID-19 in a period of sustained community transmission when the likelihood of any person having coronavirus infection is raised.

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES – Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Additional considerations, in addition to standard infection prevention and control precautions,

where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/ gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Any setting	Direct patient/resident care assessing an individual that is not currently a possible or confirmed case[2] (within 2 metres)	✓ single use[3]	✓ single use[3]	✗	✗	✓ risk assess sessional use[4,5]	✗	✓ risk assess sessional use[4,5]
Any setting	Performing an aerosol generating procedure[6] on an individual that is not currently a possible or confirmed case[2,7]	✓ single use[3]	✗	✓ single use[3]	✗	✗	✓ single use[3]	✓ single use[3]
Any setting	Patient transport service driver conveying any individual to essential healthcare appointment, that is not currently a possible or confirmed case in vehicle without a bulkhead, no direct patient care and within 2 metres	✗	✗	✗	✓ single use[3]	✗	✗	✗

Table 4

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
3. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
4. Risk assess refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets of blood or body fluids. **Where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection as determined by the individual staff member for the care episode/single session.**
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and consider the risk of infection to and from patients, residents and health and care workers where COVID-19 is circulating in the community and hospitals. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. The list of aerosol generating procedures (AGPs) is included in section 8.1 at: www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe. (Note APGs are undergoing a further review at present)
7. Ambulance staff conveying patients are not required to change or upgrade PPE for the purposes of patient handover.

15 April 2020

To:

Accountable Officers of all hospital (public and private sector) working for the NHS and discharge teams

All NHS Commissioned Community health providers – including relevant NHS Tusts, Community Interest Companies and Private Sector

Accountable Officers of Clinical Commissioning Groups

Cc:

NHS England and NHS Improvement Regional Directors and Regional Incident Response Teams

New Requirement to Test Patients being Discharged from Hospital to a Care Home

Today, the Government has made a commitment to test all residents prior to their admission to a care home. As set out in the Coronavirus: adult social care action plan published today, the roll out of this policy will begin with testing all patients discharged from a hospital to a care home. This applies to all patients being discharged into a care home, regarless of whether they were residents of the care home previously or not.

Therefore, with immediate effect, the NHS now has responsibility for testing patients being discharged from hospital to a care home, in advance of a timely discharge. Hospitals funded by the NHS will need to make the necessary arrangements to implement this.

This new testing requirement must not hold up a timely discharge. The COVID-19 hospital discharge service requirements, published 17th March 2020, remain unchanged and continue to apply. To ensure testing does not delay a timely discharge, testing for patients due to be discharged to a care home will need to be planned up to 48 hours before the scheduled discharge time. The information from the test results, with any supporting care information, must be communicated and transferred to the relevant care home.

Some care providers will be able to accommodate individuals with a confirmed COVID-19 positive status, through effective isolation strategies or cohorting policies. If appropriate isolation or cohorted care is not available with a local care provider, the Local Authority will provide alternative appropriate accommodation and care for the remainder of the required isolation period, utilising NHS community and primary care assistance as needed. This alternative accommodation should also be used in the exceptional cases of test results not being available at the point of discharge.

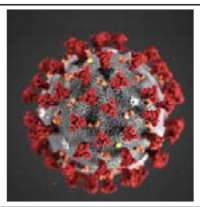
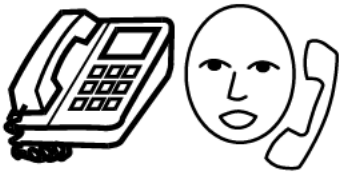
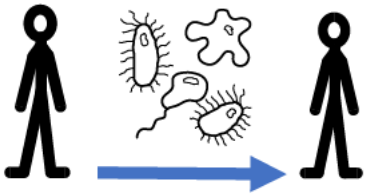
This additional testing requirement will be a small addition to the testing requirements already underway. We anticipate that this will be about a 6% increase on current testing rates in NHS labs.

Thank you for your support to implement this important new requirement. If you have any questions related to this letter, please direct them to england.covid-discharge@nhs.net

Yours faithfully,

Professor Keith Willett
NHS Strategic Incident Director (Coronavirus)

Matthew Winn
Director of Community Health, NHS England & NHS Improvement

	Changes to how we are working
	Services are not being run in the usual way
	This is due to Covid 19 (see attached sheet)
	Most home visits will not be happening
	We will use the telephone to find out how you are
	If we have to see you we will be wearing a mask, gloves and apron (see attached sheet)
	This is to stop the virus from passing from person to person
	This might last for a few months
	We will let you know when things have gone back to normal

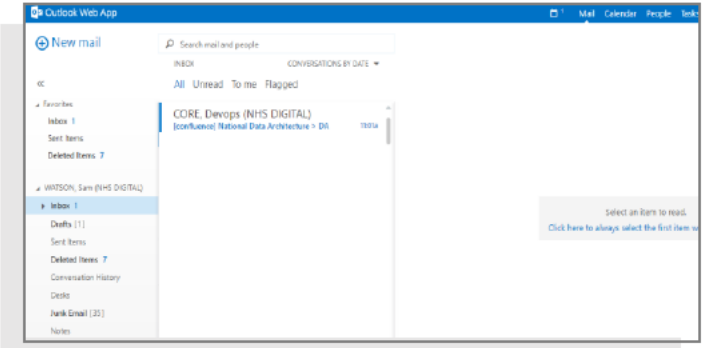
NHSMAIL TRAINING GUIDE

For Social Care Providers

1. Signing in to NHSmail

Signing in

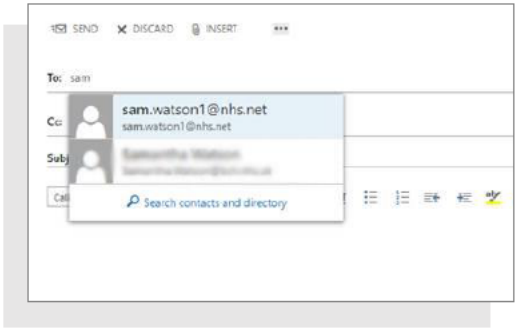
Your inbox



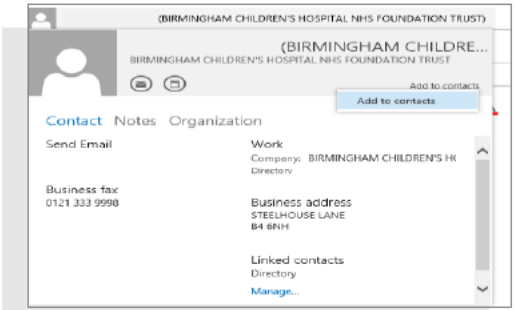
To access your inbox, log in via:
https://email.nhs.net

Tick **'This is a private computer',** if this is true, to be able to download attachments

2. Searching for email addresses using the directory



- Select **'New Mail'**, in the top left of your screen, and enter the name of the recipient in the 'To' field
- Press **enter** to search the NHSmail directory for their email address
- Select the person you were looking for from the list, using details about where they work and their role to find the right person.



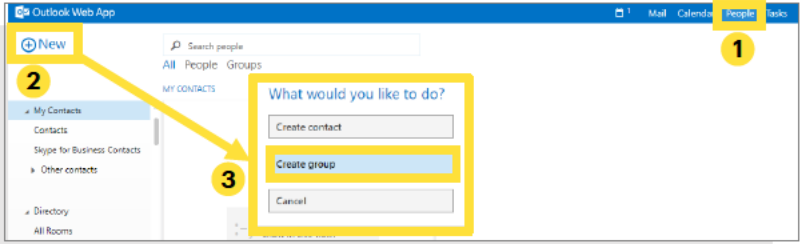
- To save this person as a contact, right click on the email address in the **'To'** field
- Select **'view details'** and select **'Add to contacts'**
- In **'view details'** you will be able to confirm that you are contacting the correct person

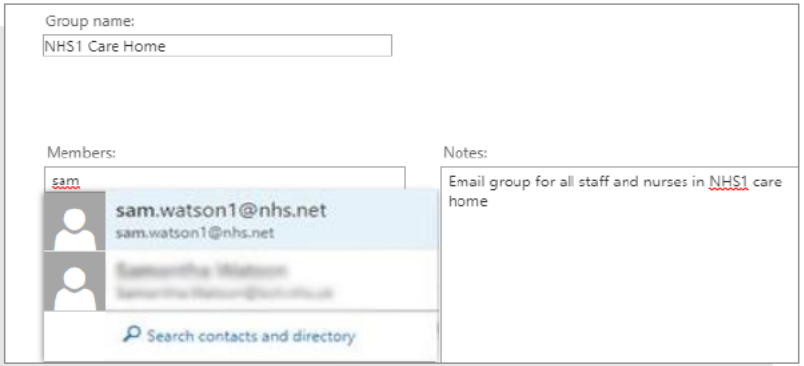
TOP TIP

Saving contact details of people you email regularly such as your pharmacist, GP or local hospital will save time.

It will also help to make sure you're always talking to the person that you intended to!

3. Creating a group email list



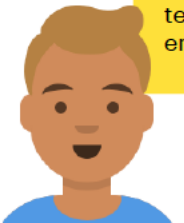


1. Select **'People'** from the top right of the page, next to your name
2. Select **'New'** from the top left side of the page
3. Select **'create group'** from the list of options that appears
4. Enter a name for the group and add the members that you would like to include (as shown in the second image)

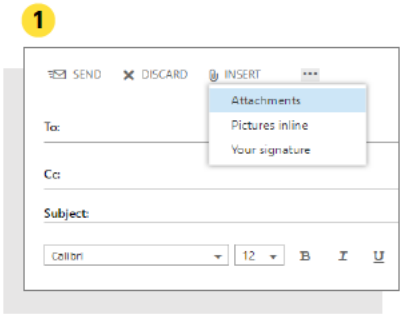
TOP TIP

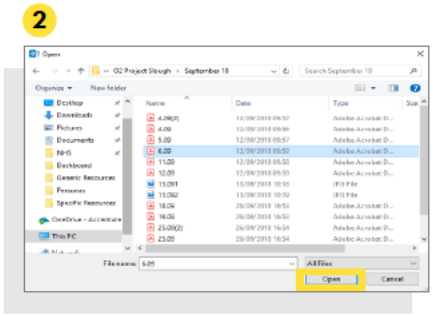
This can help managers, head nurses or admin teams to send emails out to all staff at the home in one go

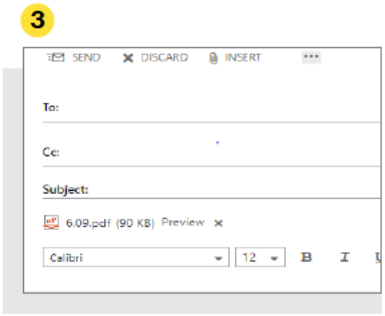
As new members of staff join the team, or existing members leave, the email group can be quickly updated.



4. Attaching documents to your emails





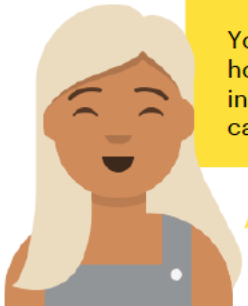


1. Select the **three dots** located above the 'To' line of the email you want to send
2. Select **'attachments'**
3. In the new pop-up box, select the **file** you would like to attach
4. Click **'open'**
5. This document will now be added to your email

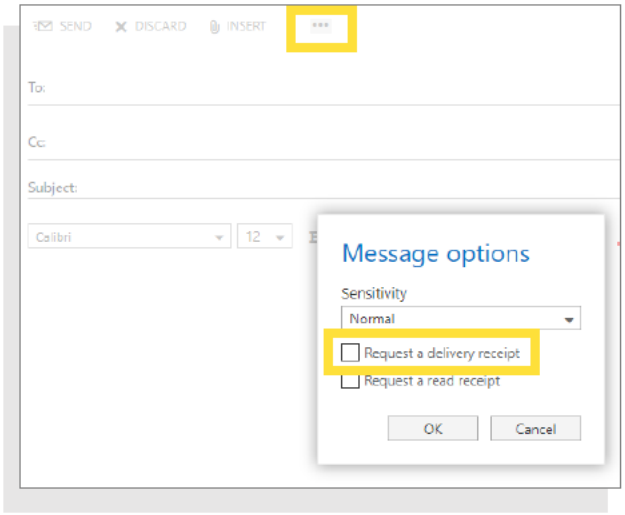
TOP TIP

Documents such as referral forms or images for community care teams can be attached and securely sent to the relevant people.

You may be able to ask your GP or hospital discharge teams to attach information to emails that previously came via fax, or even post!



5. Requesting a read receipt for your message

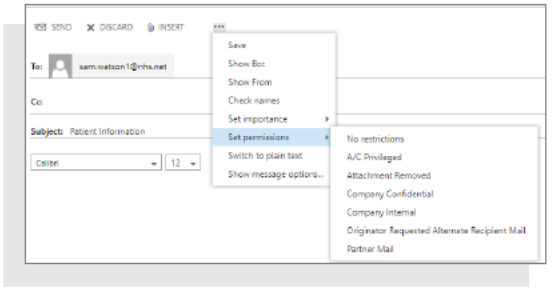


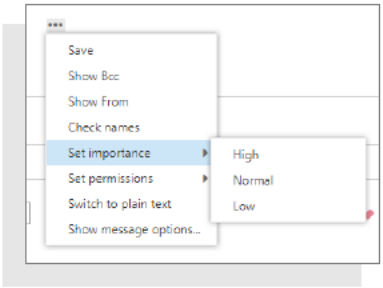
1. Click **'New Mail'**
2. Click the three dots on the top of the email and select **'show message options'**
3. Tick the box next to **'Request a read receipt'** and click 'OK'
4. You can also request a delivery receipt to confirm your email has been delivered by selecting **'Request a delivery receipt'**

TOP TIP

Requesting read receipts will help to ensure that you know when GPs, pharmacists or other care providers have seen your message. This could save time through limiting the number of follow up phone calls needed.

6. Marking emails as confidential and important





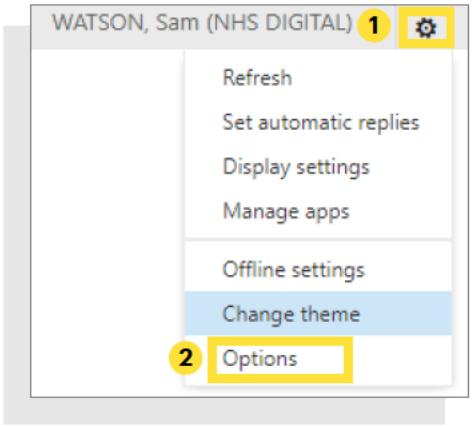
1. Select the **three dots** located on the top of your new email
2. Select **'set permissions'**
3. Choose from the list displayed. For example, selecting **'Company Confidential'** will add the following notification to the top of your email: *'This message is marked Company Confidential: This message contains proprietary information and should be handled confidentially.'*
4. To set the importance of an email follow steps 1 -2 and select **'set importance'** and choose from the list displayed.

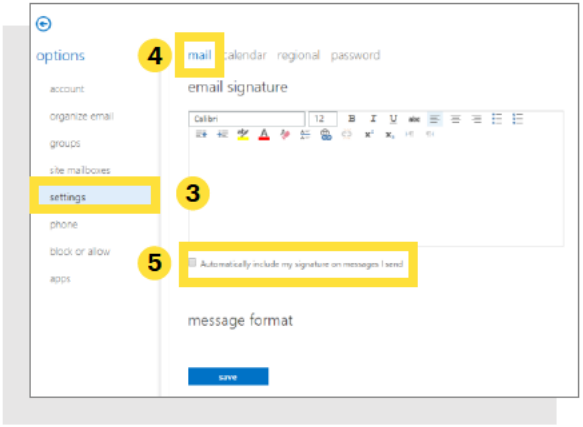
TOP TIP

Emails with resident information can be marked as confidential. This helps to ensure the recipient takes particular care when handling the message that you have sent.

This can be valuable when communicating with a service or health care provider for the first time, making sure that the resident information will remain confidential.

7. Creating your email signature





1. Click on the **gear icon** on the top right of the page, next to your name
2. Select **'options'**
3. Select **'settings'**
4. Enter in the text you would like to appear at the end of your email in the text box provided
5. Tick the box directly below which states **'Automatically include my signature on messages I send'**
6. Press **save**

This topic continues on the next page →

TOP TIP

Add an email signature in the following format to help people identify who you are:

- Full Name
- Role
- Care Home name and address
- Care Home contact number

7. Example email signatures

Ben Smith

Registered Manager
Red Tree Care Home
74 Queen Street,
London,
E3 1XX

Tel: 020 6363 484
Mob: 07111 011 011

Email: Ben.Smith87@nhs.net

Your name

Your role
Name of your care home
Address 1
Address 2,
Postcode

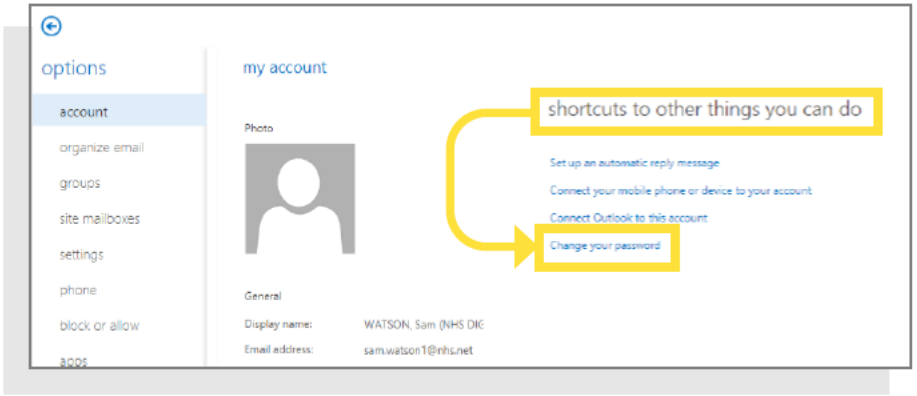
Tel: Landline number
Mob: Work mobile number

Email: Your nhs.net email address

TOP TIP

Note: This is an example for how you might set out your email signature.
You may decide to format your signature slightly differently, including more or less detail depending on what you want people to know about you, your role, and how to get in touch with you.

8. Changing your password



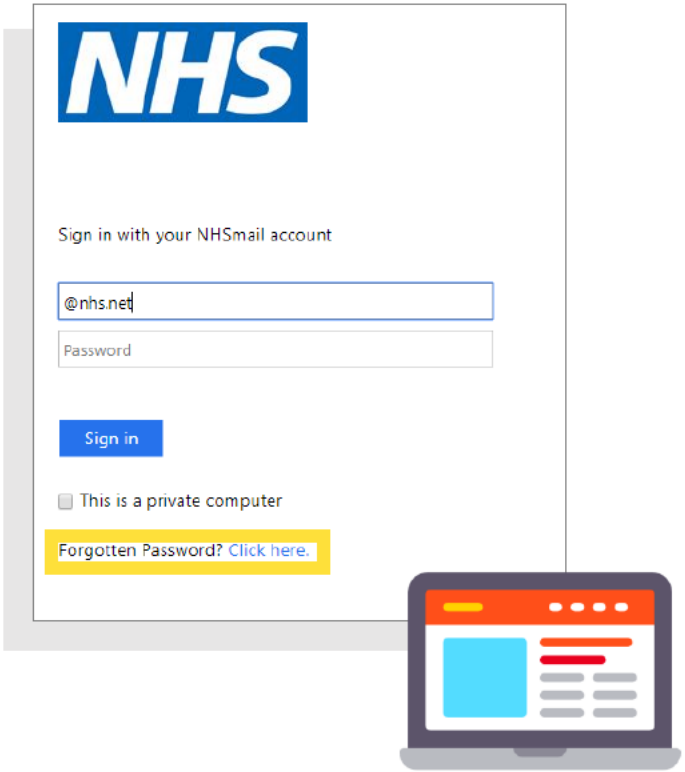
1. Select the **Gear Icon** on the top right of your email page
2. Select **'Options'** from the drop down list
3. Select the **'account'** tab on the left panel
4. Select **'change your password'** under **'shortcuts to other things you can do'**

TOP TIP

It's important to keep your password up to date for safety and security.

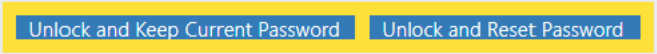
You will be reminded to change your password at least every 12 months via email.

9. Resetting a forgotten password



1. Select **'Forgotten Password?'** on the log in screen
2. Enter your NHSmail email address for verification when prompted
3. Answer your security questions
4. You will receive a temporary password to use via a text message sent to your registered mobile device

Alternatively: if your account has been locked due to too many failed log in attempts, you will be presented with the following options:

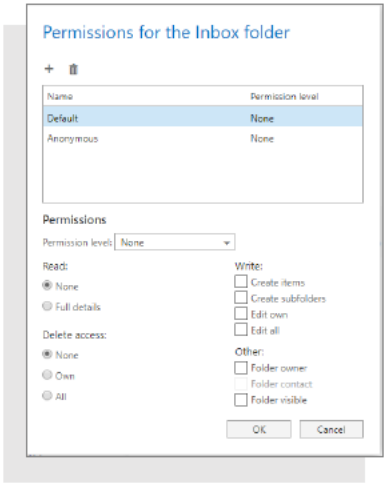


5. Select **'Unlock and Keep Current Password'** to unlock your account without changing your password

Or:

6. Select **'Unlock and Reset password'** and a temporary password will be issued via SMS to your registered mobile device

10. Giving another user access to your inbox



What the options in the permissions level list mean:

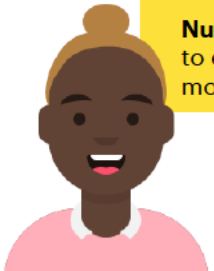
- **Owner** - full access to your mailbox
- **Publishing Editor** - same access as Owner, but unable to create folders
- **Editor** – same access as Publishing Editor, but unable to create subfolders
- **Publishing Author** - read and write emails, but only delete emails they own
- **Author** – same as Publishing Author, but unable to create subfolders

1. Right click on **'Inbox'** on the left panel of your screen and select **'Permissions'** from the list
2. Select the **plus icon** on the top of the new screen and enter in a name/email
3. Select an option from the **'Permission Level'** drop down list.

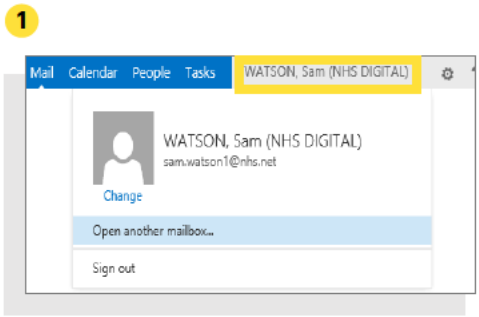
TOP TIP

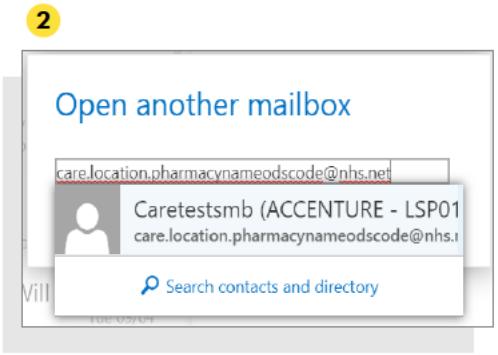
Manager: This is useful when you are out of office for an extended period, or over the weekend. You can share your inbox with your head nurse and they will be able to see emails coming in to your account. They can also access important information that does not come in to the shared mailbox, which may need to be shared with the hospital or other care provider in your absence.

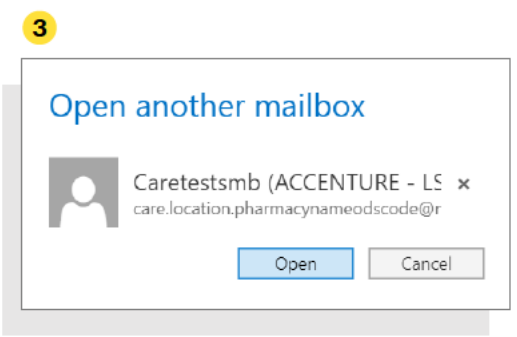
Nurse/staff: Your inbox can be shared with your manager to ensure any emails not in the shared mailbox can be monitored.



11. Accessing your shared mailbox from Outlook Web App



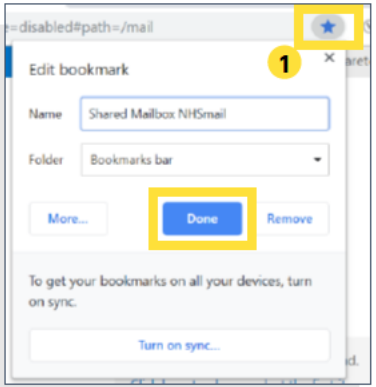


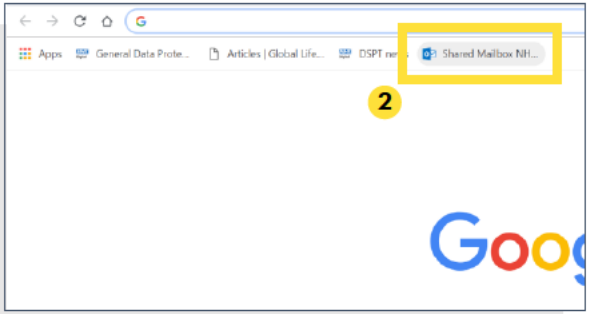


1. The first time you log into your NHSmail account click on **your name** in the top right of the page
2. Select **'open another mailbox'** from the options
3. If it doesn't appear automatically, enter the email address of your shared mailbox and then click **'Open'** (you will find this address in the email you received with your personal NHSmail email address details. If you are unsure, ask your manager)
4. You will then be directed to the shared mailbox account, which you should use to send emails relating to resident's care.

This topic continues on the next page →

11. Accessing your shared mailbox from Outlook Web App





1. Save the web address for this page to your **bookmarks** by clicking the star icon next to the internet address bar. We've named it 'Shared Mailbox NHSmail'.
2. Every time you want to login to your NHSmail account, click the **'Shared Mailbox NHSmail'** tab in your bookmarks and it will direct you to the login page.
3. Enter your login details (Your own NHSmail email address and password) and the shared mailbox will open.
4. The shared mailbox is now set as the default account that opens when you log in, rather than your individual account.

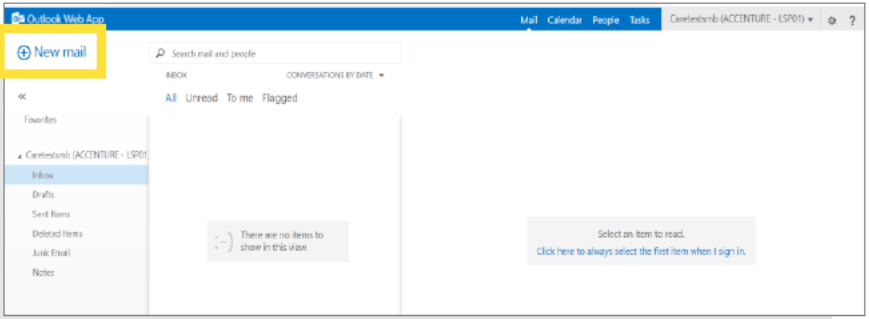
This topic continues on the next page →

TOP TIP

It is best practice for all care home staff to use the shared mailbox to send emails relating to resident's care, rather than individual user email accounts.

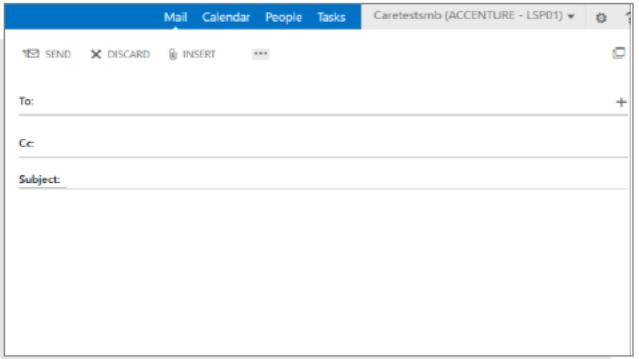
11. Sending an email from your shared Mailbox on Outlook Web App

1

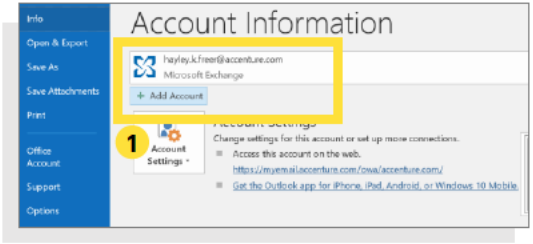


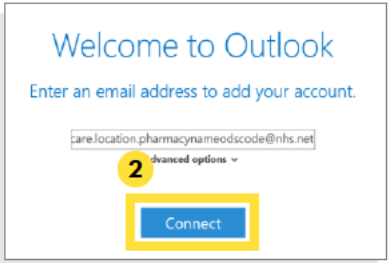
1. Once you have been directed to your home's shared mailbox account, it will look and function exactly like your personal account.
2. Select **'New Mail'** to send an email.
3. The only difference will be that the person that receives the email will see that it has come from the shared mailbox email, rather than an individual's user email address.
4. You can add your email signature to the emails you send (as shown in topic 7) so that it is clear who has sent the email.

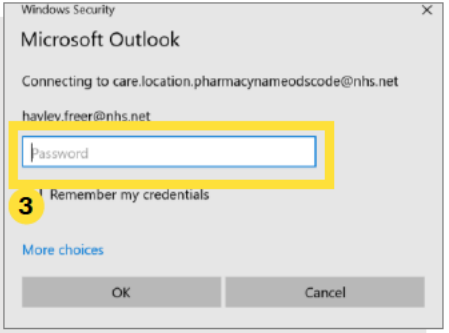
2



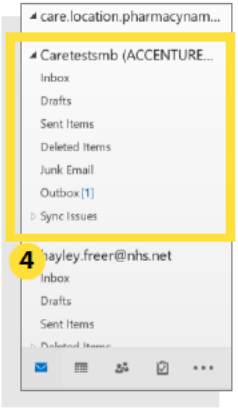
12. Accessing your shared mailbox from Outlook Desktop



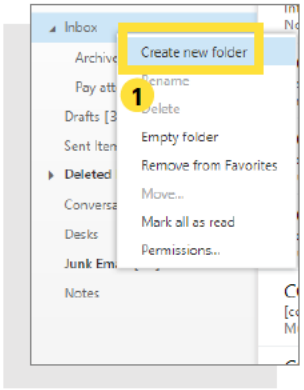




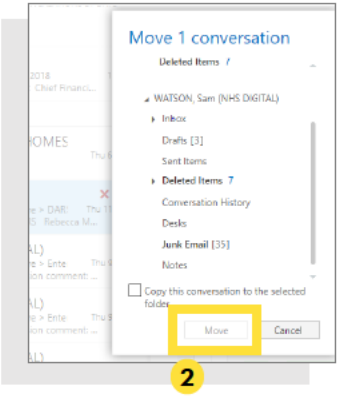
1. If it isn't working automatically after adding your individual account, you can add your shared mailbox account to your Desktop Outlook.
2. Click **'File'** in the top left corner, then, making sure the top box (1) says "Microsoft Exchange" select **'Add Account'**
3. Enter the shared mailbox email address in the box provided and click '**Connect**'
4. Enter your password for your personal NHSmail account
5. You will see a message that says **'Account set up is complete',** and you will be able to see your shared mailbox account appear in the left hand bar of Outlook, below your personal account.
6. When sending an email select the **'From'** button and make sure you select your shared mailbox email address from the drop down list to send an email from the shared mailbox.



13. Creating folders and organising your inbox



1. Right click on **'Inbox'**, located on the left of the screen, underneath your name
2. Select **'Create New folder'**
3. Enter the name of your new folder in the textbox. E.g. 'Tissue viability'
4. Press **'Enter'** on your keyboard to save



1. To move an email into the new folder you have created, right click on the email you want to move and select **'Move'**
2. Select the folder you want to move the email to, from the list that appears on your screen
3. Select **'Move'** to confirm this action

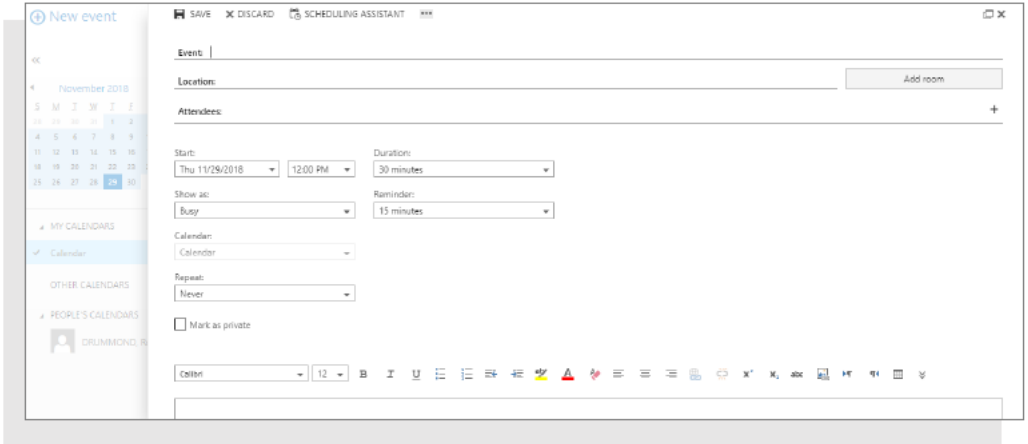
TOP TIP

This is useful to organise and separate emails from different groups of care professionals.

GP communications can be kept distinct from hospital discharge forms for instance.

Nurses who may be responsible for the care of a group of residents can create folders to catalogue emails relating each individual.

14. Creating calendar appointments & reminders



1. In Outlook Web App, select the **Calendar Icon** on the top right of your email page
2. Select **'New Event'** and fill in with the details of your appointment
3. Select **'Repeat'** to set reoccurrences of this meeting/appointment
4. Save using the **'save'** icon on the top left of the page
5. This event will now be visible in your calendar, as well as the calendar of any attendees that you have added.

TOP TIP

You can use calendar events to remind you when a GP or member from a community services team is coming to visit the home.

The calendar events can be shared with the care professional you are expecting to visit - that way you know it is definitely in their diary.

Notes

Signing up for NHSmail

NHSmail

During the current Covid-19 pandemic, secure communication between health and social care services is more important than ever. To support this we are now able to **fast track roll out of NHSmail** to the care sector, without the need to complete the Data Security and Protection Toolkit at this time.

If you'd like to get set up, follow the steps below:

1. You will receive a phone call or an email from your local team, asking if you would like to set up NHSmail.

2. Either over the phone, or by filling in the word document they share with you, please tell us:

   - The name of your care site
   - The name of your town
   - Your ODS Code (you will get help to find this!)
   - Details for **two people** that you would like to create NHSmail accounts for. This must include a personal email address for at least the mailbox owner and a personal mobile number for each person.

3. If this was over the phone, you don't need to do anything else yet!

   If this was over email, **please attach the word document to an email**, and send it back to the local regional team nhsi.miduecoperations@nhs.net

4. You will receive an email letting you know that your request for an NHSmail account is being completed!

   If you need to add any more information to your form, you will get an email asking you to do this.

5. In the next day or so, you will receive an email from NHSmail welcoming you to your new account, as well as a text message with your password.

   Each provider will have 1 shared mailbox, and 2 user accounts.

6. **Your local support teams will be in touch about webinars available every day to make sure you have the help you need to get up and running quickly!**

Now you can start using NHSmail and Microsoft Teams

Setting up your NHSmail account

NHSmail

You will now have received an email from NHSmail telling you that you have a new email account: **This is how to get started!** Additional support is available at https://support.nhs.net, as well as daily webinars that your local teams will share.

1. Click on the link which you will have received in a "Welcome to NHSmail" email.

   This email will contain your new NHSmail email address, and the details for your shared mailbox.

2. This link will take you to the NHSmail log in page.

   Log in using your new @nhs.net email address and the **temporary password sent to your mobile phone.**
   When logging in, tick **'This is a private computer'** if this is true to be able to download files.

   You will be asked to change your password and create a new one.

3. Once logged in, you will be asked to complete your profile:

   Check your mobile phone number (it will be hidden by default)

   Check your role: e.g. Registered Nurse

   Save your updated profile.

4. Next you will create your security questions:

   On the portal, select **'My Profile'**

   Select **'Security Questions'**

   Choose three security questions to answer. Both questions **and** answers must be within 5-12 characters.

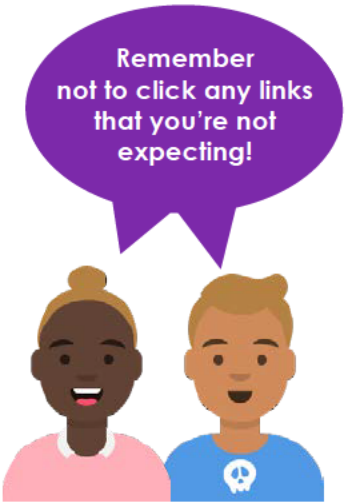
   Save your updated profile.

5. You will be asked to sign back in again, and accept the "Acceptable Use policy". **This step must be completed before you are able to send emails from your new account.**

6. You can now log into your account to send and receive emails!

   You can always access your emails by going to **https://email.nhs.net** in your internet browser.

7. When you log in for the first time, click on your name in the top right corner and then **'Open another mailbox'** to switch to the shared mailbox. Bookmark this page, and use this to send emails about resident's care, rather than your individual account.



Look out for further support on getting started with Microsoft Teams for video calls

Ask a Community Geriatrician/Clinician

(for Nottingham and Nottinghamshire Care Homes and Community Care providers)

DO YOU HAVE QUESTIONS YOU WOULD LIKE ANSWERING ABOUT MANAGING THE CARE OF YOUR RESIDENTS DURING THE COVID CRISIS?

Please join us for a series of webinars. We will start the session with a short piece on a 'hot topic'

WEEK 2: NOTTINGHAM AND NOTTINGHAMSHIRE SUPPORT OFFER

- dynamic Q&A session where you can ask Dr Kearney any clinical questions you have
- let us know what 'hot topics' you would like us to discuss next week

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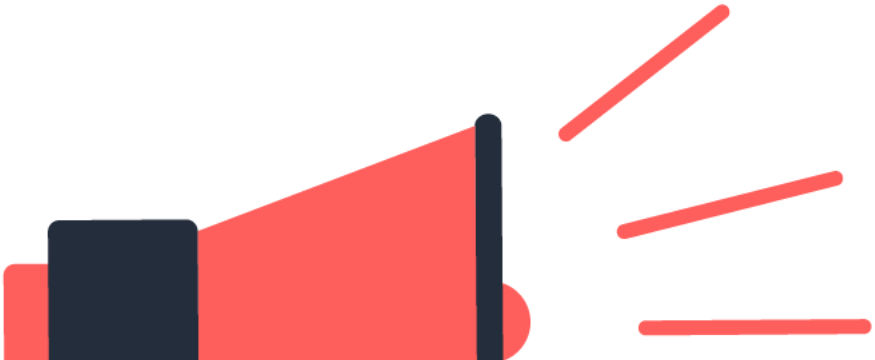

Indication and use of Personal Protective Equipment Guidance for Nottinghamshire County Council Colleagues during the COVID-19 Pandemic

Correct as of 6th April 2020

This guidance is based on current government advice and will be updated and reissued in line with any national changes.

Version 1.0

This guide is intended to assist you to assess if PPE is required. It is essential that stocks of PPE are conserved and used appropriately in accordance with national recommendations. It is important for other service users and colleagues that we only use PPE when it is genuinely needed.

Before considering whether PPE is needed you should decide whether the contact needs to take place face-to-face or could be delayed and if it needs to take place do so electronically where possible e.g. by phone or email

Three key factors should guide the assessment of whether PPE is appropriate or not and which PPE would be appropriate if required. These are:

- Whether the citizen **does or does not** have COVID-19 (suspected or confirmed) or is self-isolating because a member of their family/household is symptomatic
- Whether the colleague is having **close personal contact** such as **providing direct care** for an individual
- Whether there is someone in the household who is shielding as they are in a vulnerable group

Direct care can include services such as support with continence, washing and bathing, changing and assistance moving. It does not include cleaning, cooking or delivery of meals to a person's home.

Conducting a risk assessment prior to entering a setting where care or support will be delivered is crucial in order to ascertain if PPE is required and ensure PPE is worn upon entering the setting to minimise exposure risk.

Symptoms which indicate COVID-19 include:

- **A high temperature** – this means feeling hot to touch on the chest or back
- **A new, continuous cough** – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours

Using your PPE

Make sure you put on and take off your PPE safely
https://www.youtube.com/watch?v=oUo5O1JmLH0

Table 1: PPE required when delivering care to a citizen who has suspected or confirmed COVID-19, are self-isolating because a member of their household is symptomatic, **or they or a member of their household is shielding.**

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Recommended PPE for primary, outpatient and community care by setting, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Any setting	Performing an aerosol generating procedure[2] on a possible or confirmed case[3]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✓ single use[4]	✓ single use[4]
Primary care, ambulatory care, and other non emergency outpatient and other clinical settings e.g. optometry, dental, maternity, mental health	Direct patient care – possible or confirmed case(s)[3] (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
	Working in reception/communal area with possible or confirmed case(s)[3] and unable to maintain 2 metres social distance[6]	✗	✗	✗	✗	✓ sessional use[5]	✗	✗
Individuals own home (current place of residence)	Direct care to any member of the household where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ risk assess single or sessional use[4,5,8]
	Direct care or visit to any individuals in the extremely vulnerable group or where a member of the household is within the extremely vulnerable group undergoing shielding[9]	✓ single use[4]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✗
	Home birth where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✓ single use[4]	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
Community-care home, mental health inpatients and other overnight care facilities e.g. learning disability, hospices, prison healthcare	Facility with possible or confirmed case(s)[3] – and direct resident care (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ sessional use[5]	✗	risk assess sessional use[5,8]
Any setting	Collection of nasopharyngeal swab(s)	✓ single use[4]	✓ single or sessional use[4,5]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]

Table 2

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. The full list of aerosol generating procedures (AGPs) is within the IPC guidance [note APGs are undergoing a further review at present].
3. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
4. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. Non clinical staff should maintain 2m social distancing, through marking out a controlled distance; sessional use should always be risk assessed and considered where there are high rates of community cases.
7. Initial risk assessment should take place by phone prior to entering the premises or at 2 metres social distance on entering; where the health or social care worker assesses that an individual is symptomatic with suspected/confirmed cases appropriate PPE should be put on prior to providing care.
8. Risk assessed use refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids.
9. For explanation of shielding and definition of extremely vulnerable groups see guidance: 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

This matter is being dealt with by:
Melanie Brooks
Reference:
E melanie.brooks@nottscc.gov.uk
W nottinghamshire.gov.uk

Nottinghamshire County Council

Open letter for social care providers in Nottinghamshire: support during Covid–19 pandemic.

15 April 2020

The Council has always taken a proactive approach in supporting social care providers who work in Nottinghamshire to ensure that there is a sustainable, safe range of services available for local people, whether they receive funding from the Council or whether they fund their own care.

A high proportion of services provided on behalf of the Council is provided by independent companies including very small providers, right through to some national organisations with whom we have very positive and proactive partnerships that we value very highly. This has stood us in good stead during the current pandemic.

We also support people who have Direct Payments and arrange their own care either with individuals or organisations and who may well employ their own care staff.

Whilst we always have very regular communication with our providers, we now send out daily updates with extra support where this is needed. We ensure we communicate all new national guidance about Covid-19, how to access training and the different sources of support.

We work with providers to ensure that the rates we pay are sufficient to support a robust and sustainable market. We review the fees that we pay to all providers annually whether they be residential and nursing homes or community providers. The annual increase to cover the cost of the National Living Wage was approved on 16th March 2020 and the increased rates commenced in April.

When the Covid-19 pandemic began, we very quickly developed 'financial principles' for working with our partners recognising the financial pressure the crisis presented. One of the things we did was to agree to pay commissioned hours irrespective of what was delivered, as long as the provider worked with us to best support the needs of our residents. This gave providers reassurance about what their income would be to enable them to concentrate on providing their services to local people during these very challenging times.

Understandably some staff were not able to work because of the protection measures but providers were able to pay their staff who were off as well as pay for staff that they used to provide cover. In addition to this, providers are able to seek agreement for other additional costs on an individual basis reflecting the different circumstances that providers are in. These principles are to be reviewed at the end of June 2020 but in the interim we do ask providers to communicate with us so that we are able to offer appropriate support.

One of our main concerns is that as staff become well or care for others at home, providers may well start to have concerns about their workforce capacity. We have created a pool of Council staff who have undertaken training in key aspects of care and we have the ability to redeploy staff to support services that are struggling. We have not had to call upon this yet.

A challenge for the Health and Care sector has been the supply of Personal Protective Equipment (PPE) to support people that were either symptomatic or diagnosed with Covid-19. This has meant that providers are unable to have more than a few days of stock available. We have worked through all channels to try and tackle this National problem, but also put into place local arrangements to make sure that any urgent needs for PPE could be met as soon as a Provider flags this need.

In addition to social care providers, we also work with other partners of the Local Resilience Forum who work to support the whole local system during times of crisis. This includes Public Health, the NHS, local district and borough councils, the City Council, the Care Quality Commission and the Police.

I would like to thank providers and their staff for their hard work and dedication at this time. We rely on our carers to support the most vulnerable people in Nottinghamshire, and every one of those residents is important to us.

Having started my career in residential care, I have been particularly moved to hear some of the stories you have sent me – pictures of activities in Supported Living, blogs from homecare workers, staff going the extra mile to keep caring, the efforts to change operating models to offer online and remote support, and the steps taken to care for one another. This is valued by Officers, the Leader of the Council and Chair of Committee alike.

Thank you.

Yours sincerely

Melanie Brooks
Corporate Director, Adult Social Care and Public Health
Nottinghamshire County Council

Personal Protective Equipment (PPE)
Interim Local Guidance for social care and council staff in Nottinghamshire County regarding contact with confirmed Covid-19 cases or with those self-isolating because they or a member of their household is symptomatic

19 March 2020

THE INTERIM LOCAL ADVICE BELOW IS PROVIDED FOR USE PENDING AVAILABILITY OF PPE STOCKS OR UNTIL FURTHER NATIONAL GUIDANCE ON PPE IN NON-CLINICAL SETTINGS IS PUBLISHED. COVID-19 IS A RAPIDLY EVOLVING SITUATION SO THIS INTERIM GUIDANCE IS SUBJECT TO CHANGE IN THE COMING DAYS AND BY 18 APRIL AT THE LATEST

Who is this guidance for?

This guidance is intended for organisations and staff in Nottinghamshire County who have contact with people who either have confirmed Covid-19 or are self-isolating because they or a member of their household is symptomatic.

When to use PPE and conserving stocks

If neither the worker nor the individual receiving care and support is symptomatic, then no personal protective equipment is required above and beyond normal good hygiene practices.

Other general interventions should include increased cleaning activity and keeping property properly ventilated by opening windows whenever safe and appropriate.

It is essential that stocks of PPE are conserved and deployed sensibly. Local risk assessment and practical management should be pragmatic and proportionate, including consideration of whether there is actually a requirement to wear PPE at all.

What to do if PPE is not available

Where PPE is available, follow the national guidance which is referenced further down this document. There is currently no national guidance on what to do if PPE is not available and cannot be reasonably secured within an acceptable timescale. Where essential care for an individual necessitates a visit

- Consider whether the purpose of the visit could be achieved by other contact measures, e.g. telephone.
- Consider whether the visit can be deferred until stocks of PPE are available.
- Try to source stocks of PPE from other areas.

If all the alternatives have been considered and there is no other option but to visit the person/property, then follow these infection control suggestions:

1. At the start and at the end of the visit, wash hands thoroughly with soap and water, dry using your own towel – or use 60% alcohol sanitiser. Do not touch your mouth, nose or eyes during the visit. Try to avoid close personal contact with the service user if possible but, if this is unavoidable, then ask the service user to wash their hands and if they need to sneeze/cough, to do this into a tissue and wash hands afterwards.

2. Try to keep at least two metres distance between yourself and the service user and any other household members self-isolating and do not stay in their vicinity for more than 15 minutes. Ideally they should move as far away as possible or into another room.

3. Disinfect areas that you will be working on if possible using household disinfectant – viruses can survive on hard surfaces for up to 72 hours. Use either:

    a. A combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
    b. A general-purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm av.cl.

4. Consider how to implement staff cohorting to minimise mixing staff between confirmed Covid-19 cases or those self-isolating and those who are not.

Guidance for staff

Purpose of contact	PPE needed?	Priority in case of PPE rationing?	Infection prevention and control guidance
Close personal contact (e.g. washing and bathing, personal hygiene and contact with bodily fluids) a) Residential care homes b) Domiciliary care providers c) CYP with complex needs at home	Yes - aprons, gloves and fluid repellent surgical masks. If there is a risk of splashing, then eye protection will minimise this.	HIGH	Refer to official guidance for residential care, supported living and home care: https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance New PPE must be used for each episode of care If care workers support the individual with laundry, then they should not shake dirty laundry. This minimises the possibility of dispersing virus through the air. Dirty laundry that has been in contact with an ill person can be washed with other people's items. If the individual does not have a washing machine, wait a further 72 hours after the 7-day isolation period has ended. The laundry can then be taken to a public laundromat. Items heavily soiled with body fluids, for example vomit or diarrhoea, or items that cannot be washed, should be disposed of, with the owner's consent.
Personal contact (e.g. face to face) but not close or touching	Yes – facemasks, gloves	LOW	Risk assess if actual visit needed or whether technology can be used to make contact in a virtual way

Purpose of contact	PPE needed?	Priority in case of PPE rationing?	Infection prevention and control guidance
a) Children's residential home b) DVA refuges c) Homeless shelters			Speak to service user from safe distance (more than 2 metres away for less than 15 minutes), then tell them to withdraw to another room/as far away as possible. Afterwards wash hands thoroughly with soap and water, dry using your own towel – or use 60% alcohol sanitiser.
Deliveries (e.g. meals on wheels) – into the premises	Yes – gloves, facemasks	MEDIUM	New PPE should be used for each visit. Speak to service user from safe distance (more than 2 metres away) – if you are in the property for more than 15 minutes, ask them to withdraw to another room/as far away as possible. Afterwards wash hands thoroughly with soap and water, dry using your own towel – or use 60% alcohol sanitiser.
Deliveries (e.g. meals on wheels) – where deliveries can be left on the doorstep	No	LOW	The delivery should be left outside the property. You can telephone the service user to advise them when you deliver the item.
Emergency property services (e.g. gas repair, water leak, pest control etc.)	Yes – gloves and mask	MEDIUM based on the visit being longer than 15 mins if big leak etc	Speak to service user from safe distance (more than 2 metres away) while receiving instructions (less than 15 minutes), then ask them to withdraw to another room/as far away as possible. New PPE must be used for each episode. Afterwards wash hands thoroughly with soap and water, dry using your own towel – or use 60% alcohol sanitiser.
Cleaning service (e.g. LA-run temporary accommodation with communal areas)	Yes - aprons/gloves, face mask if cleaning bodily fluids	MEDIUM	If area can be vacated with window open, then mask not needed if no people around so this would be the aim to reduce risk. Speak to service user from safe distance (more than 2 metres away for less than 15 minutes), then tell them to withdraw to another room/as far away as possible. New PPE must be used for each new area.

Purpose of contact	PPE needed?	Priority in case of PPE rationing?	Infection prevention and control guidance
			Use usual household products, for example detergents and bleach – be aware that viruses can survive on hard surfaces for up to 72 hours Clean frequently touched surfaces. Personal waste (for example used tissues, continence pads and other items soiled with bodily fluids) and disposable cleaning cloths can be stored securely within disposable rubbish bags. (Disposal as for PPE, see below) The Government has produced specific guidance on COVID-19 decontamination in non-healthcare settings https://www.gov.uk/government/publications/Covid-19-decontamination-in-non-healthcare-settings/covid-19-decontamination-in-non-healthcare-settings If risk assessment identifies higher level of virus (e.g. hotel rooms or dormitories, or contamination of body fluids, then may need additional PPE to protect eyes, nose and mouth. Afterwards wash hands thoroughly with soap and water, dry using your own towel – or use 60% alcohol sanitiser.

Guidance for managers

In order to maintain supplies in the face of anticipated demand, it is important to ensure the appropriate use of PPE in all settings.

1. **PPE inventory and stock management**

Inventory systems should be employed by individual organisations to track daily usage and ensure that use of PPE is appropriate, with the aim of conserving stocks of PPE for indicated uses.

Organisations must not stockpile PPE beyond normal levels. The Health and Social Care Tactical Coordinating Group (HSC TCG) is to be tasked to identify options for stock control and management of use.

2. **Optimal use of PPE**

Staff should only use PPE where it is indicated. Where not indicated, e.g. when working with people who are not symptomatic, staff should follow normal good hygiene practices, as per the

Covid-19 Government infection control guidance:
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Ways to minimise use of PPE when use is indicated include:

- Restricting the number of carers who enter a room where people are with Covid -19 – to reduce the number of people who need to use PPE
- Bundling tasks so that they are performed by one person wearing PPE at the same time – e.g. a care worker takes in food and conducts other required tasks whilst in the room – to reduce the number of times that PPE needs to be used

Obtaining supplies of PPE

Supply of personal protective equipment to the health and social care sector is fundamental for the good care of individuals with suspected symptoms of Covid -19.

National arrangements have been made to distribute free supplies of fluid repellent face masks to care homes / providers to tide over the initial rise in demand. No action is needed by providers; stock will be delivered to them.

Nationally, work is underway to ensure a longer-term supply of all aspects of personal protective equipment, including gloves, aprons, facemasks and hand sanitiser. For future PPE requirements, care providers should order PPE from their usual suppliers.

If care providers have immediate concerns overs their supply of PPE, there is now a dedicated line for the health and social care sector: **The National Supply Disruption line**

Tel: 0800 915 9964 Email: supplydisruptionservice@nhsbsa.nhs.uk

In the future, if a care provider is unable to get PPE from their normal supplier, the supplier is will be asked to report this to the National Supply Disruption Response (NSDR) team (as above), who can advise on alternative suppliers.

Safe disposal of used PPE

Used PPE must be stored securely within disposable rubbish bags. These bags should be placed into another bag, tied securely and kept separate from other waste within the room. This should be put aside for at least 72 hours before being put in the usual household waste bin.

Interim Personal Protective Equipment Guidance for Nottinghamshire County Council Colleagues during the COVID-19 Pandemic

Date: 06/04/2020
Version: 2.0 Updated version with revised national guidance issued 02/04/020
Last reviewed: 06/04/2020 (To be reviewed/updated every week as a minimum)

This guidance reflects the national guidance published by Public Health England and NHS England.

COVID-19 is a rapidly evolving situation and this guidance is subject to change in line with national guidance, and by 26th April at the latest.

Contents

Tables

1. When is Personal Protective Equipment needed?

PPE is used where risk assessment determines the need. Other control measures should be considered first before resorting to the use of PPE. In relation to COVID-19, PPE is used to prevent exposure or cross infection between colleagues and citizens or from contamination from the working environment.

Symptoms which indicate COVID-19 is suspected include:

- **a high temperature** – this means feeling hot to touch on the chest or back
- **a new, continuous cough** – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours

Risk assessment

National guidance requires that decisions about use of PPE are made on the basis of risk assessment and with reference to the national guidance. The risk assessment must be made with reference to what can be reasonably determined about the COVID-19 status of the service user and the other members of their household and whether they are shielding. In other words, if anyone in the household has COVID-19 symptoms, a medical diagnosis of COVID-19, or are shielding, appropriate PPE should be put on prior to providing care.

This risk assessment needs to take place by phone or from another remote setting prior to entering the premises or clinical area.

Where the potential risk to health and social care workers cannot be established prior to face-to-face assessment or delivery of care (within 2 metres), the recommendation is for health and social care workers in any setting to have access to and where required wear aprons, fluid- resistant surgical masks (FRSMs), eye protection and gloves.

Health and social care workers should consider need for PPE based on the nature of care or task being undertaken. Risk assessment on use of eye protection for example, should consider the likelihood of encountering a case(s) and the risk of droplet transmission (risk of droplet transmission to eye mucosa associated with a service user who coughs, sneezes or spits) during the care episode. This may also include care for those whose behaviour we cannot predict, who may be aggressive or who may not understand or cooperate with 2m social distancing.

Ultimately, where an assessment of risk made with reference to this guidance indicates that the situation represents an actual risk to themselves or to the individuals they are caring for, the staff member should wear a fluid repellent surgical mask and, depending on the risk they have identified, eye protection.

What to do if you think exposure has occurred, without PPE

Health and social care workers who come into contact with a COVID-19 patient while not wearing PPE can remain at work. This is because in most instances this will be a short-lived exposure.

If despite taking the measures and precautions outlined, a staff member finds they may have been exposed (e.g. a service user has coughed or sneezed into the air who had not previously disclosed symptoms as part of the risk assessment), s/he should:

- Wash hands thoroughly with soap and water, dry using your own towel (rather than from household visited) – or use 60% alcohol hand sanitiser. If washing hands also wash exposed forearms. Do not touch your mouth, nose or eyes.
- Consider changing clothing if there was a risk of clothing being contaminated with bodily fluids
- If risk of splashing to the face has occurred, wash face thoroughly.

1.1 Business as usual: Working with citizens who don't have COVID-19 or symptoms of COVID-19, who are not self-isolating because a member of their household is symptomatic, have recovered from COVID-19 or have completed isolation.

If the citizen receiving care and support does not have COVID-19, is not symptomatic of COVID-19 and is not self-isolating because a family member has COVID-19, then no personal protective equipment (PPE) is necessary above what would usually be required to deliver care to that person (e.g. gloves and an apron to deliver personal care), unless someone in the household is shielding (see section 1.2). Government guidance for social distancing should be followed alongside thorough handwashing.

This also applies when a citizen, who lives alone, has had suspected or confirmed COVID-19 and it is after the 7 days isolation period and/or when a family has completed 14 days isolation as a family member was symptomatic. For more information see: https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

It is essential that stocks of PPE are conserved and deployed sensibly. Local risk assessment and practical management should be pragmatic and proportionate, including ensuring PPE is not worn unless it is necessary to do so. This should also consider whether care and support can be provided without close contact, using technology or whilst maintaining social distancing (2 metres).

1.2 Working with citizens who don't have COVID-19 or symptoms of COVID-19 and they or a member of their household require shielding as they are extremely vulnerable to COVID-19

If the citizen receiving care, or a member of their household is classed as "clinically extremely vulnerable", then in addition to the guidance in section 1.1, there is specific guidance on shielding. These citizens should have been contacted by NHS England or their GP to inform them they are in this category and have been advised to stay at home at all times and avoid any face-to-face contact for a period of at least 12 weeks. However, visits from essential support such as healthcare, personal support with daily needs or social care should continue. This guidance also applies to extremely vulnerable people living in long-term care facilities.

Extremely vulnerable citizens include those who have:

- Received solid organ transplant recipients.
- Specific cancers:
    - Cancer and are undergoing active chemotherapy or radical radiotherapy for lung cancer
    - Cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
    - Are having immunotherapy or other continuing antibody treatments for cancer
    - Other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
- Had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
- Severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD.
- Rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell).
- Are on immunosuppression therapies sufficient to significantly increase risk of infection.
- Women who are pregnant with significant heart disease, congenital or acquired.

'Shielding' measures

In addition to the PPE recommendations in section 1.1, if the citizen requiring care or any member of their household is shielding, colleagues should:

- **Wear a disposable plastic apron, disposable gloves and a standard surgical mask (this does not have to be a fluid repellent mask)**
- Wash their hands with soap and water for at least 20 seconds on arrival to the individual's home or room (in the case of residential care setting), in addition to normal good hygiene practice.
- Consider whether the purpose of the visit can be achieved by other contact measures, e.g. using remote technology such as phone, internet and social media.

For more information see full guidance at:
https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19

1.3 Working with citizens who have COVID-19 or symptoms of COVID-19 or who are self-isolating because they or a member of their household is symptomatic

Who is this section of the guidance for?

This section of the guidance is intended for colleagues who have contact with citizens who either have confirmed COVID-19, symptoms of COVID-19 or who are self-isolating because a member of their household is symptomatic.

When to use PPE and conserving stocks

It is essential that stocks of PPE are conserved and deployed sensibly. Local risk assessment and practical management should be pragmatic and proportionate, including consideration of whether there is actually a requirement to wear PPE. This should also consider whether care and support can be provided without close contact, using technology or whilst maintaining social distancing (2 metres).

Ultimately, where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection, as determined by the individual staff member for the episode of care or single session.

Which PPE to use

Tables 1 and 2 show the actions needed regarding PPE when colleagues have contact with citizens who have confirmed COVID-19, symptoms of COVID-19 and/or who are self-isolating because they or a household member is symptomatic.

Table 1 also includes PPE actions for colleagues in households where someone is shielding.

Table 3 shows additional precautions recommended in sustained transmission settings.

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For more information see: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Sessional use of PPE

Fluid repellent surgical masks, eye protection and long-sleeved disposable fluid repellent gowns are indicated for use for a 'session' of care rather than single use. Aprons and gloves are subject to single use as per standard infection control precautions.

A 'session' of care refers to a period of time where a health and social care colleague is undertaking duties in a specific clinical care setting or exposure environment. An example of a session of care may include taking observations of patients in a cohort area in a care home, or delivering care in an individual's home. A session ends when the colleague leaves the exposure environment, such as leaving the cohort area or the citizens home.

Aerosol generating procedures (AGP's)- AGP's require enhanced PPE to be worn due to the increased risk of transmission of respiratory viruses. Table 1 details the PPE required when performing these procedures (e.g. insertion, open suctioning or removal of tracheotomy or tracheostomy). Appendix 1 outlines procedures which are classed as 'aerosol generating'.

Sustained transmission and PPE- Where the national guidance refers to "sustained transmission" (e.g. Table 3 of this document), PHE have confirmed that this specifically refers to the circumstances in a particular setting where there are two or more possible or confirmed cases. If these circumstances occur, the PPE set out in Table 3 is recommended. For example, care home staff where 2 or more residents have confirmed/possible COVID-19 would require PPE.

It is important to note that in many other settings (e.g. early years, most schools) there will not be sustained transmission within the setting because any individuals with symptoms of Covid-19 should follow guidance to self-isolate. In these instances PPE should be used as indicated in table 1.

Table 1: Copy of the national guidance showing PPE required when delivering care to citizen who has suspected or confirmed COVID-19, is self-isolating because a member of their household is symptomatic, or they or a member of their household is shielding

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES – Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Recommended PPE for primary, outpatient and community care by setting, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Any setting	Performing an aerosol generating procedure[2] on a possible or confirmed case[3]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✓ single use[4]	✓ single use[4]
Primary care, ambulatory care, and other non emergency outpatient and other clinical settings e.g. optometry, dental, maternity, mental health	Direct patient care – possible or confirmed case(s)[3] (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
	Working in reception/communal area with possible or confirmed case(s)[3] and unable to maintain 2 metres social distance[6]	✗	✗	✗	✗	✓ sessional use[5]	✗	✗
Individuals own home (current place of residence)	Direct care to any member of the household where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ risk assess single or sessional use[4,5,8]
	Direct care or visit to any individuals in the extremely vulnerable group or where a member of the household is within the extremely vulnerable group undergoing shielding[9]	✓ single use[4]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✗
	Home birth where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✓ single use[4]	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
Community-care home, mental health inpatients and other overnight care facilities e.g. learning disability, hospices, prison healthcare	Facility with possible or confirmed case(s)[3] – and direct resident care (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ sessional use[5]	✗	risk assess sessional use[5,8]
Any setting	Collection of nasopharyngeal swab(s)	✓ single use[4]	✓ single or sessional use[4,5]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]

Table 2

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. The full list of aerosol generating procedures (AGPs) is within the IPC guidance [note APGs are undergoing a further review at present].
3. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
4. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. Non clinical staff should maintain 2m social distancing, through marking out a controlled distance; sessional use should always be risk assessed and considered where there are high rates of community cases.
7. Initial risk assessment should take place by phone prior to entering the premises or at 2 metres social distance on entering; where the health or social care worker assesses that an individual is symptomatic with suspected/confirmed cases appropriate PPE should be put on prior to providing care.
8. Risk assessed use refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids.
9. For explanation of shielding and definition of extremely vulnerable groups see guidance: 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

Table 2: Further guidance for colleagues working with citizens who have confirmed COVID-19, symptoms of COVID-19 or who are self-isolating because they or a household member is symptomatic

Purpose of contact	**PPE needed?**	**Infection prevention and control guidance**
Direct care (e.g. washing and bathing, personal hygiene and contact with bodily fluids) a) Residential care homes b) Domiciliary care providers c) CYP with complex needs at home	Yes - aprons, gloves and fluid repellent surgical masks. If there is a risk of splashing, then eye protection will minimise this. In addition, use FFP3 and disposable gown for aerosol generating procedures (e.g. insertion, open suctioning or removal of tracheotomy or tracheostomy).	Refer to official guidance for residential care, supported living and home care: https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance New aprons and gloves must be used for each episode of care. Fluid repellent surgical masks may be used for a 'session' of care in a single exposure environment. If care workers support the individual with laundry, then they should not shake dirty laundry. This minimises the possibility of dispersing virus through the air. Dirty laundry that has been in contact with an ill person can be washed with other people's items at 60^0. If the individual does not have a washing machine, wait a further 72 hours after the 7-day isolation period has ended. The laundry can then be taken to a public laundromat. Items heavily soiled with body fluids, for example vomit or diarrhoea, or items that cannot be washed, should be disposed of, with the owner's consent.
Personal contact (e.g. face to face) but not close or touching a) Children's residential home b) DVA refuges c) Home visit	No, unless 2m distance cannot be maintained. In which case use aprons, gloves and fluid repellent surgical mask. PPE required if someone in the household is shielding.	Risk assess if actual visit needed or whether technology can be used to make contact in a virtual way Speak to service user from safe distance (more than 2 metres away for less than 15 minutes), then tell them to withdraw to another room/as far away as possible. Afterwards wash hands thoroughly with soap and water, dry using your own towel – or use 60% alcohol sanitiser.

Purpose of contact	PPE needed?	Infection prevention and control guidance
Deliveries (e.g. meals on wheels) – into the premises	No- unless 2m distance cannot be maintained. In which case use apron, gloves and fluid repellent surgical mask PPE required if someone in the household is shielding.	Speak to service user from safe distance (more than 2 metres away) – if you are in the property for more than 15 minutes, ask them to withdraw to another room/as far away as possible. Afterwards wash hands thoroughly with soap and water, dry using your own towel – or use 60% alcohol sanitiser. If required, new PPE should be used for each visit.
Deliveries (e.g. meals on wheels) – where deliveries can be left on the doorstep	No	The delivery should be left outside the property. You can telephone the service user to advise them when you deliver the item.
Emergency property services (e.g. gas repair, water leak, pest control etc.)	No- unless 2m distance cannot be maintained. In which case use apron, gloves and fluid repellent surgical mask PPE required if someone in the household is shielding.	Speak to service user from safe distance (more than 2 metres away) while receiving instructions (less than 15 minutes), then ask them to withdraw to another room/as far away as possible. Clean surfaces where you will be working if possible. Use usual household products, for example detergents and bleach – be aware that viruses can survive on hard surfaces for up to 72 hours New PPE must be used for each episode if required. Afterwards wash hands thoroughly with soap and water, dry using your own towel – or use 60% alcohol sanitiser.

Purpose of contact	PPE needed?	Infection prevention and control guidance
Cleaning service (e.g. LA-run temporary accommodation with communal areas)	Yes – aprons, gloves, face mask Consider use of eye protection and if risk of splashing of bodily fluids.	Speak to service user from safe distance (more than 2 metres away for less than 15 minutes), then tell them to withdraw to another room/as far away as possible. New PPE must be used for each new area. Use usual household products, for example detergents and bleach – be aware that viruses can survive on hard surfaces for up to 72 hours Clean frequently touched surfaces. Personal waste (for example used tissues, continence pads and other items soiled with bodily fluids) and disposable cleaning cloths can be stored securely within disposable rubbish bags. (Disposal as for PPE, see below) The Government has produced specific guidance on COVID-19 decontamination in non-healthcare settings https://www.gov.uk/government/publications/Covid-19-decontamination-in-non-healthcare-settings/covid-19-decontamination-in-non-healthcare-settings If risk assessment identifies higher level of virus (e.g. hotel rooms or dormitories, or contamination of body fluids, then may need additional PPE to protect eyes, nose and mouth. Afterwards wash hands thoroughly with soap and water, dry using your own towel – or use 60% alcohol sanitiser.

Table 3: Copy of national guidance showing additional precautions recommended in settings with sustained transmission of COVID-19

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES – Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Additional considerations, in addition to standard infection prevention and control precautions,

where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/ gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Any setting	Direct patient/resident care assessing an individual that is not currently a possible or confirmed case[2] (within 2 metres)	✓ single use[3]	✓ single use[3]	✗	✗	✓ risk assess sessional use[4,5]	✗	✓ risk assess sessional use[4,5]
Any setting	Performing an aerosol generating procedure[6] on an individual that is not currently a possible or confirmed case[2]	✓ single use[3]	✗	✓ single use[3]	✗	✗	✓ single use[3]	✓ single use[3]

Table 4

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
3. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
4. Risk assess refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets of blood or body fluids. **Where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection as determined by the individual staff member for the care episode/single session.**
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and consider the risk of infection to and from patients, residents and health and care workers where COVID-19 is circulating in the community and hospitals. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. The full list of aerosol generating procedures (AGPs) is within the IPC guidance [note APGs are undergoing a further review at present].

2. Anticipating demand for Personal Protective Equipment and managing stock

In order to maintain supplies in the face of anticipated demand, it is important to ensure the appropriate use of Personal Protective Equipment (PPE) in all settings.

PPE inventory and stock management

Inventory systems should be employed by individual teams to track daily usage and ensure that use of PPE is appropriate, with the aim of conserving stocks of PPE for indicated uses.

Teams must not stockpile PPE beyond normal levels; typically 2 weeks. The Local Resilience Forum (LRF) Health and Social Care Tactical Coordinating Group (HSC TCG) is to be tasked to identify options for stock control and management of use and the LRF logistics cell will support and enable PPE stock distribution.

Optimal use of PPE

Staff should only use PPE where it is indicated. Where not indicated, e.g. when working with people who are not symptomatic, in isolation or shielding, staff should follow normal good hygiene practices, as per the COVID-19 Government infection control guidance: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Ways to minimise use of PPE when use is indicated include:

- Restricting the number of carers who enter a room where people are with Covid-19 to reduce the number of people who need to use PPE
- Bundling tasks so that they are performed by one person wearing PPE at the same time e.g. a care worker takes in food and conducts other required tasks whilst in the room to reduce the number of times that PPE needs to be used.

Staff should ensure they know how to safely use all PPE, including putting it on (donning) and putting it off (doffing) correctly (see appendix 2 and 3).

Obtaining supplies of PPE

Supply of personal protective equipment to the health and social care sector is fundamental for the good care of individuals with suspected symptoms of COVID-19.

Nationally, work is underway to ensure a longer-term supply of all aspects of personal protective equipment, including gloves, aprons, facemasks and hand sanitiser. Work across the Health and social care system via the Local Resilience Forum is taking place to coordinate stocks of PPE.

For external providers: For future PPE requirements, care providers should order PPE from their usual suppliers.

If care providers have immediate concerns overs their supply of PPE, there is now a dedicated line for the health and social care sector:

The National Supply Disruption line: Tel: 0800 915 9964

Email: supplydisruptionservice@nhsbsa.nhs.uk

In the future, if a care provider is unable to get PPE from their normal supplier, the supplier is will be asked to report this to the National Supply Disruption Response (NSDR) team (as above), who can advise on alternative suppliers.

For internal providers: please contact ppe@nottscc.gov.uk for your PPE enquiries, including urgent need for stock.

Safe disposal of used PPE

Used PPE must be stored securely within disposable rubbish bags. These bags should be placed into another bag, tied securely and kept separate from other waste within the room. This should be put aside in a secure specified area for at least 72 hours before being put in the usual household waste bin.

Appendix 1. Aerosol Generating Procedures (AGPs)

APGs are undergoing a further review at present and this list may be updated – please check https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe.

The following procedures are currently considered to be potentially infectious AGPs for COVID-19:

- intubation, extubation and related procedures, for example manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract)
- tracheotomy or tracheostomy procedures (insertion or open suctioning or removal)
- bronchoscopy and upper ENT airway procedures that involve suctioning
- upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract
- surgery and post mortem procedures involving high-speed devices
- some dental procedures (for example, high-speed drilling)
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- induction of sputum (cough)
- high flow nasal oxygen (HFNO)

For patients with possible or confirmed COVID-19, any of these potentially infectious AGPs should only be carried out when essential. Where possible, these procedures should be carried out in a single room with the doors shut. Only those healthcare staff who are needed to undertake the procedure should be present.

Procedures where AGP PPE is not required

Certain other procedures or equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk. Procedures in this category include administration of pressurised humidified oxygen, entonox or medication via nebulisation.

Chest compressions and defibrillation (as part of resuscitation) are not considered AGPs; first responders (any setting) can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other clinicians to undertake airway manoeuvres.

Appendix 2. Guide to donning and doffing standard PPE for health and social care settings

Public Health England

Guide to donning and doffing standard Personal Protective Equipment (PPE)

for health and social care settings

Donning or putting on PPE

Before putting on the PPE, perform hand hygiene. Use alcohol handrub or gel or soap and water. Make sure you are hydrated and are not wearing any jewellery, bracelets, watches or stoned rings.

1. Put on your plastic apron, making sure it is tied securely at the back.

2. Put on your surgical face mask, if tied, make sure securely tied at crown and nape of neck. Once it covers the nose, make sure it is extended to cover your mouth and chin.

3. Put on your eye protection if there is a risk of splashing.

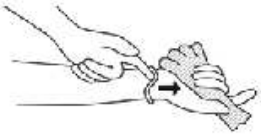
4. Put on non-sterile nitrile gloves.

5. You are now ready to enter the patient area.

Doffing or taking off PPE

Surgical masks are single session use, gloves and apron should be changed between patients.

1. Remove gloves, grasp the outside of the cuff of the glove and peel off, holding the glove in the gloved hand, insert the finger underneath and peel off second glove.



2. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

3. Snap or unfasten apron ties the neck and allow to fall forward.

Snap waste ties and fold apron in on itself, not handling the outside as it is contaminated, and put into clinical waste.

4. Once outside the patient room. Remove eye protection.

5. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

6. Remove surgical mask.

7. Now wash your hands with soap and water.

Please refer to the PHE standard PPE video in the COVID-19 guidance collection:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures

If you require the PPE for aerosol generating procedures (AGPs) please visit:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

Appendix 3. Donning and Doffing PPE for aerosol generating procedures (AGPs)

Public Health England

COVID-19

Quick guide

Putting on (donning) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

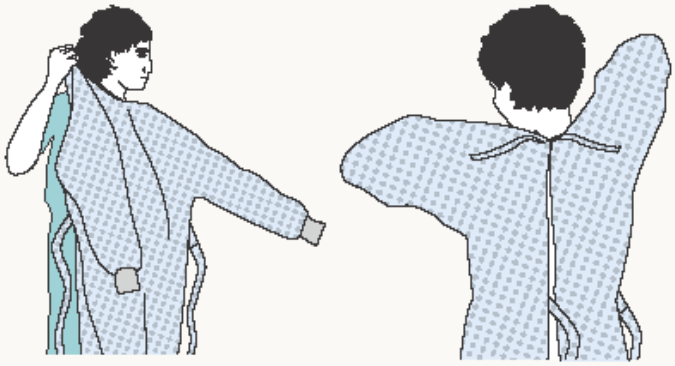
This is undertaken outside the patient's room.

Pre-donning instructions

- ensure healthcare worker hydrated
- tie hair back
- remove jewellery
- check PPE in the correct size is available

Perform hand hygiene before putting on PPE

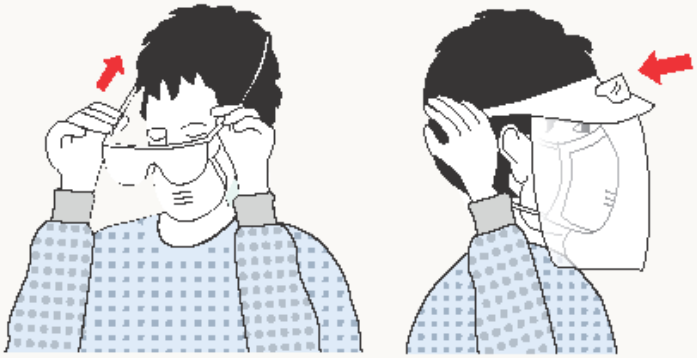
1 Put on the long-sleeved fluid repellent disposable gown



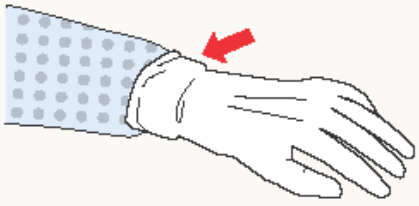
2 Respirator

Perform a fit check.

3 Eye protection



4 Gloves



Appendix 3. Donning and Doffing PPE for aerosol generating procedures (AGPs)

Public Health England

COVID-19

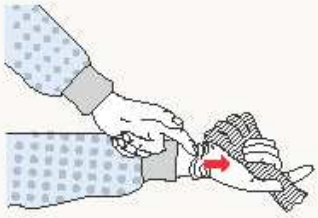
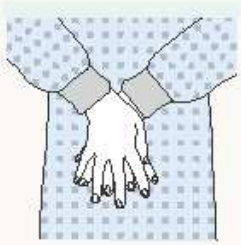
Quick guide

Removal of (doffing) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

PPE should be removed in an order that minimises the potential for cross contamination.

The order of removal of PPE is as follows:

1 **Gloves –**
the outsides of the gloves are contaminated

Clean hands with alcohol gel

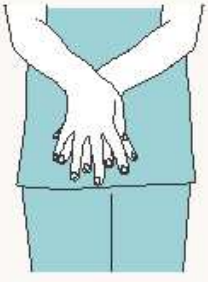
2 **Gown –**
the front of the gown and sleeves will be contaminated



3 **Eye protection -**
the outside will be contaminated

4 **Respirator**
Clean hands with alcohol hand rub. Do not touch the front of the respirator as it will be contaminated

5 Wash hands with soap and water



Interim Personal Protective Equipment Guidance for Nottinghamshire County Council Colleagues during the COVID-19 Pandemic

Date: 13/04/2020
Version: 3.0 Updated version with revised national guidance issued 10/04/020 and 12/04/2020
Last reviewed: 13/04/2020 (To be reviewed/updated every week as a minimum)

This guidance reflects the national guidance published by Public Health England and NHS England.

COVID-19 is a rapidly evolving situation and this guidance is subject to change in line with national guidance, and by 26th April at the latest.

Contents

Tables

1. When is Personal Protective Equipment needed?

PPE is used where risk assessment determines the need. Other control measures should be considered first before resorting to the use of PPE. In relation to COVID-19, PPE is used to prevent exposure or cross infection between colleagues and citizens or from contamination from the working environment.

Symptoms which indicate COVID-19 is suspected include:

- **a high temperature** – this means feeling hot to touch on the chest or back
- **a new, continuous cough** – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours

Risk assessment

National guidance requires that decisions about use of PPE are made on the basis of risk assessment and with reference to the national guidance. This risk assessment needs to take place by phone or from another remote setting prior to entering the premises or clinical area.

Health and social care workers should consider the need for PPE based on:

- the nature of care or task being undertaken, i.e. **close personal contact** such as **providing direct care** for an individual and any risk of contamination with splashes, droplets of blood or bodily fluids
- whether you will be able to reliably maintain 2m distance from the service user and any other people in the household
- whether a patient or resident has COVID-19 (suspected or confirmed) or is self-isolating because a member of their family/household is symptomatic
- whether there is someone in the household who is shielding as they are in an extremely vulnerable group

Where a service user or household member does not currently have COVID-19 symptoms, or a medical diagnosis of COVID-19, if direct care will be delivered, a **risk assessment should be undertaken to assess the need for** PPE. These recommendations are set out in table 3.

Where the potential risk to health and social care workers cannot be established prior to face-to-face assessment or delivery of care (within 2 metres), the recommendation is for health and social care workers in any setting to have access to and where required wear aprons, fluid- resistant surgical masks (FRSMs), eye protection and gloves.

Health and social care workers should consider need for PPE based on the nature of care or task being undertaken. Risk assessment on use of eye protection for example, should consider the likelihood of encountering a case(s) and the risk of droplet transmission (risk of droplet transmission to eye mucosa associated with a service user who coughs, sneezes or spits) during the care episode. This may also include care for those whose behaviour we cannot predict, who may be aggressive or who may not understand or cooperate with 2m social distancing.

Ultimately, where an assessment of risk made with reference to this guidance indicates that the situation represents an actual risk to themselves or to the individuals they are caring for, the staff member should wear a fluid repellent surgical mask and, depending on the risk they have identified, eye protection.

What to do if you think exposure has occurred, without PPE

Health and social care workers who come into contact with a COVID-19 patient while not wearing PPE can remain at work. This is because in most instances this will be a short-lived exposure.

If despite taking the measures and precautions outlined, a staff member finds they may have been exposed (e.g. a service user has coughed or sneezed into the air who had not previously disclosed symptoms as part of the risk assessment), s/he should:

- Wash hands thoroughly with soap and water, dry using your own towel (rather than from household visited) – or use 60% alcohol hand sanitiser. If washing hands also wash forearms when forearms have been exposed or may have been exposed to respiratory droplets or other body fluids. Do not touch your mouth, nose or eyes.
- Consider changing clothing if there was a risk of clothing being contaminated with bodily fluids
- If risk of splashing to the face has occurred, wash face thoroughly.

1.1 Patient use of PPE

In clinical areas, communal waiting areas and during transportation, it is recommended that possible or confirmed COVID-19 cases wear a surgical face mask if this can be tolerated. The aim of this is to minimise the dispersal of respiratory secretions, reduce both direct transmission risk and environmental contamination.

A face mask should **not** be worn by patients if there is potential for their clinical care to be compromised (for example, when receiving oxygen therapy via a mask). A face mask can be worn until damp or uncomfortable.

1.2 Working with citizens who <u>don't have</u> COVID-19 or symptoms of COVID-19, who are not self-isolating because a member of their household is symptomatic, have recovered from COVID-19 or have completed isolation.

If the citizen receiving care and support does not have COVID-19, is not symptomatic of COVID-19 and is not self-isolating because a family member has COVID-19, then PPE is only necessary if delivering direct care (within 2m). Table 3 describes when to use PPE for direct care assessing an individual that is not currently a possible or confirmed case, at a time at a time when there is sustained community transmission of COVID-19, **as is currently occurring in the UK**, and the likelihood of any patient having coronavirus infection is raised

If direct care is not being delivered, and a 2m distance can be maintained, no personal protective equipment (PPE) is necessary above what would usually be required to deliver that service (e.g. gloves that may usually be worn on an environmental health visit).

If someone in the household is shielding (see section 1.2), PPE should be worn. Government guidance for social distancing should be followed alongside thorough handwashing.

This also applies when a citizen, who lives alone, has had suspected or confirmed COVID-19 and it is after the 7 days isolation period and/or when a family has completed 14 days isolation as a family member was symptomatic. For more information see: https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

It is essential that stocks of PPE are conserved and deployed sensibly. Local risk assessment and practical management should be pragmatic and proportionate, including ensuring PPE is not worn unless it is necessary to do so. This should also consider whether care and support can be provided without close contact, using technology or whilst maintaining social distancing (2 metres).

1.3 Working with citizens who don't have COVID-19 or symptoms of COVID-19 and they or a member of their household require shielding as they are extremely vulnerable to COVID-19

If the citizen receiving care, or a member of their household is classed as "clinically extremely vulnerable", then in addition to the guidance in section 1.1, there is specific guidance on shielding. These citizens should have been contacted by NHS England or their GP to inform them they are in this category and have been advised to stay at home at all times and avoid any face-to-face contact for a period of at least 12 weeks. However, visits from essential support such as healthcare, personal support with daily needs or social care should continue. This guidance also applies to extremely vulnerable people living in long-term care facilities.

Extremely vulnerable citizens include those who have:

- Received solid organ transplant recipients.
- Specific cancers:
    - Cancer and are undergoing active chemotherapy or radical radiotherapy for lung cancer
    - Cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
    - Are having immunotherapy or other continuing antibody treatments for cancer
    - Other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
- Had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
- Severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD.
- Rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell).
- Are on immunosuppression therapies sufficient to significantly increase risk of infection.
- Women who are pregnant with significant heart disease, congenital or acquired.

'Shielding' measures

In addition to the PPE recommendations in section 1.1, if the citizen requiring care or any member of their household is shielding, colleagues should:

- **Wear a disposable plastic apron, disposable gloves and a standard surgical mask (this does not have to be a fluid repellent mask)**
- Wash their hands with soap and water for at least 20 seconds on arrival to the individual's home or room (in the case of residential care setting), in addition to normal good hygiene practice.
- Consider whether the purpose of the visit can be achieved by other contact measures, e.g. using remote technology such as phone, internet and social media.

For more information see full guidance at:
https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19

1.4 Working with citizens who have COVID-19 or symptoms of COVID-19 or who are self-isolating because they or a member of their household is symptomatic

Who is this section of the guidance for?

This section of the guidance is intended for colleagues who have contact with citizens who either have confirmed COVID-19, symptoms of COVID-19 or who are self-isolating because a member of their household is symptomatic.

When to use PPE and conserving stocks

It is essential that stocks of PPE are conserved and deployed sensibly. Local risk assessment and practical management should be pragmatic and proportionate, including consideration of whether there is actually a requirement to wear PPE. This should also consider whether care and support can be provided without close contact, using technology or whilst maintaining social distancing (2 metres).

Ultimately, where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection, as determined by the individual staff member for the episode of care or single session.

Which PPE to use

Tables 1 and 2 show the actions needed regarding PPE when colleagues have contact with citizens who have confirmed COVID-19, symptoms of COVID-19 and/or who are self-isolating because they or a household member is symptomatic.

Table 1 also includes PPE actions for colleagues in households where someone is shielding.

Table 3 shows additional PPE recommended at a time when there is sustained community transmission of COVID-19, **as is currently occurring in the UK,** and the likelihood of any patient having coronavirus infection is raised.

For more information see: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Sessional use of PPE

In some circumstances PPE can be worn for an entire session and does not need to be changed between each patient.

Fluid repellent surgical masks, eye protection and long-sleeved disposable fluid repellent gowns are indicated for use for a 'session' of care rather than single use. Aprons and gloves are subject to single use as per standard infection control precautions.

A 'session' of care refers to a period of time where a health and social care colleague is undertaking duties in a specific clinical care setting or exposure environment. An example of a session of care may include taking observations of patients in a cohort area in a care home, or delivering care in an individual's home. A session ends when the colleague leaves the exposure environment, such as leaving the cohort area or the citizens home.

Re-usable PPE- re-usable eye/face protection is acceptable if decontaminated between single or single sessional use, and must be done so according to the manufacturer's instructions or local infection control policy.

Guidance on how to clean re-usable eye/face protection can be found here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877533/Routine_decontamination_of_reusable_noninvasive_equipment.pdf

Disposable aprons, gloves, fluid-repellent surgical masks are all for either single or sessional use and NOT to be re-used.

Aerosol generating procedures (AGP's)- AGP's require enhanced PPE to be worn due to the increased risk of transmission of respiratory viruses. Table 1 details the PPE required when performing these procedures (e.g. insertion, open suctioning or removal of tracheotomy or tracheostomy). Appendix 1 outlines procedures which are classed as 'aerosol generating'.

Sustained transmission and PPE- We are currently experiencing sustained transmission across the UK. Table 3 sets out the PPE recommended for direct care of all patients/residents (not just patients with suspected or confirmed COVID-19) at a time when there is sustained community transmission of COVID-19, as is currently occurring in the UK, and the likelihood of any patient having coronavirus infection is raised.

Table 1: Copy of the national guidance showing PPE required when delivering care to citizen who has suspected or confirmed COVID-19, is self-isolating because a member of their household is symptomatic, or they or a member of their household is shielding

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES – Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Recommended PPE for primary, outpatient and community care by setting, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Any setting	Performing an aerosol generating procedure[2] on a possible or confirmed case[3]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✓ single use[4]	✓ single use[4]
Primary care, ambulatory care, and other non emergency outpatient and other clinical settings e.g. optometry, dental, maternity, mental health	Direct patient care – possible or confirmed case(s)[3] (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
	Working in reception/communal area with possible or confirmed case(s)[3] and unable to maintain 2 metres social distance[6]	✗	✗	✗	✗	✓ sessional use[5]	✗	✗
Individuals own home (current place of residence)	Direct care to any member of the household where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ risk assess single or sessional use[4,5,8]
	Direct care or visit to any individuals in the extremely vulnerable group or where a member of the household is within the extremely vulnerable group undergoing shielding[9]	✓ single use[4]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✗
	Home birth where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✓ single use[4]	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
Community-care home, mental health inpatients and other overnight care facilities e.g. learning disability, hospices, prison healthcare	Facility with possible or confirmed case(s)[3] – and direct resident care (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ sessional use[5]	✗	risk assess sessional use[5,8]
Any setting	Collection of nasopharyngeal swab(s)	✓ single use[4]	✓ single or sessional use[4,5]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]

Table 2

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. The full list of aerosol generating procedures (AGPs) is within the IPC guidance [note APGs are undergoing a further review at present].
3. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
4. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. Non clinical staff should maintain 2m social distancing, through marking out a controlled distance; sessional use should always be risk assessed and considered where there are high rates of community cases.
7. Initial risk assessment should take place by phone prior to entering the premises or at 2 metres social distance on entering; where the health or social care worker assesses that an individual is symptomatic with suspected/confirmed cases appropriate PPE should be put on prior to providing care.
8. Risk assessed use refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids.
9. For explanation of shielding and definition of extremely vulnerable groups see guidance: 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

Table 2: Further guidance for colleagues working with citizens who have confirmed COVID-19, symptoms of COVID-19 or who are self-isolating because they or a household member is symptomatic

Purpose of contact	PPE needed?	Infection prevention and control guidance
Direct care (e.g. washing and bathing, personal hygiene and contact with bodily fluids) a) Residential care homes b) Domiciliary care providers c) CYP with complex needs at home	Yes - aprons, gloves and fluid repellent surgical masks. Eye protection if there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids. In addition, use FFP3 and disposable gown for aerosol generating procedures (e.g. insertion, open suctioning or removal of tracheotomy or tracheostomy).	Refer to official guidance for residential care, supported living and home care: https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance New aprons and gloves must be used for each episode of care. Fluid repellent surgical masks may be used for a 'session' of care in a single exposure environment. If care workers support the individual with laundry, then they should not shake dirty laundry. This minimises the possibility of dispersing virus through the air. Linen must be handled, transported and processed in a manner that prevents exposure to the skin and mucous membranes of staff, contamination of their clothing and the environment. Disposable gloves and an apron should be worn when handling infectious linen Dirty laundry that has been in contact with an ill person can be washed with other people's items at 60^0. If the individual does not have a washing machine, wait a further 72 hours after the 7-day isolation period has ended. The laundry can then be taken to a public laundromat. Items heavily soiled with body fluids, for example vomit or diarrhoea, or items that cannot be washed, should be disposed of, with the owner's consent.
Personal contact (e.g. face to face) but not close or touching a) Children's residential home b) DVA refuges c) Home visit	No, unless 2m distance cannot be maintained. In which case use aprons, gloves and fluid repellent surgical mask. Eye protection if there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids. PPE required if someone in the household is shielding.	Risk assess if actual visit needed or whether technology can be used to make contact in a virtual way Speak to service user from safe distance (more than 2 metres away for less than 15 minutes), then tell them to withdraw to another room/as far away as possible. Afterwards wash hands thoroughly with soap and water, including forearms if exposed, dry using your own towel – or use 60% alcohol sanitiser.

Purpose of contact	PPE needed?	Infection prevention and control guidance
Deliveries (e.g. meals on wheels) – into the premises	No- unless 2m distance cannot be maintained. In which case use apron, gloves and fluid repellent surgical mask. Eye protection if there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids. PPE required if someone in the household is shielding.	Speak to service user from safe distance (more than 2 metres away) – if you are in the property for more than 15 minutes, ask them to withdraw to another room/as far away as possible. Afterwards wash hands thoroughly with soap and water, including forearms if exposed, dry using your own towel – or use 60% alcohol sanitiser. If required, new PPE should be used for each visit.
Deliveries (e.g. meals on wheels) – where deliveries can be left on the doorstep	No	The delivery should be left outside the property. You can telephone the service user to advise them when you deliver the item.
Emergency property services (e.g. gas repair, water leak, pest control etc.)	No- unless 2m distance cannot be maintained. In which case use apron, gloves and fluid repellent surgical mask. Eye protection if there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids. PPE required if someone in the household is shielding.	Speak to service user from safe distance (more than 2 metres away) while receiving instructions (less than 15 minutes), then ask them to withdraw to another room/as far away as possible. Clean surfaces where you will be working if possible. Use usual household products, for example detergents and bleach – be aware that viruses can survive on hard surfaces for up to 72 hours New PPE must be used for each episode if required. Afterwards wash hands thoroughly with soap and water, including forearms if exposed, dry using your own towel – or use 60% alcohol sanitiser.

Purpose of contact	PPE needed?	Infection prevention and control guidance
Cleaning service (e.g. LA-run temporary accommodation with communal areas)	Yes – aprons, gloves, face mask Eye protection if there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids.	Speak to service user from safe distance (more than 2 metres away for less than 15 minutes), then tell them to withdraw to another room/as far away as possible. New PPE must be used for each new area. Use usual household products, for example detergents and bleach – be aware that viruses can survive on hard surfaces for up to 72 hours Clean frequently touched surfaces. Personal waste (for example used tissues, continence pads and other items soiled with bodily fluids) and disposable cleaning cloths can be stored securely within disposable rubbish bags. (Disposal as for PPE, see below) The Government has produced specific guidance on COVID-19 decontamination in non-healthcare settings https://www.gov.uk/government/publications/Covid-19-decontamination-in-non-healthcare-settings/covid-19-decontamination-in-non-healthcare-settings If risk assessment identifies higher level of virus (e.g. hotel rooms or dormitories, or contamination of body fluids, then may need additional PPE to protect eyes, nose and mouth. Afterwards wash hands thoroughly with soap and water, including forearms if exposed, dry using your own towel – or use 60% alcohol sanitiser.

Table 3: Copy of national guidance showing additional precautions recommended in settings with sustained transmission of COVID-19

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Additional considerations, in addition to standard infection prevention and control precautions,

where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/ gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Any setting	Direct patient/resident care assessing an individual that is not currently a possible or confirmed case[2] (within 2 metres)	✓ single use[3]	✓ single use[3]	✗	✗	✓ risk assess sessional use[4,5]	✗	✓ risk assess sessional use[4,5]
Any setting	Performing an aerosol generating procedure[6] on an individual that is not currently a possible or confirmed case[2,7]	✓ single use[3]	✗	✓ single use[3]	✗	✗	✓ single use[3]	✓ single use[3]
Any setting	Patient transport service driver conveying any individual to essential healthcare appointment, that is not currently a possible or confirmed case in vehicle without a bulkhead, no direct patient care and within 2 metres	✗	✗	✗	✓ single use[3]	✗	✗	✗

Table 4

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
3. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
4. Risk assess refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets of blood or body fluids. **Where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection as determined by the individual staff member for the care episode/single session.**
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and consider the risk of infection to and from patients, residents and health and care workers where COVID-19 is circulating in the community and hospitals. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. The list of aerosol generating procedures (AGPs) is included in section 8.1 at: www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe. (Note APGs are undergoing a further review at present)
7. Ambulance staff conveying patients are not required to change or upgrade PPE for the purposes of patient handover.

2. Anticipating demand for Personal Protective Equipment and managing stock

In order to maintain supplies in the face of anticipated demand, it is important to ensure the appropriate use of Personal Protective Equipment (PPE) in all settings.

PPE inventory and stock management

Inventory systems should be employed by individual teams to track daily usage and ensure that use of PPE is appropriate, with the aim of conserving stocks of PPE for indicated uses.

Teams must not stockpile PPE beyond normal levels; typically 2 weeks. The Local Resilience Forum (LRF) Health and Social Care Tactical Coordinating Group (HSC TCG) is to be tasked to identify options for stock control and management of use and the LRF logistics cell will support and enable PPE stock distribution.

Optimal use of PPE

Staff should only use PPE where it is indicated. Where not indicated, e.g. when care can be delivered more than 2m away, staff should follow normal good hygiene practices, as per the COVID-19 Government infection control guidance: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Ways to minimise use of PPE when use is indicated include:

- Restricting the number of carers who enter a room where people are with Covid-19 to reduce the number of people who need to use PPE
- Bundling tasks so that they are performed by one person wearing PPE at the same time e.g. a care worker takes in food and conducts other required tasks whilst in the room to reduce the number of times that PPE needs to be used.

Staff should ensure they know how to safely use all PPE, including putting it on (donning) and putting it off (doffing) correctly (see appendix 2 and 3).

Obtaining supplies of PPE

Supply of personal protective equipment to the health and social care sector is fundamental for the good care of individuals with suspected symptoms of COVID-19.

Nationally, work is underway to ensure a longer-term supply of all aspects of personal protective equipment, including gloves, aprons, facemasks and hand sanitiser. Work across the Health and social care system via the Local Resilience Forum is taking place to coordinate stocks of PPE.

For external providers: For future PPE requirements, care providers should order PPE from their usual suppliers.

If care providers have immediate concerns overs their supply of PPE, there is now a dedicated line for the health and social care sector:

The National Supply Disruption line: Tel: 0800 915 9964

Email: supplydisruptionservice@nhsbsa.nhs.uk

In the future, if a care provider is unable to get PPE from their normal supplier, the supplier is will be asked to report this to the National Supply Disruption Response (NSDR) team (as above), who can advise on alternative suppliers.

For internal providers: please contact ppe@nottscc.gov.uk for your PPE enquiries, including urgent need for stock.

Safe disposal of used PPE

Used PPE must be stored securely within disposable rubbish bags. These bags should be placed into another bag, tied securely and kept separate from other waste within the room. This should be put aside in a secure specified area for at least 72 hours before being put in the usual household waste bin.

Appendix 1. Aerosol Generating Procedures (AGPs)

APGs are undergoing a further review at present and this list may be updated – please check https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe.

The following procedures are currently considered to be potentially infectious AGPs for COVID-19:

- intubation, extubation and related procedures, for example manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract)
- tracheotomy or tracheostomy procedures (insertion or open suctioning or removal)
- bronchoscopy and upper ENT airway procedures that involve suctioning
- upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract
- surgery and post mortem procedures involving high-speed devices
- some dental procedures (for example, high-speed drilling)
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- induction of sputum (cough)
- high flow nasal oxygen (HFNO)

For patients with possible or confirmed COVID-19, any of these potentially infectious AGPs should only be carried out when essential. Where possible, these procedures should be carried out in a single room with the doors shut. Only those healthcare staff who are needed to undertake the procedure should be present.

Procedures where AGP PPE is not required

Certain other procedures or equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk. Procedures in this category include administration of pressurised humidified oxygen, entonox or medication via nebulisation.

Chest compressions and defibrillation (as part of resuscitation) are not considered AGPs; first responders (any setting) can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other clinicians to undertake airway manoeuvres.

Appendix 2. Guide to donning and doffing standard PPE for health and social care settings

Public Health England

Guide to donning and doffing standard Personal Protective Equipment (PPE)

for health and social care settings

Donning or putting on PPE

Before putting on the PPE, perform hand hygiene. Use alcohol handrub or gel or soap and water. Make sure you are hydrated and are not wearing any jewellery, bracelets, watches or stoned rings.

1. Put on your plastic apron, making sure it is tied securely at the back.

2. Put on your surgical face mask, if tied, make sure securely tied at crown and nape of neck. Once it covers the nose, make sure it is extended to cover your mouth and chin.

3. Put on your eye protection if there is a risk of splashing.

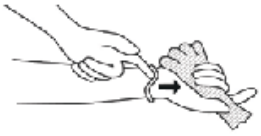
4. Put on non-sterile nitrile gloves.

5. You are now ready to enter the patient area.

Doffing or taking off PPE

Surgical masks are single session use, gloves and apron should be changed between patients.

1. Remove gloves, grasp the outside of the cuff of the glove and peel off, holding the glove in the gloved hand, insert the finger underneath and peel off second glove.



2. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

3. Snap or unfasten apron ties the neck and allow to fall forward.

Snap waste ties and fold apron in on itself, not handling the outside as it is contaminated, and put into clinical waste.

4. Once outside the patient room. Remove eye protection.

5. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

6. Remove surgical mask.

7. Now wash your hands with soap and water.

Please refer to the PHE standard PPE video in the COVID-19 guidance collection:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures

If you require the PPE for aerosol generating procedures (AGPs) please visit:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

Appendix 3. Donning and Doffing PPE for aerosol generating procedures (AGPs)

Public Health England

COVID-19

Quick guide

Putting on (donning) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

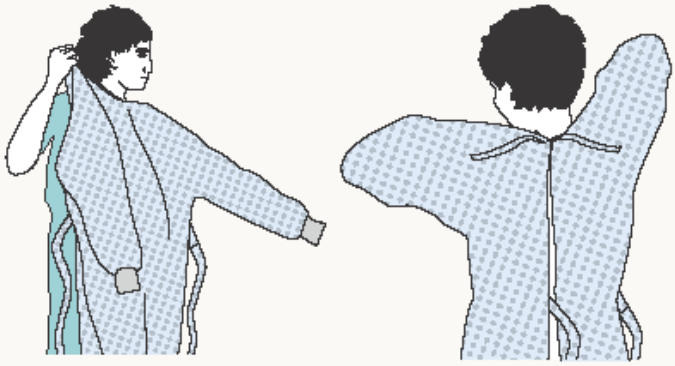
This is undertaken outside the patient's room.

Pre-donning instructions

- ensure healthcare worker hydrated
- tie hair back
- remove jewellery
- check PPE in the correct size is available

Perform hand hygiene before putting on PPE

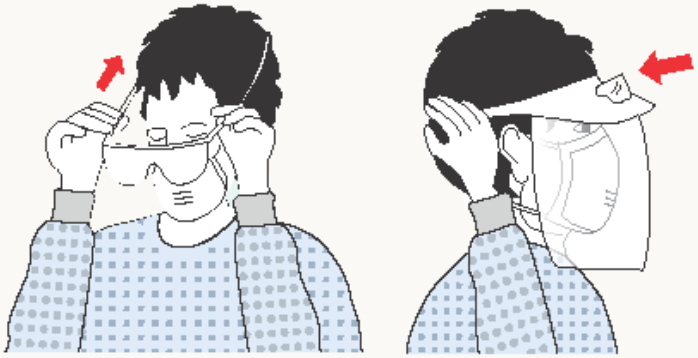
1 Put on the long-sleeved fluid repellent disposable gown



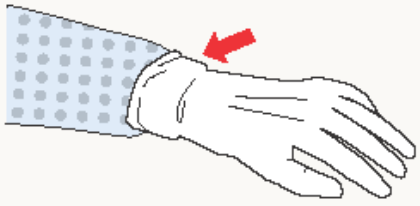
2 Respirator

Perform a fit check.

3 Eye protection



4 Gloves



Appendix 3. Donning and Doffing PPE for aerosol generating procedures (AGPs)

Public Health England

COVID-19

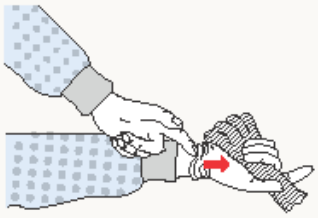
Quick guide

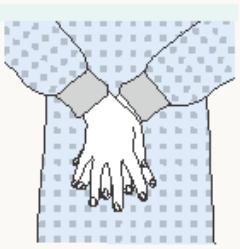
Removal of (doffing) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

PPE should be removed in an order that minimises the potential for cross contamination.

The order of removal of PPE is as follows:

1 **Gloves –**
the outsides of the gloves are contaminated





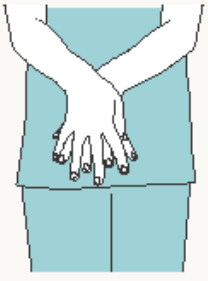
Clean hands with alcohol gel

2 **Gown –**
the front of the gown and sleeves will be contaminated

3 **Eye protection -**
the outside will be contaminated

4 **Respirator**
Clean hands with alcohol hand rub. Do not touch the front of the respirator as it will be contaminated

5 Wash hands with soap and water



PPE (COVID-19) Order Form c13.04.20

Nottinghamshire County Council

Provider/service/home name: **Name of person requesting PPE:**	Before deciding that you need personal protective equipment (PPE), consider whether the contact: • Is urgent or could be postponed? If not, • Could take place over the phone or by email? If not, • Could social distance, more than 2 metres, be maintained throughout the contact? If not, • Has been fully risk assessed? Following risk assessment consider what PPE is appropriate based on national guidance. You can reduce your chances of being infected or spreading COVID-19 by taking some simple precautions: Regularly and thoroughly wash your hands with soap and water or clean them with an alcohol-based hand rub
Address: **Contact Number**: **Email Address:**	
Date of request:	

No. of People/Residents in Service		**No. of People /Residents Symptomatic / in shielding category**	
No. of Staff in Service		**Are you providing direct care (Y/N)**	

YOUR REQUEST (please review table overleaf before submitting requests)		**Quantity Ordered**	**Quantity Issued**
Business as usual request:			
	Disposable Plastic Aprons		
	Disposable gloves (state size) S, M, L, XL		
	Hand Sanitiser		
	Overshoes (pods)		
Enhanced request:			
* if performing an aerosol generating procedure	Disposable fluid-repellent coverall/gown*		
	Eye Protectors – Safety glasses		
	Goggles		
	Fluid-resistant (Type IIR) surgical masks		
* if performing an aerosol generating procedure	FFP3 respirator*		
** if visiting household with any member within extremely vulnerable group undergoing shielding	Surgical masks**		
Isolated Request:	PPE Waste Bags & Ties **(Note: You must double Bag and leave for 72 hours before binning)**		
Other request (please specify):			

If PPE is needed please use this form to request PPE following the guidance overleaf, and email to **PPE@nottscc.gov.** We will contact you to arrange delivery/collection of your PPE.

Collection is from: Nottinghamshire County Council County Hall West Bridgford Nottingham NG2 7QP

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Recommended PPE for primary, outpatient and community care by setting, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Any setting	Performing an aerosol generating procedure[2] on a possible or confirmed case[3]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✓ single use[4]	✓ single use[4]
Primary care, ambulatory care, and other non emergency outpatient and other clinical settings e.g. optometry, dental, maternity, mental health	Direct patient care – possible or confirmed case(s)[3] (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
	Working in reception/communal area with possible or confirmed case(s)[3] and unable to maintain 2 metres social distance[6]	✗	✗	✗	✗	✓ sessional use[5]	✗	✗
Individuals own home (current place of residence)	Direct care to any member of the household where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✗	✗	✓ single or sessional use[4,5]	✗	✓ risk assess single or sessional use[4,5,8]
	Direct care or visit to any individuals in the extremely vulnerable group or where a member of the household is within the extremely vulnerable group undergoing shielding[9]	✓ single use[4]	✓ single use[4]	✗	✓ single use[4]	✗	✗	✗
	Home birth where any member of the household is a possible or confirmed case[3,7]	✓ single use[4]	✓ single use[4]	✓ single use[4]	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]
Community-care home, mental health inpatients and other overnight care facilities e.g. learning disability, hospices, prison healthcare	Facility with possible or confirmed case(s)[3] – and direct resident care (within 2 metres)	✓ single use[4]	✓ single use[4]	✗	✗	✓ sessional use[5]	✗	risk assess sessional use[5,8]
Any setting	Collection of nasopharyngeal swab(s)	✓ single use[4]	✓ single or sessional use[4,5]	✗	✗	✓ single or sessional use[4,5]	✗	✓ single or sessional use[4,5]

Table 2

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. The full list of aerosol generating procedures (AGPs) is within the IPC guidance [note APGs are undergoing a further review at present].
3. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
4. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. Non clinical staff should maintain 2m social distancing, through marking out a controlled distance; sessional use should always be risk assessed and considered where there are high rates of community cases.
7. Initial risk assessment should take place by phone prior to entering the premises or at 2 metres social distance on entering; where the health or social care worker assesses that an individual is symptomatic with suspected/confirmed cases appropriate PPE should be put on prior to providing care.
8. Risk assessed use refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids.
9. For explanation of shielding and definition of extremely vulnerable groups see guidance: 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

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES – Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Additional considerations, in addition to standard infection prevention and control precautions,

where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/ gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection[1]
Any setting	Direct patient/resident care assessing an individual that is not currently a possible or confirmed case[2] (within 2 metres)	✓ single use[3]	✓ single use[3]	✗	✗	✓ risk assess sessional use[4,5]	✗	✓ risk assess sessional use[4,5]
Any setting	Performing an aerosol generating procedure[6] on an individual that is not currently a possible or confirmed case[2,7]	✓ single use[3]	✗	✓ single use[3]	✗	✗	✓ single use[3]	✓ single use[3]
Any setting	Patient transport service driver conveying any individual to essential healthcare appointment, that is not currently a possible or confirmed case in vehicle without a bulkhead, no direct patient care and within 2 metres	✗	✗	✗	✓ single use[3]	✗	✗	✗

Table 4

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. A case is any individual meeting case definition for a possible or confirmed case: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection
3. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
4. Risk assess refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets of blood or body fluids. **Where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection as determined by the individual staff member for the care episode/single session.**
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and consider the risk of infection to and from patients, residents and health and care workers where COVID-19 is circulating in the community and hospitals. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. The list of aerosol generating procedures (AGPs) is included in section 8.1 at: www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe. (Note APGs are undergoing a further review at present)
7. Ambulance staff conveying patients are not required to change or upgrade PPE for the purposes of patient handover.

Publications approval reference: 001559

To:

Chief executives of all NHS trusts and foundation trusts

CCG Accountable Officers

GP practices and Primary Care Networks

Providers of community health services

Homecare providers

Independent sector providers

Copy to:

Local authority chief executives and directors of adult social care

Chairs of Local Resilience Forums

NHS Regional Directors

20 March 2020

Dear colleague

GUIDANCE ON SUPPLY AND USE OF PPE

We are setting out, in a single document, everything that you need to know on the supply and use of Personal Protective Equipment (PPE).

1. Supplies you will be receiving

We have now moved to providing substantial extra deliveries and support will be available 24 hours a day, 7 days a week. Services across the NHS are urgently being sent stocks of PPE to help them manage cases and potential cases of COVID-19 and keep staff safe. See section 6 for details of equipment being sent.

- On Thursday 2.6 million face masks and 10,000 hand sanitisers went to trusts in London.
- On Friday 150 hospital trusts will have extra PPE kit delivered. Over the weekend every other hospital trust will receive a further special delivery of PPE.
- Every GP practice, dental practice and community pharmacy has now had a PPE delivery.
- All care homes, hospices, and home care providers will have a PPE delivery, and these began earlier this week.

To meet your needs, we are putting on substantial extra deliveries. We will aim to deliver these in usual working hours but, given the volume of deliveries, please ensure your organisation is prepared to receive some deliveries at evenings and weekends.

You can access NHS Supply Chain's Delivery Schedule here: https://www.supplychain.nhs.uk/covid19/delivery-schedules/

2. Reporting supply disruption

The supply distribution helpline can answer PPE calls and emails 24/7 via the supply disruption helpline on 0800 915 9964 or email supplydisruptionservice@nhsbsa.nhs.uk to help with queries. Emails will be answered within one hour.

Trusts should raise non-PPE orders with NHS Supply Chain in the usual way.

3. Securing additional supplies from manufacturers

COVID-19 is generating unprecedented global demand on the supply chain, combined with a manufacturing slowdown in affected countries, especially China which manufactures a large amount of PPE.

Government, NHS Supply Chain, and the NHS are doing everything to work with industry to secure additional supplies and manufacture further PPE.

4. Shelf life of PPE items

The NHS's stockpiled PPE is checked as part of the stock management process operated through the NHS Supply Chain. This means rotating stock to make sure that items which have been there the longest are issued first.

Some products may appear to have out-of-date 'use by/expiration' dates or have relabelled 'use by/expiration' dates. Please be assured products being issued have passed stringent tests that demonstrate they are safe. The PPE is exposed to extreme conditions for prolonged periods, to see how the product deteriorates. All that are not up to standard are destroyed and not distributed to trusts.

We have been working with independent test facilities and the Health and Safety Executive (HSE) who, after being provided with scientific evidence, were content with our assessment that these are safe to use by NHS staff.

5. Correct use of PPE

NHS England and NHS Improvement collates all advice to clinical staff, including safe systems of working including the of use PPE, online here:

https://www.england.nhs.uk/coronavirus/

The full COVID-19 guidance collection is available at https://www.gov.uk/government/collections/coronavirus-covid-19-list-of-guidance

6. Putting on PPE and fit test training

Public Health England (PHE) recommended PPE ensemble for healthcare workers within a metre of a patient with possible or confirmed COVID-19 is:

- Fluid repellent facemask
- Apron
- Gloves
- Eye protection if there is a risk of splashing

The recommended PPE ensemble to be used for aerosol generating procedures on patients with possible or confirmed COVID-19 is:

- FFP3 respirator
- Long sleeved disposable gown
- Gloves
- Eye protection (disposable goggles or full-face visor)

Some healthcare workers will not have worn items like FFP3 respirators before. To protect their safety, we are asking trusts to ensure that all relevant staff have received the necessary fit test training.

PHE has engaged with RPA (an independent Respiratory Protective Equipment (RPE) fit testing company) who are running fit-test training sessions via webinars to help staff who will be training to use Qualitative or Quantitive fit test methods for FFP3 respirators for the first time or those seeking refresher training to ensure they are able to train FFP3 users safely. Booking on to these courses is via RPA's helpline on 07947 968972 and 07947 968922. This training is free.

The linked Public Health England poster is intended as a guide for staff about how to put on PPE, including FFP3 respirators.

A YouTube video is also available here: https://youtu.be/kKz_vNGsNhc

7. Disposing of PPE correctly

All PPE that is used when encountering confirmed cases of COVID-19 is single-use only and should be changed immediately after each patient and/or following completion of a procedure or task.

PPE should be disposed of after use into the correct waste stream i.e. healthcare/clinical waste (this will require disposal via orange or yellow bag waste). There might be further local guidance depending on the impact of the disease.

Please ensure the Public Health England poster on the removal of PPE for full guidance on doing this safely is shared with staff.

A YouTube video is also available here: https://youtu.be/oUo5O1JmLH0

Full list of resources around PPE use

- COVID-19 Guidance for infection prevention and control guidance
- Coronavirus guidance for clinicians
- Posters and videos on donning and doffing of PPE

Kind regards

Professor Keith Willett
NHS Strategic Incident Director
NHS England and NHS Improvement

Nottinghamshire County Council

Principles for Paying Providers

We understand that at this difficult time a key concern for all our contracted providers will be around payment for the delivery of the crucial services that you deliver to local people. To support you and ensure stability in the social care market across the County, we are pleased to share the information below.

The situation is changing rapidly, and we want to reassure you that we anticipate these principles for payment will remain in place at least until June and this end date will be subject to regular review. We sincerely hope that this will enable you to continue to deliver your services to the best of your ability during this time.

In line with the ADASS recommendations and the new guidance on Supplier Relief, we propose that we put in place the following principles:

1. We will continue to pay on the basis of commissioned or planned activity for our current contracts (this includes existing DP packages) until at least the 30th June and to be reviewed thereafter. This payment will be subject to the agreement between the provider and the County Council of an agreed delivery plan. It is recognised that in many cases, the nature of the service will need to change to reflect staffing levels and restrictions around face to face contact.

2. We will in general pay for "as commissioned" rather than "as delivered" if:
    a. The provider pays occupation sick pay to their staff
    b. The provider is not making staff redundant or laying them off
    c. The provider is willing to consider redeployment of staff to assist other services in appropriate circumstances

3. Services will be expected to keep basic records to monitor activity, but there will be no future reconciliation against commissioned hours

4. We will not continue to pay for a service if we have to commission another service to permanently replace it (i.e. we won't pay for a vacant fostering or residential place when a child has been moved out to another setting). However, there are some exceptions to this:
    a. If a PA is temporarily unable to deliver a service due to self-isolating or illness
    b. Where an alternative service is provided e.g. an outreach service instead of a day centre place, but this needs to be substituted with additional provision

5. We will not to continue to pay for a service that has ended due to the service no longer being required or death of the service user.

6. We will not commission a new service if it cannot be delivered.

7. New arrangements for payments will be implemented from 23/3/20 in line with other changes to provision

8. Normal procedures i.e Returns/invoices will still be expected for service delivery up to 22/3/20. Any outstanding returns will aim to be paid on the next payment run after receipt.

Nottinghamshire County Council

Should you have any queries concerning the above guidelines, please email qmm@nottscc.gov.uk.

Clare Gilbert and Cherry Dunk
24/03/20

Nottinghamshire County Council

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Nottinghamshire County Council

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Clare Gilbert and Cherry Dunk
24/03/20

This matter is being dealt with by:
Clare Gilbert
Reference: CG/PL/April 2020
T 0300 500 80 80
E enquiries@nottscc.gov.uk
W nottinghamshire.gov.uk

Nottinghamshire County Council

Dear Colleagues,

30th April 2020

Covid-19: Supporting Adult Social Care Services to Maintain Capacity and Viability.

I know you have been working extremely hard in recent weeks to prepare for and support people with the impact of Covid-19 and I want to personally thank you for all that you have been doing. I know It is only because of your hard work that we are as well prepared as we are.

I wrote to you on 27th April, to explain how the Council would offer financial assistance to contracted providers through a cash advance whilst a longer-term solution could be put in place.

As you may know Central Government has provided the Council with funding to strengthen support arrangements given to people vulnerable to Covid-19. These funds will allow us to continue to provide essential services and support to those who need it most. This includes getting rough sleepers off the street, supporting new shielding programmes for people who are clinically extremely vulnerable and assistance for our public health workforce and fire and rescue services. The funding will also mean councils can provide vital services including adult social care and children's services. However, our current forecast of the likely additional costs and lost income across all our services is well in excess of the amount we have received.

In this respect please find enclosed arrangements to support the sustainability of social care services in Nottinghamshire and how we will administer funds to address additional cost pressures being experienced by providers of care and support services for adults.

Care Services Sustainability Fund

The Council has created a Care Services Sustainability Fund to respond to the current pressures that services face.

We are inviting providers to make application for financial support to meet their most pressing business needs, where they have incurred additional costs that are Covid-19 related. Any application needs to be made along with supporting evidence which says where their business has incurred the cost. This is so we can:

- Identify and help respond to operational areas that are generating financial pressures for providers
- Provide financial support where necessary to those providers where there is a perceived risk of service failure
- Work jointly with the sector to ensure on-going provider sustainability
- Monitor take up of this support and provide an audit trail for the use of the funding

Key Principles

The Key Principles we have agreed for allocation of any additional support to providers is that it should be:

- Broadly equitable and consistent across different providers and care types
- Proportionate to the level of provision commissioned by Nottinghamshire County Council
- Simple and easy to administer through existing systems (we want to avoid significant administrative overheads for both providers and the Council)
- Comply with procurement law and contractual arrangements
- Evidence-based and supported by 'open-book' accounting
- Affordable within the funding available
- Apply for an initial period up to end of May 2020.

What type of costs can I include?

Clearly each organisation will experience different financial pressures arising from Covid-19 but as an example the following areas may be included but not limited to:

- Additional equipment or PPE purchased
- Additional agency/temporary staff employed
- Additional overtime paid to regular staff
- Appropriate additional costs of recruitment including any additional advertising and training costs for staff to cover workforce shortages
- SSP costs for days 1-4 for organisations with >250 employees
- Anything else we might reasonably assess as a direct impact of Covid-19, such as a proportion of capital expenditure to facilitate staff home working

We would not expect to receive a claim, where your organisation as a whole has not incurred any net additional costs due to the Covid-19 crisis, for example, the increased costs in one part are offset by the decreased costs in another.

How do I apply?

The Council has developed a simple claim form. (The form is available for completion and submission here.

This can be submitted at any time and once received it will be logged, reviewed and either:

- passed for payment or,
- where we have questions quickly responded to so that we can process claims as swiftly as possible in order to provide the necessary support

What information do I need to include?

The online form has Guidance Notes available at each section. Please revisit these if you make more than one claim, as they will be updated as we move through and adapt the claim process.

Use the notes area for supporting comments to help evidence the claim as more information and justification you provide will mean we need to make fewer queries.

Requests for financial support will only be considered from organisations that continue to accept new service requests.

Open Book Accounting

Where a claim is received, this will be progressed with an expectation that alongside the information identified above, such claims will be considered on an 'open book' accounting basis. To aid processing times we are asking providers to supply evidence to support their claim up front. Where that isn't possible the Council reserves the right to request such open book accounting information and evidence later to demonstrate that costs have been incurred as per the claim. Where evidence cannot be provided, the Council will seek to recover the monies.

Where at the end of the scheme, the value of claims authorised is less than your cash advance (where such an advance has been made), then the remaining cash advance will be clawed back over future payments.

What happens once my claim is submitted?

Once your claim is submitted you will receive an automated acknowledgement to the email address entered on the form. Your claim will be reviewed, and confirmation of its progress will be notified to you, including whether we require additional information.

We do not know the volume or value of claims that will be received but we are aiming to review all claims from providers within a week, with payment following thereafter.

Once agreed payment will be made via BACS, less any cash advances already made.

What if I need to contact you about my claim?

Should you have any questions about the process, the progress of a claim that has already been submitted, or wish to provide us with further supporting information then please ensure that any enquiries are sent by email to financeaccountancy.ss@nottscc.gov.uk. It is important that you use this email address so that we can be sure that your enquiry is tracked and dealt with as soon as possible.

Reviewing the Scheme

This is a new scheme that has been specifically set up to support adult social care during the current Covid-19 crisis. As such the Council will be continually monitoring its progress and reserves the right to amend the process as required should this prove necessary.

Other Information

I just want to let you know that we will be monitoring the receipt of claims and email address constantly and we will do our utmost to address your claim and any resulting enquiries as soon as we possibly can.

Finally, I do want to again reiterate my thanks to you all for your fantastic work over the last few weeks and that of your staff. I know that we'll feel the same pressures over the coming weeks but as ever we are grateful for the commitment your staff display and their willingness to go the extra mile for the people, we all support in Nottinghamshire.

Should you have any enquiries or need general support and advice outside of the above scheme then please do not hesitate to contact us.

Yours sincerely

Personal Infirmation

Clare Gilbert
Group Manager – Strategic Commissioning
Nottinghamshire County Council

Published guidance and resources

Produced by NHSE/I

[Clinical guidelines for children and young people with palliative care needs in all care settings]
Published 17 April 2020

[Hospice funding announcement letter]
Published 16 April 2020

[Community health services, Standard Operating Procedure] appendix 5, Advice on support for people with palliative and end of life care needs in the community
Published 15 April 2020

[Advance Care Plan guidance and editable template]
Published 13 April 2020

[Update on anticipatory medicines at the end of life]
Published 10 April 2020

[Letter from Steve Powis and Ruth May re: maintaining standards and quality of care in pressurised circumstances]
Published 7 April 2020

[GP standard operating procedure] appendix 7, Advance Care Plan guidance and template
Published 6 April 2020

[Clinical specialty guide for palliative and end of life care in secondary care]
Published 28 March 2020

Produced by other organisations

[NICE Rapid Guidelines – Managing symptoms (including at the end of life) in the community]
Published 3 April 2020

[Discussing Unwelcome News: a framework for communication] - series of COVID19 conversation films available on HEE e-LfH
Published 2 April 2020

[Macmillan Courageous Conversations Resources]

[Helix Centre end of life care toolkits for carers at home]

[Joint statement on advance care planning]
Published 30 March 2020

[Community Palliative, End of Life and Bereavement Care in the COVID Pandemic]
Published 30 March 2020 by RCGP and APM

[RCGP COVID19 Resource Hub]

[Association of Palliative Medicine - COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care - Role of the specialty and guidance to aid care]
Regularly updated – use APM homepage to access latest version

[COVID-19 Adult Social Care Action Plan], pg.23 'Supporting people at the end of their lives'
Published 15 April 2020 on gov.uk

Partners

As the situation regarding Coronavirus evolves, it's likely that services who have responsibilities for undertaking Safeguarding Adults Enquiries will face increased pressures as a result of staff absence and potentially increased work volumes. In order for those most at risk of abuse and neglect to continue to be prioritised, a consistent approach to Safeguarding Adults Referrals is needed. Nottinghamshire's Adult at Risk Referral Pathways are available as a resource to inform decision making in conjunction with the Multi Agency Guidance and Procedures.

Safeguarding duties apply to an adult over 18 years who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

Concerns relating to poor quality of care provided by a Care Provider which do not constitute abuse or neglect can be reported to Quality Marketing at qmm@nottscc.gov.uk or 0115 9773317.

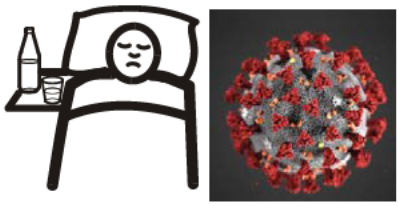
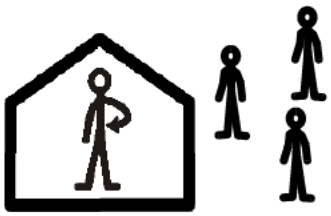
In response to the current situation with Covid-19 there are many volunteer and community groups being established across the County to support adults at risk. Whilst this is an extremely positive and helpful way of supporting services and ensuring those who need to stay at home are able to, we must remain vigilant to the threat of those who will use this as an opportunity to exploit adults at risk, especially those with no other support mechanisms . For more information on community and voluntary groups please visit https://www.nottinghamshire.gov.uk/care/coronavirus/community-support-and-volunteering

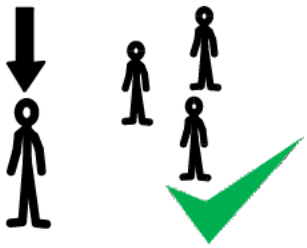
We also ask that consideration be given to how Safeguarding Adults Referrals are made. Where possible, Safeguarding Adults Referrals should be made using the online via the Nottinghamshire County Council Website and if this referral is urgent, by telephoning the Multi Agency Safeguarding Hub on 0300 500 80 90 (professionals only). Please try to include as much information as possible to assist the MASH to prioritise and manage workloads.

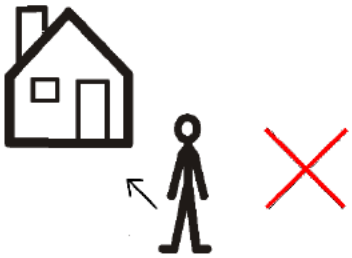
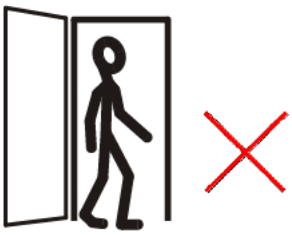
As the situation develops and changes, we may need to re-assess the way Safeguarding Referrals are managed. With this in mind, we would ask you to look out for further communication from the Board and would be grateful if this information could be shared with those in your organisation who have a responsibility for making Safeguarding Adults Referrals.

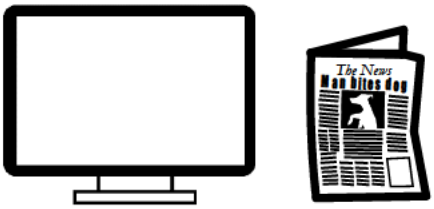
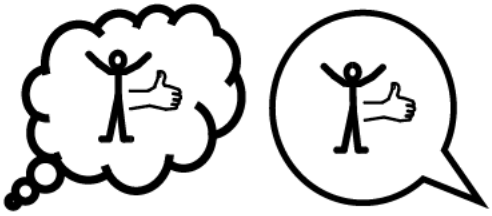
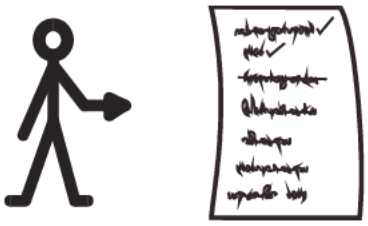
Nottinghamshire Healthcare
NHS Foundation Trust

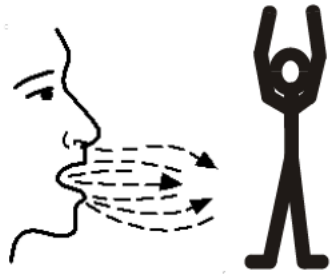
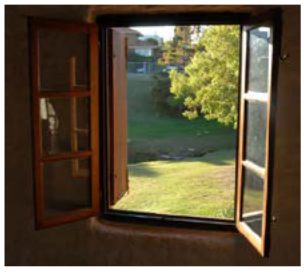
Self-Isolation

	Lots of people are getting poorly at the moment because of a new illness called coronavirus
	If you get have a cough, temperature or breathing difficulties you will be told to **self-isolate**
	**Self-isolation** means **staying at home** and away from lots of people
	This is to help you and other people not get poorly
	If you have to self-isolate **you should:**

	Stay inside your house
	Try to keep away from other people in your house, especially older people
	Ask other people to bring shopping and the things you need to your house They can leave it at the door for you
	Sleep on your own if you can
	Wash your hands
	Drink lots of water

	Someone you live with might be able to give you some medicine that will help you
	If you are in self-isolation you should not
	Have visitors come inside your house
	Leave the house. You can go in your own garden if you have one.
	This will help to keep people safe
	This will help you and other people to stay well

	If you are in self-isolation you can do some things to help keep yourself feeling ok on the inside as well
	Take breaks from social media and the news
	Try to get information from the news instead of social media
	Think and talk about things that make you feel good
	Try to keep doing things that you are interested in
	It might help to make a plan for each day

	Take deep breaths and stretch
	Get enough sleep
	Make sure you exercise
	Talk to other people about how you feel. You could try skype, facebook/whatsapp video calls, FaceTime or messaging.
	Make sure you get some fresh air. You can try opening a window or going out into your own garden.

Portland College

This document was produced by The Speech and Language Therapy Team at Portland College

Support for registered managers from Skills for Care

In response to the COVID-19 pandemic, Skills for Care has developed a support offer for registered managers in adult social care which includes:

- an advice line for registered managers and other frontline managers
- recorded webinars on COVID-19 related topics and guidance
- local WhatsApp groups and virtual network meetings for registered managers
- a Facebook group for registered and front-line managers
- guidance and funding related to essential training.

Much of this offer including our advice line, webinars, training guidance and Facebook group will also be relevant to other frontline and care managers, deputy managers and nominated individuals. Full details are published here.

Covid-19 advice line

Skills for Care have launched an advice line for registered and front-line managers, managing CQC regulated adult social care services through the COVID-19 crisis.

This advice line can help managers access the latest information, resources, funding, online learning and other opportunities provided from Skills for Care. We can also direct managers to the latest guidance and advice produced by other agencies.

This advice line is open between 9.00 – 17.00 Monday to Friday.

Find out more at: www.skillsforcare.org.uk/adviceline

Call us: 0113 341 1260

Email us: RMAdvice@skillsforcare.org.uk

COVID-19 webinars

Skills for Care has developed a series of 30-minute recorded webinars on a range of topics to support managers in adult social care during the COVID-19 pandemic.

Subjects include:

- Essential training
- Human resources (HR) (supported by ACAS)
- Attracting workers
- Using digital technology
- Motivating staff

We're developing new webinars as issues and priorities emerge during the crisis, and we're also working with the DBS service and CQC on webinars.

Managers can access the webinars via: www.skillsforcare.org.uk/COVID-19webinars

Registered manager networks

Skills for Care supports local networks for registered managers across England. The groups are an important way for managers to share advice and information, and to access peer support. Many networks are establishing WhatsApp groups or meeting virtually to allow managers to stay in touch.

If you're a registered manager and would like to join your nearest group email your Skills for Care locality manager and ask to be added or contact your network chair. Networks will also be meeting virtually over the coming months.

A full list of networks is available at: www.skillsforcare.org.uk/networks

Managers Facebook group

Skills for Care have opened their registered manager members' Facebook group to all registered managers, and other front-line managers in similar roles. Staying connected with each other and sharing advice, experiences and guidance is vital.

Managers can join the group via: www.skillsforcare.org.uk/facebookgroup

Covid-19 essential training

Skills for Care have identified training that remains a priority during the COVID-19 crisis to ensure staff are skilled and competent.

Managers can access advice and guidance here:
www.skillsforcare.org.uk/essentialtraining

Some of Skills for Care have secured funding to deliver virtual training for adult social care employers, including:

- training for volunteers
- training for existing staff
- rapid induction for new staff.

Details of these providers are published on Skills for Care's essential training webpage.

NHSmail
better connected, better care

CARE PROVIDER NHSMAIL SIGN UP FORM

Provider information – Please complete all fields below	
Organisation Type:	Social Care
Social Care Site name:	
Name of Town: (Max 11 characters)	
ODS Site Code: https://odsportal.hscic.gov.uk/Organisation/Search	
User information Please complete the information below for 2 staff members in your service.	

	First Name	Surname	Role	Current/ personal e-mail address	Current/ personal mobile number	shared mailbox access type (member/ owner)
Shared Mailbox Owner						
User						

NHSmail
better connected, better care

CARE PROVIDER NHSMAIL SIGN UP FORM

Provider information – Please complete all fields below	
Organisation Type:	Social Care
Social Care Site name:	
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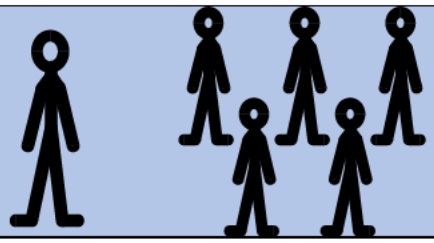
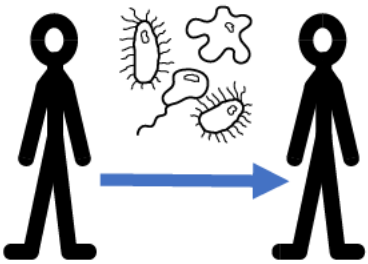
ODS Site Code: https://odsportal.hscic.gov.uk/Organisation/Search	
User information Please complete the information below for 2 staff members in your service.	

	First Name	Surname	Role	Current/ personal e-mail address	Current/ personal mobile number	shared mailbox access type (member/ owner)
Shared Mailbox Owner						
User						



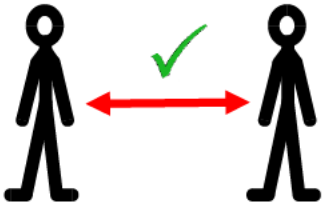
Social Distancing

Lots of people are **getting poorly** at the moment because of a new illness called **coronavirus**



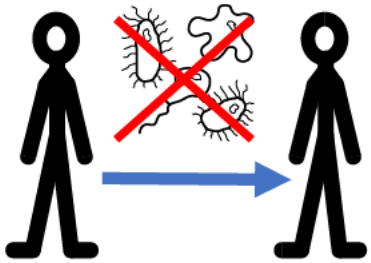
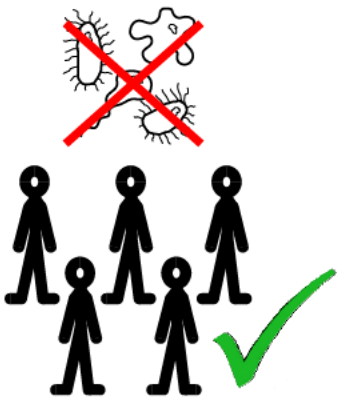
The virus is passed from **person to person** by **germs**

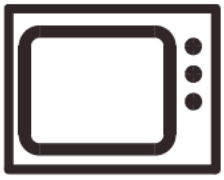
To **help stop** the spread of **germs**, we need to think about how we spend time with other people.



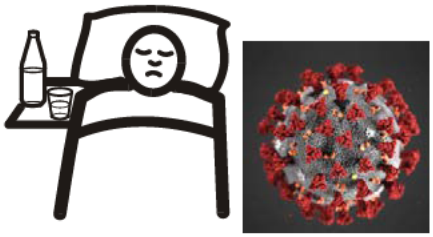
The government are advising people to have **bigger spaces** between each other.

This means that some places where people go are **closing** e.g. pubs, cafes, restaurants.

	Some people are being told to **stay indoors**
	and to **stay away from other people** so they don't catch the virus or give it others.
	This can help to **stop germs spreading** so easily. This will help to keep everyone safe.
	This is only **temporary**. Things will go back to normal after the virus has gone.

What to do at home	
	Read a book or magazine
	Watch some TV
	Play a board game or a card game
	Do college work
	Try to do some exercise You could: March on the spot Jump on the spot Lift your arms up and down Stretch your body
	Baking

	Cooking
	Cleaning
	Social media – talking to your friends
	Colouring and drawing

	**Keeping you safe** Nottinghamshire Healthcare NHS Foundation Trust
	Lots of people are getting poorly at the moment because of a new illness called coronavirus
	Your Nurse will still come to visit you to help you
	We want to **stay well** and not get poorly.
	To **keep you safe** we might wear some **protective clothing**. This might make us look different.

	We might wear **plastic gloves**
	And an **apron**
	And a **face mask**
	This will help you and other people to **stay well**

COMPENDIUM OF GUIDANCE ON WORKFORCE ISSUES FOR COMMUNITY SERVICES, CARE HOME AND DOMICILIARY CARE PROVIDERS AND STAFF

(Version 5: 5 May 2020)

This document pulls together in one place some of the latest key guidance issued to employers and staff in response to the COVID-19 incident

COVID-19 HOMEPAGES FOR NATIONAL BODIES	
Organisations	**Web Link**
Association of Directors of Adult Social Care	[LINK]
Care Quality Commission	[LINK]
Department of Health and Social Care	[LINK]
Health Education England	[LINK]
Local Government Association	[LINK]
NHS England and NHS Improvement	[LINK]
NHS England and NHS Improvement's Community based health, social care, mental health trusts and ambulance services pages	[LINK]
National Institute for Health and Care Excellence	[LINK]
NHS Employers	[LINK]
Public Health England	[LINK]
Skills for Care	[LINK]

GUIDANCE ON DELIVERY OF CARE		
Issuing organisation(s)	**Title/Subject**	**Web Link**
Care Quality Commission	**CQC: COVID-19 pages** For providers of care services: how we're changing the way we work and how it affects you	[LINK]
Care Quality Commission	**CQC: COVID-19 updates for providers** Information for adult social care services during the coronavirus – summarising elements of CQC advice and guidance which have changed during the COVID-19 incident	[LINK]
Department of Health & Social Care	**DHSC: Getting tested** Guidance on coronavirus testing, including who is eligible for a test, how to get tested and the different types of test available	[LINK]
Department of Health & Social Care	**DHSC: Care Act Easements** How Local Authorities can use the new Care Act easements, created under the COVID-19 Act 2020, to ensure the best possible care for people in our society during this exceptional period.	[LINK]
Department of Health & Social Care	**DHSC: Ethical Framework for Adult Social Care** A framework to support the planning and organisation of adult social care during the COVID-19 (COVID-19) outbreak	[LINK]
Department of Health & Social Care	**DHSC: COVID-19: adult social care action plan** An overview of support from the government for the adult social care sector	[LINK]

Department of Health & Social Care	**DHSC: COVID-19: Looking after people who lack mental capacity** Guidance for health and social care staff who are caring for, or treating, a person who lacks the relevant mental capacity	[LINK]
Department of Health & Social Care	**DHSC: Guidance on re-use of medicines in care homes and hospices** The guidance promotes safe and effective use of medicines in care homes by advising on processes for prescribing, handling and administering medicines	[LINK]
Department of Health & Social Care	**DHSC: Guidance for people receiving direct payments** Advice for people who buy care and support through a direct payment, as well as local authorities, clinical commissioning groups and those who provide care and support.	[LINK]
Department of Health & Social Care	**DHSC: COVID-19 - guidance for people receiving direct payments** Advice for people who buy care and support through a direct payment, as well as local authorities, clinical commissioning groups and those who provide care and support.	[LINK]
Joint Organisational Guidance	**Joint Guidance: information for council adult social care commissioners** Shared guidance to local authority commissioners on social care provider resilience during COVID 19	[LINK]
Joint Organisational Guidance	**Joint Guidance: Guidance for adult social care** Collation of relevant guidance for providers of adult social care	[LINK]
Joint Organisational Guidance	**Joint Guidance: Guidance for health professionals** Information on COVID-19, including guidance on the assessment and management of suspected UK cases	[LINK]
Joint Organisational Guidance	**Joint Guidance: Admission and Care of Patients during COVID-19 Incident in a Care Home** Support for Care Home providers to protect their staff and residents, ensuring that each person is getting the right care in the most appropriate setting for their needs	[LINK]
Joint Organisational Guidance	**Joint Guidance: Advance Care Planning** Joint BMA, Care Providers Alliance, CQC and RCGP statement on importance of having a personalised care plan in place, especially for older people, people who are frail or have other serious conditions	[LINK]

Local Government Association	**LGA: Changes to local authority powers and duties resulting from the Coronavirus Act 2020** This is a guide to the provisions of the Coronavirus Act 2020 and to new, modified or suspended local government powers and duties	[LINK]
Local Government Association	**LGA: Guidance on protecting vulnerable people** Guidance giving an overview of the system for supporting vulnerable people, vulnerable groups and how they can be identified, types of support available, and key considerations for councils in coordinating local support	[LINK]
Local Government Association	**LGA: Adult Safeguarding and Homelessness: a briefing on positive practice** The purpose of this briefing is to assist colleagues who are working across relevant sectors and agencies in this field, to support people who are homeless and at risk of or experiencing abuse or neglect	[LINK]
Local Government Association	**LGA: Tackling domestic abuse during the COVID-19 pandemic** The document aims to provide a range of resources which offer help, guidance and support to tackle domestic abuse	[LINK]
NHS England and NHS Improvement	**NHS England and NHS Improvement: Primary care and community health support care home residents** Letter outlining evidence-based guidance and good practice on support that primary care and community health services can offer to care homes	[LINK]
NHS England and NHS Improvement	**NHS England and NHS Improvement: Guidance on Clinical Prioritisation in Community Health Services** Guidance for providers of community services on how they can prioritise capacity to support the COVID-19 preparedness and response	[LINK]
NHS England and NHS Improvement	**NHS England and NHS Improvement: Standard Operating Procedures During COVID-19 – Community Pharmacy** Guidance to support Community Pharmacy in the response to COVID-19	[LINK]
NHS England and NHS Improvement	**NHS England and NHS Improvement: Standard Operating Procedures During COVID-19 – Primary Care** Practical guidance to support primary care teams in managing contact with, and presentations of, patients who suspect they may have COVID-19	[LINK]

NHS England and NHS Improvement	**NHS England and NHS Improvement: standard operating procedure: Community health services** This guidance applies to all providers of community health services in England, operating within the NHS Standard Contract. It clarifies the expected approach of community health services to the management of patients, both adults and children, in the community during the COVID-19 pandemic	[LINK]
NHS England and NHS Improvement	**NHS England and NHS Improvement: Managing capacity and demand within inpatient and community mental health, learning disabilities and autism services for all ages** It provides guidance for how best to manage their capacity across inpatient and community services	[LINK]
NHS England and NHS Improvement	**NHS England and NHS Improvement: Deploying our people safely** Principles to consider when deploying staff into settings and roles which are unfamiliar to them: consideration of the issues facing each professional group, the position of the professional regulators, training resources, and indemnity arrangements for NHS staff	[LINK]
NICE	**NICE: Rapid Guidelines** Various rapid guidance, including on critical care in adults, managing symptoms (including at end of life) in the community and on managing suspected or confirmed pneumonia in adults in the community	[LINK]
Public Health England	**PHE: Guidance for stepdown of infection control precautions within hospitals and discharging patients** Advice on appropriate infection prevention and control precautions for stepdown in hospital or discharge to home or residential settings	[LINK]
Public Health England	**PHE: COVID-19 - Infection prevention and control (IPC)** Guidance on infection prevention and control for COVID-19	[LINK]
Public Health England	**PHE: COVID-19 - Guidance for residential care, supported living, and home care** Guidance for residential care, supported living and home care in the event of a coronavirus (COVID-19) outbreak	[LINK]
Skills for Care	**Skills for Care: Guidance for Individual Employers and Personal Assistant** Information and guidance dedicated to Individual employers and personal assistants that may be of help during COVID-10	[LINK]

PERSONAL PROTECTIVE EQUIPMENT (PPE)		
Issuing organisation(s)	**Title/Subject**	**Web Link**
Joint Organisational Advice	**Joint Guidance: Guidance on supply and use of PPE** Everything that you need to know on the supply and use of PPE	[LINK]
Public Health England	**PHE: Guidance on use of PPE** Revised Guidance on use of PPE by health and social care workers, in the context of COVID-19	[LINK]
Public Health England	**PHE: COVID-19: how to work safely in care homes** Guidance and videos for those working in care homes providing information on how to work safely during this period of sustained transmission of COVID-19	[LINK]
Public Health England	**PHE: How to work safely in domiciliary care in England** A resource for those working in domiciliary care providing information on the use of personal protective equipment (PPE)	[LINK]
NHS England and NHS Improvement	**NHSE/I: Accessing supplies of Personal Protective Equipment** Information for NHS Trusts, Foundation Trusts, primary care, hospices, social care and home care providers	[LINK]
DATA & INFORMATION		
Issuing organisation(s)	**Title/Subject**	**Web Link**
Joint Organisational Guidance	**Joint Guidance: Registration for Capacity Tracker** The COVID-19 Hospital Discharge Service Requirements required the rapid system-wide adoption of Capacity Tracker by all care homes, all hospices (including children's hospices) and all providers of inpatient community rehabilitation and end of life care. More information is available in Annex I of the Joint Guidance on Admission and care of residents during COVID-19 incident in a care home	[LINK]
Digital Social Care	**Digital Social Care: Information Governance and Information Sharing Guidance** Guidance to help ensure that carers, social care professionals, and clinicians are able to talk to each other and to the people they care for during COVID-19	[LINK]

Digital Social Care	**Digital Social Care: Guidance on how to obtain quick access to NHSmail** Guidance on the fast **track roll out of NHSmail** to the care sector	[LINK]
Digital Social Care	**Digital Social Care: Guidance on how to access Microsoft Teams** Guidance on how to use MS Teams to access video calling functionality so that it can be used by people receiving care to keep in touch with friends and relatives, and by people receiving care and care workers to communicate with other health and care organisations - for example, with GPs, district nurses, pharmacists, social workers etc.	[LINK]
TRAINING & INDUCTION RESOURCES		
Issuing organisation(s)	**Title/Subject**	**Web Link**
Health Education England	**HEE: e-learning for Healthcare (HEE e-LfH) COVID-19 programme** Expanding programme of training resources freely available to colleagues working in the NHS, independent sector and social care	[LINK]
Queen's Nursing Institute	**QNI: Orientation and Induction Checklist for COVID-19** Practical guidance on what to include in induction	[LINK]
Queen's Nursing Institute	**QNI: Care Home Nursing: Covid19 Rapid Training** Training resources for deployment of nurses to Care Homes	[LINK]
Queen's Nursing Institute	**QNI: General Practice Nursing: Covid19 Rapid Training** Training resources for deployment of nurses to General Practice	[LINK]
Queen's Nursing Institute	**QNI: Community Nursing: Covid19 Rapid Training** Training resources for deployment of nurses to Community Nursing	[LINK]
Skills for Care	**Skills for Care: training for volunteers, existing staff, rapid induction of new staff, and training for staff who are being redeployed** Collation of essential training resources and information on how to access them, including guidance on funding and training providers	[LINK]

HEALTH & WELLBEING RESOURCES		
Issuing organisation(s)	**Title/Subject**	**Web Link**
NHS Employers	**NHS Employers: Health, safety and wellbeing resources** Guidance on Staff wellbeing and support, Support available for NHS staff, Fatigue, Mental wellbeing	[LINK]
Skills for Care	**Skills for Care: Greater resilience, better care** A guide for adult social care managers to help them to reduce work-related stress and build the resilience of staff	[LINK]
Skills for Care	**Skills for Care: Supporting staff that work alone** A guide for adult social care employers	[LINK]
Our Frontline	**Our Frontline: Mental health support offers** Our Frontline offers round-the-clock one-to-one support, by call or text, from trained volunteers, plus resources, tips and ideas to look after your mental health. Support offer is available to all health & social care staff	[LINK]
RECRUITMENT RESOURCES		
Issuing organisation(s)	**Title/Subject**	**Web Link**
Department of Health & Social Care	**DHSC: Announcement of social care recruitment campaign** Launch materials for 'Care for others. Make a difference' adult social care recruitment campaign, including website linking to campaign resources and materials	[LINK]
Department of Work & Pensions	**DWP: Advertising adult social care roles** A guide for employers on how to advertise social care roles on DWP Find a Job	[LINK]
Skills for Care	**Skills for Care: Safe and rapid recruitment** This includes information on values-based recruiting: getting the right people, recruiting from your local community and robust employment checks	[LINK]
Skills for Care	**Skills for Care: Recruitment support materials** A Question of Care: resources to help support people wishing to pursue a career in care	[LINK]

ACCESSING SUPPORT FROM VOLUNTEERS		
Issuing organisation(s)	**Title/Subject**	**Web Link**
Local Government Association	**LGA: Advice on how to access local and national volunteering initiatives** Accessible at page 4 of the LGA's Briefing on protecting vulnerable people during the COVID-19 outbreak	[LINK]
Royal Voluntary Service	**NHS Volunteers/Good Sam App scheme** NHS Volunteer Responders has been set up to support the NHS and the care sector during the COVID-19 outbreak. Individuals themselves, Doctors, nurses, those working in local authorities, and other professionals can make referrals via the NHS Volunteer Responders referrers' portal	[LINK]
RESOURCES FOR EMPLOYERS		
Issuing organisation(s)	**Title/Subject**	**Web Link**
ACAS	**ACAS: COVID-19 Advice for employers and employees** Guidance on key employment issues arising from COVID-19	[LINK]
Care Quality Commission	**CQC: Interim guidance on DBS and other recruitment checks** Guidance for providers recruiting staff and volunteers to health and social care services in response to COVID-1	[LINK]
Care Quality Commission	**CQC: Information for adult social care services during COVID-19** CQC's answers to frequently asked questions from adult social care services about COVID-19, including regulatory issues, staffing issues, and hospital discharge and admissions issues	[LINK]
Care Quality Commission	**CQC: Interim supplement to CQC Guidance on Trusted Assessors during COVID-19** Guidance to support NHS and social care providers and Trusted Assessor schemes during the COVID-19	[LINK]
Joint Organisational Guidance	**Joint Guidance: For employees, employers and businesses** Guidance for employees, employers and businesses in providing advice about COVID-19.	[LINK]

Joint Organisational Guidance	**Joint Guidance: Social care provider resilience during COVID-19** Shared guidance to local authority commissioners from the Association of Directors of Adult Social Services, the Local Government Association and the Care Provider Alliance	[LINK]
NHS Employers	**NHS Employers: guidance for NHS workforce leaders** To help workforce leaders across the health system with plans to respond to COVID-19, the collated resources deal with the workforce issues that are likely to arise during the current pandemic	[LINK]
Skills for Care	**Skills for Care: Advice line for registered managers of CQC regulated adult social care services** Advice line and email inbox have been set up to support those managing CQC regulated adult social care services. Support for managers to access the latest workforce related guidance, information, resources, funding, online learning and other opportunities in response to COVID-19.	[LINK]

ADVICE AND SUPPORT FROM PROFESSIONAL REGULATORS

Issuing organisation(s)	Title/Subject	Web Link
Joint Organisational Guidance	**Joint Guidance: Statement from health and social care professional regulators for staff who are responding to COVID-19** Shared statement from professional regulators on their approach to professional regulatory issues during COVID-19	[LINK]
Health & Care Professions Council	**HCPC: COVID-19 pages** Advice for regulated staff and employers	[LINK]
Nursing & Midwifery Council	**NMC: COVID-19 pages** Advice for regulated staff and employers	[LINK]
Social Work England	**Social Work England: COVID-19 pages** Advice for regulated staff and employers	[LINK]

RESOURCES FOR STAFF

Title/Subject	Web Link
Trusted sources of information	
Health advice from the NHS	[LINK]
The government's response to COVID-19	[LINK]
PHE's information for the public	[LINK]

Protecting you, your family, and others	
Symptoms of COVID-19 and what to do if you think you have them	[LINK]
What you need to do	[LINK]
Advice on who is at high risk	[LINK]
Staying at home if you think you have COVID-19 (self-isolating)	[LINK]
Staying at home and away from others (social distancing)	[LINK]
How to protect extremely vulnerable people (shielding)	[LINK]
School closures, education and childcare	
What parents and carers need to know about closures	[LINK]
School opening for children of key workers	[LINK]
Dealing with COVID-19 in nurseries, schools and universities	[LINK]
Supporting vulnerable children	[LINK]