FAO:

Chief Executives of NHS Trusts
Chief Executives of NHS Foundation Trusts
NHS Medical Directors
STP /ICS leads
CCG clinical leads
CCG accountable officers
NHS England and NHS Improvement Regional Directors
Regional EPRR leads **(please cascade to emergency planning leads in trusts and CCGs)**
Regional Heads of Nursing **(please cascade to all directors of nursing)**
Regional Heads of Primary Care and Regional Heads of Public Health – (for information)
Health and Justice leads (Secure and detained estate):

Emergency Preparedness
Resilience and Response
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Dear colleague

COVID-19 NHS preparedness and response

As you will be aware, the current outbreak of a novel coronavirus is resulting in national and international preparations to be stepped up.

In declaring a level 4 incident, NHS England and NHS Improvement have established an Incident Management Team (National) (IMT- N) with an operational Incident Coordination Centre established 7 days a week, working closely with the Department of Health and Social Care (DHSC), Public Health England (PHE) and other government departments.

All NHS Regions have also been asked to establish an operational COVID-19 Incident Coordination Centre to the same hours working with the national team and their NHS local organisations, CCGs, other health care providers and LRFs.

Health providers and commissioners are working together with Local Resilience Forum (LRF) partners to ensure that they are ready to respond to any outbreaks, including social care for supporting discharge and home care arrangements.

This letter covers what is required of NHS organisations and includes annexes detailing a new requirement to establish case detection for intensive care admissions, and guidance on the decontamination of an NHS 111 coronavirus pod. We have also separately asked NHS laboratories to commence working up the PHE approved protocol test to further increase the available testing capacity for COVID-19.

To date COVID-19 has been managed as a high consequence infectious disease through our specialist centres so we could learn as much as possible about the virus and course of the illness. It is now appropriate to begin to manage some patients within wider infectious disease units and, in due course if the number of cases continues to grow, we will need to use all acute units, for example through the cohorting of patients.

Therefore, in light of the continued spread of the virus in multiple countries and the impact on health and social care we are asking all NHS organisations, following Joint Emergency Services Interoperability Principles (JESIP), to establish a COVID-19 Incident Management Team led by your Accountable Emergency Officer (AEO).

For all NHS organisations the AEO should**:**

- Establish an Incident Management Team functioning 7 days a week

- Have a single point of contact available 24/7 for liaison and coordination for all COVID-19 patient management, alerts, referrals and tracking. This is particularly important for receiving and acting on COVID-19 test results and should be available to NHSE/I regional teams, PHE, CCGs and local providers.

- Ensure the organisation has processes in place to ensure timely returns of any information needed nationally including situation reporting (SitReps). Ensure appropriate senior representation is available to join any NHS England and NHS Improvement regional teleconferences that may be called to brief on the situation.

- Ensure that all arrangements for the management of infectious disease patients, specifically those with COVID-19 are known and understood throughout the organisation (including fit testing training, Personal Protective Equipment (PPE) refresher training, and hand wash training/refresher).

- Ensure that any guidance issued by PHE and NHS England and NHS Improvement is cascaded to all your relevant staff recognising the evolving incident and frequent changes (in and out of hours arrangements should be in place). Engage with staff side organisations to support changes in working practices, risk management and staff information and safety.

- Ensure that your procurement and materials management teams have processes in place for the close monitoring and control of PPE, medical devices and other clinical consumables required to support your response, and that staff are aware of processes for ordering additional product and identifying suitable alternatives where necessary.

- Ensure local stock levels are maintained at levels proportionate to anticipated short term demand, underpinned by regular replenishment from normal supply routes and NHS Supply Chain. Medicines, medical devices and clinical consumables should not be stockpiled by organisations or patients as this may put a strain on the supply chain and exacerbate any potential shortages. These stocks are being monitored daily, with additional stock being ordered where necessary.

- Review business continuity arrangements to ensure that you can maintain business critical services.

- Ensure that you cooperate with the Local Resilience Forum (LRF) and Local Health Resilience Partnerships (LHRPs) to review and align arrangements within the area.

- With your LRF, review your organisation's plans against the infectious disease reasonable worst-case scenario.

- Engage with your social care partners and ensure that they are ready to locally manage their residents that may be impacted and that they have infection prevention control measures in place, and their staff are aware of how to maintain these measures.

- Review mutual aid agreements with other care providers including specialist, private and voluntary agency providers.

- Ensure that any member of staff, including bank staff and sub-contractors, who has to be physically present at an NHS facility to carry out their duties, receives full pay for any period in which they are required to self-isolate as a result of public health advice.

- Notify your local NHS England and NHS Improvement Emergency Preparedness Resilience and Response (EPRR) lead of any current or scheduled works or operational changes currently affecting service delivery within your organisation.

- Refresh business continuity plans for the maintenance of essential services.

Acute care providers are also asked to:

- Review all pathways, specifically those in ‘medicine’ that support those with respiratory illness and consider the impact that a possible surge in medical patients might have on services and stocks.

- Clearly identify how your organisation will implement the sequence of segregation of clinical areas (in Emergency Departments (ED), wards, critical care) and diagnostic and intervention suites to support the continued response in the event of a significant escalation in COVID-19 cases.

- Assume that they will need to look after COVID-19 cases in due course so will need to ensure support services are in place to facilitate this and identified areas are, or can be modified to, provide a cohorting model of infectious disease care.

- Review your critical care and high dependency capacity and consider how you could increase capacity and the impact of doing so.

- Where possible, consider implementing alternative models such as remote consultations for those patients who can be supported at home and review arrangements to support vulnerable individuals in alternative settings, including in the community.

- All Intensive Care Units and Severe Respiratory Failure (ECMO) centres should commence case detection (please see Annex A).

Ambulance trusts are also asked to:

- Ensure resilient arrangements are in place to support the safe transfer of COVID-19 positive patients to designated facilities 24/7.

- Implement arrangements to support/deliver the case transfer framework.

Community and mental health providers are also asked to:

- Review arrangements for the management of patients that are ill within the community and ensure that all staff have appropriate awareness of infection prevention control measures in community settings.

- Ensure plans are in place to support the medium and long term psychosocial support required by individuals, communities and staff.

- Where possible, consider implementing alternative models such as remote consultations for those patients who can be supported at home and review arrangements to support vulnerable individuals in alternative settings, including in the community.

Secure and detained estate are asked to:

- Ensure they follow approved PHE guidelines for healthcare staff in secure and detained premises.

- Review current infection control practice to ensure they have achieved a state of preparedness in the event of COVID-19 infection outbreak.

- Adhere to wider PHE guidance in relation to staff presenting in work as unwell and ensure all staff are aware and adhere to said guidance.

- Ensure engagement with the estate managers (Governors and Directors) to support and secure immediate isolation procedures as appropriate in and across establishments.

Sustainability and Transformation Partnerships/Integrated Care Systems, Clinical Commissioning Groups and Commissioning Support Units are required to:

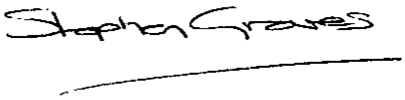
- Undertake and support the implementation of incident response structures within your areas and that a central coordinating function is established.

- Review appropriate local cascades to all of Primary Care within your commissioning area, both in and out of hours.

- Undertake a coronavirus exercise which aims to review arrangements in place across the NHS in your area.

Thank you for your leadership at this time. If you have any queries, please discuss them with your Regional Incident Management Team in the first instance.

Kind regards,



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NHS Strategic Incident Director
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Annex A: COVID-19 case detection for intensive care admissions

In recent days, new COVID-19 infections have been diagnosed in intensive care units in a number of European countries, without any epidemiological links to high risk areas. Nosocomial transmission has occurred in these units affecting other patients and staff. It is essential that we detect cases admitted to intensive care at the earliest opportunity.

We are requesting that all Intensive Care Units and Severe Respiratory Failure (ECMO) centres commence case detection.

Those trusts which have already begun case detection early, as part of the SCOVER system, should continue.

Case detection
The case detection process **does not apply** to any patients that meet the current COVID-19 case definition. These patients should be isolated and tested as usual, according to the PHE guidance.

General and paediatric intensive care units are asked to test all patients that meet the following criteria:

- Admitted to intensive care AND
- Presenting condition is an acute community acquired respiratory infection of any kind, regardless of known or suspected causative pathogen and clinical features.

Severe Respiratory Failure (ECMO) centres are asked to test all patients admitted through the SRF referral pathway, regardless of level of respiratory support required.

Sampling
The samples sent for testing should be nose and throat swabs in viral or universal transport medium and lower respiratory tract samples (e.g. BAL, ETA, or sputum) if available.

Residual samples from the samples used for clinical testing on admission (e.g. for routine influenza testing) can be used; if no residual sample is available, repeat nose and throat swabs in viral or universal transport medium as required, and lower respiratory specimens should also be sent if available.

As these samples are being submitted for early case detection there is no need to isolate these patients or take any other special measures outside normal care.

Staff should wear PPE as they would for managing severe influenza in ICU (e.g. gloves, aprons and fluid repellent mask) and should also follow their local PPE protocols for aerosol generating procedures, incorporating FFP3 respirator, eye protection, gown and gloves.

Please discuss this with your local microbiology/ virology department who will assist you in sending the samples to a PHE laboratory. The turnaround time for the test is 24 to 48 hours; the samples need to be received in the PHE laboratory before 8am

to allow testing on that day. Results will be reported to your microbiology laboratory and positive results notified to the clinician rapidly for immediate management with the support of the NHS High Consequence Infectious Diseases Network.

Annex B: Decontamination of the NHS 111 coronavirus pod

General principles

The NHS 111 coronavirus pod ('the pod') will need full decontamination, with appropriate Personal Protective Equipment (PPE), following use by any individuals who are deemed to require diagnostic sampling following assessment by NHS 111.

Any associated designated waiting areas must also be decontaminated in line with this guidance and any staff performing decontamination must be fully trained in these protocols, and the appropriate donning and doffing of PPE.

If NHS 111 has determined that the suspected case does not require diagnostic sampling, then decontamination of the facility is not required and, if visibly clean, is deemed ready for the next individual.

Cleaning the pod once the patient has left the pod

Preparation

Once a suspected case has left the pod, the pod should not be used. The door should remain shut, if possible with windows opened and any air conditioning switched off, until it has been cleaned with detergent and disinfectant. Once this process has been completed, the pod can be put back in use immediately.

The responsible person undertaking the cleaning with detergent and disinfectant should be familiar with these processes and procedures and should collect all cleaning equipment and clinical waste bags before entering the room.

Personal Protective Equipment (PPE)

Before entering the pod, perform hand hygiene then put on a disposable plastic apron and gloves. An FFP3 respirator does not need to be worn. If there is any reason to suspect a patient presents a higher risk, due to the length of time spent in the pod or their clinical symptoms, then a risk assessment of the need for additional PPE should be undertaken in conjunction with the trust infection prevention and control team.

On entering the pod to undertake cleaning and disinfection

- keep the door closed with windows open to improve airflow and ventilation whilst using detergent and disinfection products
- bag all items that have been used for the care of the patient as infectious clinical waste
- ideally no linen should need to be used in the pod. If deemed essential (ie a blanket for warmth) then this should be bagged inside the pod in accordance with procedures for infectious linen.

Cleaning process

Communal cleaning trollies should not enter the pod. Use disposable cloths, paper roll or disposable mop heads to clean and disinfect all horizontal surfaces, chairs, sanitary fittings, door handles and floor in the pod, following one of the two options below:

1. use either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.)
2. 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 that are in the pod prior to their removal
- clean all reusable equipment systematically from the top or furthest away point

On leaving the pod

- discard detergent or disinfectant solutions safely at disposal point
- all waste from suspected contaminated areas should be removed from the pod and disposed of as category B clinical waste
- disinfect, clean, dry and store re-usable parts of cleaning equipment, such as mop handles
- remove and discard PPE as clinical waste
- perform hand hygiene

Cleaning of waiting areas

If a suspected case spent time in a waiting area or toilet facilities, then these areas should be cleaned with detergent and disinfectant (as above) as soon as practicably possible, unless there has been a blood or body fluid spill which should be dealt with immediately. Once cleaning and disinfection have been completed, the area can be put back in use.