

Novel coronavirus (COVID-19) standard operating procedure: Community health services

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

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1. Scope and background

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. This document will be updated every two weeks or more frequently as necessary.

This document should be used alongside the [COVID-19 Prioritisation within Community Health Services guidance](#) covering adults and children's services, the [COVID-19 Hospital Discharge Service Requirements guidance](#) and infection prevention and control [guidance](#) for the coronavirus pandemic.

Make all staff aware of this standard operating procedure (SOP) through local organisational processes, the latest Personal Protective Equipment (PPE) [guidance](#), the latest COVID-19 case [definition](#) and any updated government guidance as it is produced or changed including updated PPE [advice](#) for specific areas of care. Please see Appendix 1 for more information on how to stay up to date.

1.1 Background: COVID-19 and the impact on community services

Coronavirus (COVID-19) is caused by a type of virus called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). As a group of viruses, coronaviruses are common across the world. Typical symptoms of coronavirus include fever, shortness of breath and a cough that may progress to severe pneumonia causing shortness of breath and breathing difficulties.

COVID-19 is a new coronavirus. It is no longer designated as a high consequence infectious disease (HCID) but still requires a national, coordinated response. For most people, COVID-19 will be a mild illness but may result in pneumonia or severe acute respiratory infection for some people.

The most common symptoms of COVID-19 are recent onset of:

- new continuous cough and/or
- high temperature

All UK residents should follow the stay at home [guidance](#) for households with possible COVID-19 infection.

Clinicians and managers can access additional coronavirus [guidance](#) for community services.

Priorities for community health services

As outlined in a [letter](#) to community health services on 19 March 2020, the following priorities apply during this pandemic:

1. Teams should support home **discharge** today of patients from acute and community beds, as mandated in the new [guidance](#) for Hospital Discharge Service Requirements, and ensure patients cared for at home receive urgent care when they need it
2. By default, use digital **technology** to provide advice and support to patients wherever possible
3. Prioritise **support for high-risk individuals** who will be advised to self-isolate for 12 weeks
4. Apply the principle of **mutual aid** with health and social care partners, as decided through your local resilience forum.

2. COVID-19: Standard operating procedure for community health services

In line with the refreshed general practice operating procedure, this standard operating procedure is following these principles:

1. Utilising NHS 111 online as the first port of call for people with COVID-19 symptoms rather than approaching their GP practice or local services
2. Prioritising support for those patients identified as being at the highest risk from COVID-19 and who have been advised to shield themselves, proactively managing a comprehensive health and care support package and drawing on volunteers and wider services
3. Adopting remote triage as the default and delivering care and treatment remotely wherever possible and appropriate, based on your clinical judgement
4. Manage essential face-to-face services (including home visits) through designating facilities / premises and teams to minimise the spread of infection to those who are suspected non COVID-19, particularly those most at risk and healthcare workers.

NHS 111 has been commissioned nationally to provide a dedicated COVID-19 response service and may refer patients to community health services alongside other referrers such as hospitals and general practice in line with prioritisation guidance. This includes patients who self-refer to specialist community health services.

All referrers to community health services should state whether the person or anyone in their household is suspected of having COVID-19 symptoms, has been diagnosed as having COVID-19, is practising shielding or is in an at-risk group in order to minimise risks to patients and staff and enable prioritisation.

It is recommended that each service segments their caseload into the following cohorts:

- Confirmed positive or suspected COVID-19 households
- Those advised to practice shielding
- Other at-risk groups who require active management of their ongoing, often significant, health and care needs
- All other community patients who are not in the above cohorts. This should include consideration of safeguarding and children with a child protection plan (Appendix 2).

2.1 Clinical and service prioritisation and assessment to manage demand and risks

Support should be prioritised for those patients identified at most high risk and services should deliver a comprehensive health and care support package drawing on volunteers and wider services to meet their wider needs. This support must be delivered with general practice and social care colleagues, to review and adapt care plans, arrange electronic dispensing of medicines through support of the local resource and voluntary sector partners and address urgent medical questions, remotely where possible.

Existing patients and those newly being referred to community health services need to be prioritised in line with the COVID-19 Prioritisation Health Services [guidance](#) and COVID-19 Hospital Discharge Service Requirements [guidance](#).

Virtual assessment

All new patients should be virtually assessed taking into consideration clinical need to identify if:

- Care and advice can be given using virtual consultation
- Carers/relatives/volunteers can provide care and support with guidance
- A face-to-face contact is clinically necessary

The assessment should always include the following screening questions:

- Do you or anyone in your household have coronavirus?
- Do you have a new, continuous cough?
- Do you have a high temperature (37.8°C or over)?
- Does anyone in your household have a new, continuous cough or a high temperature?

If they answer yes to any of the above questions, ask:

- Do you feel you can cope with your symptoms at home?

If they answer yes, advise the patient they should self-isolate and follow the NHS COVID-19 advice. They should be advised to get in contact if their condition deteriorates.

A clinical decision will need to be made whether a face-to-face care intervention is required – this may be separate to them having COVID-19. If a face-to-face intervention is essential Personal Protective Equipment (PPE) guidance and good infection control precautions should be followed. If the visit can be safely clinically deferred ensure there is regular and supportive communication to explain this. Some of these patients may have mental health needs (whether pre-existing or emerging as a result of the COVID-19 outbreak), dementia, learning disability or autism or other needs (appendix 3). There may also be additional strain for parents, carers, children and vulnerable families. Their needs may be exacerbated by the impact of shielding and subsequent reduction in social contact and support. Social isolation, reduction in physical activity, unpredictability and changes in routine can all contribute to increasing stress and subsequently mental health needs. Services must ensure they provide appropriate additional support to them so they can continue receiving access to care and contact their keyworker if applicable.

2.2 Digital technology for patient support by default

To minimise risk of transmission, services should adopt virtual triage as the default and deliver care and treatment remotely where appropriate and based on clinical judgement. In practice, this means services should be using telephone, video and online consultation technology, potentially supplemented by any remote monitoring, available to the patient in their home (eg temperature, blood pressure).

Use of virtual consultations should be done in line with the COVID-19 Prioritisation within Community Health Services [guidance](#) and used as a viable alternative to meet the demand presented by the 'Continue' and 'Partial Stop' services. Where a service is no longer being provided ('Stop'), patients can be referred to online resources to release clinical time.

The NHS is working on rapid acceleration of virtual consultations and a national procurement has just been completed. Further information is available in this [guidance](#) for providers of NHS services to introduce this into your organisation, particularly for those who are not currently able to work in this way along with guidance on mobile working.

NHSX has recently published COVID-19 Information Governance [guidance](#) to support health and care professionals, social care and IG professions and provide further clarity into the safety of various digital methods of communication with patients. This includes using Skype, WhatsApp and FaceTime where there is no alternative. Practical advice can be found within the [support guide](#) for the implementation of remote consultations.

2.3 Essential face-to-face care

Essential face-to-face services and home visits should be managed through designating teams, facilities / premises to segregate COVID-19 positive (including those individuals and households with symptoms) and non-COVID-19 services and patients to minimise the spread of infection, particularly to those most at risk.

All services will need to consider, along with their CCG, the operating model (using Table 1) that best suits their local arrangements and supports clinical decision making. The operating model will need to be tailored to each service, the current workforce capacity and numbers of patients in each of the cohorts described in Section 2. It may be necessary to change the established operating model for each

service, depending on changes in demand and workforce capacity as the pandemic evolves. Ensure you document the rationale for any operating model changes at a local level, eg where separating a workforce is not possible and what risk mitigations have been put in place.

Face-to-face treatment and consultations need to be carefully managed either in a designated way on premises set up to deliver these services or by home visit, always with appropriate infection control precautions and PPE.

Table 1. Considerations for essential face-to-face care

1. Home visits	2. Zoning within facilities	3. Site designation
<p><i>Brief description</i></p> <p>Manage cohort as normal and separate workforce for a COVID-19/non-COVID-19 service to avoid cross contamination. Individuals in households where there is a suspected or confirmed case should be treated as if they are a possible/confirmed case also. This applies to care homes also.</p>	<p><i>Brief description</i></p> <p>Manage patients within facilities but with designated areas and workforce to maintain separation to either treat those with suspected COVID-19 needing face-to-face contact (rare) or those patients without COVID-19 symptoms needing essential care.</p>	<p><i>Brief description</i></p> <p>Designate facilities to either treat those with suspected COVID-19 needing face-to-face contact (rare) or those patients without COVID-19 symptoms needing essential care.</p>
<p><i>Considerations</i></p> <p>Community teams may need to separate their workforce to treat patients with suspected COVID-19 (based on triage) or those patients without COVID-19 symptoms needing essential care.</p> <p>Staff will require separate bases and / or start and end shifts from home.</p> <p>More time should be factored in for PPE / infection control between visits.</p> <p>If separation is not possible due to numbers, geographical spread or specialist workforce, agree with partners, such as home carers, to deliver care by one individual where possible and skills allow.</p> <p>Where clinically appropriate visit most vulnerable first without COVID-19 symptoms.</p>	<p><i>Considerations</i></p> <p>Designating a specific zone/area within each facility/site to treat patients triaged as suspected COVID-19 needing face-to-face contact. Reducing impact on patient travel to and from health care centres.</p> <p>However, the interface between where suspected COVID-19 patients are treated will need careful management to minimise cross contamination with strict decontamination protocols in place – this would need to be extended to staff to maintain a ‘COVID-19 free’ home service including those most at risk.</p> <p>Not all premises are likely to have separate entry/exits point to help maintain this kind of separation.</p>	<p><i>Considerations</i></p> <p>Sites may wish to adopt such a model to better manage increasing demand as infection rates increase.</p> <p>Those sites that treat those without COVID-19 symptoms will need protocols in place to ensure patients remain symptom free prior to contact. These sites may also carry out other essential work such as childhood vaccines and immunisation. This option is likely to be the most effective option in managing cross contamination.</p> <p>Workforce capacity constraints mean pooling may be required. Additional support will be needed for those staff working in sites dealing with those with suspected COVID-19 symptoms – these cases should be rare.</p> <p>Any sites treating those without COVID-19 symptoms that become compromised would need decontaminating.</p>

2.4 Home visits

Any home visit must be prioritised using the COVID-19 Prioritisation within Community Health Services [guidance](#).

Before each home visit screening questions should be asked (see Section 2.1) both before booking in the visit and before entering the premises and at a safe distance where possible.

Home visits should be structured to see the most vulnerable non COVID-19 patients first to minimise the risk of cross contamination to those who either are confirmed or have symptoms of COVID-19, or are in households with confirmed/possible cases of COVID-19.

Good infection prevention practice principles continue to be essential. If a patient indicates before entry that they or a household member may be symptomatic of COVID-19 the following should be followed:

- Establish whether the visit can be deferred clinically. If so, confirm that the patient's (and/or carer's) contact details are correct. The patient should then be contacted remotely where possible to support and follow up.
- If the visit cannot be deferred, the appropriate PPE should be worn and the guidance below followed for **confirmed or suspected COVID-19 home visits**.
- If the patient needs emergency medical care in hospital, an ambulance should be requested where appropriate, and the 999 call handler informed of COVID-19 risk. If the patient requires emergency care while awaiting ambulance transfer, the healthcare professional should use PPE and keep exposure to a minimum.
- If, following a face-to-face visit, the patient does not meet the possible COVID-19 definition, no additional measures are needed.
- If following face-to-face home consultation, the patient is suspected COVID-19 positive, the environmental decontamination [guidance](#) should be used including clothes / uniform decontamination. If symptoms are identified during a home visit please inform the local health protection [team](#).

Places and items that **home-based** care staff come into contact with, which must be considered as potential means of cross-infection, include:

- Vehicle/mode of transportation

- Start/finish base
- Technology (eg mobile and electronic devices)
- Clinical waste (eg PPE, waste bag)
- Office equipment (eg plastic pens)

Ensure that 'home visit' bags contain necessary additional PPE and when used are disposed of correctly in line with [guidance](#), including environmental (non-healthcare settings) decontamination [guidance](#).

Where any of these patients have dementia, a learning disability or autism or other complex needs, additional support should be provided (see [additional information](#)).

[Guidance](#) is also available for partners managing cases of suspected COVID-19 in residential care, supported living and home care.

New [guidance](#) has been produced to support care homes in how they manage COVID-19.

2.4.1 Cohort considerations for home visits

A. Confirmed positive or suspected COVID-19 – home visits

- Where a home visit is essential for someone with possible/confirmed COVID-19, or for someone in a household with possible/confirmed COVID-19, healthcare staff should follow the infection control measures as outlined in the infection prevention and control [guidance](#). This includes the use of PPE in [guidance](#) by healthcare context to support community teams. Additional PPE precautions need to be taken when visiting a patient with possible COVID-19 who is on home non-invasive ventilation, and/or is receiving interventions which encourage cough/ increased respiratory effort.
- If, during a home visit possible COVID-19 is identified, staff should immediately apply PPE equipment to protect themselves, wash their hands and use alcohol gel.
- Thorough handwashing techniques must be performed before, during and after direct patient care, using soap and water (where the home environment allows), or alcohol gel where this is not possible.

B. Shielded 'extremely clinically vulnerable' patients – home visits

- [PPE](#) is required for interactions with this group of patients

- This group of patients have been advised to practice shielding. Shielding, in this context, means remaining at home always and avoiding any face-to-face contact for at least twelve weeks. The definition of this group and additional information can be found [here](#) and in the associated [guidance](#) on shielding.
- Those people at most clinical risk [can access help here](#).
- Clinician and Patient FAQs for this group are available [here](#).
- GP IT systems now have a functionality that identifies patients who are potentially at risk from COVID-19 and produces alerts within patient records.
- Review case lists and use the core screening questions and check if they have received a letter advising them to self-isolate.
- All efforts need to be taken to mitigate risk of infection including the ordering of home visits to see these people first and segregating the workforce where possible.

C. Other at-risk patients – home visits

- This group of patients have been advised to practice [social distancing](#).
- Review case lists to identify patients over 70 years of age or with a long-term health condition (ie anyone advised to get a flu jab as an adult each year on medical grounds) including children and young people.
- All efforts need to be taken to mitigate risk of infection including ordering home visits and segregating the workforce.

D. All other community patients – home visits

- Care given in line with standard infection prevention and control measures.

2.4.2 Infection control for home visits

- Practitioners should ensure that home visit bags have necessary PPE and clinical waste disposal. Community organisations will need to establish how much PPE is required for each member of staff visiting homes for this to be possible.
- Following the patient consultation, PPE should be removed and placed in a clinical waste bag and then hands decontaminated with soap and water or alcohol hand rub.
- All waste items that have been in contact with the individual (eg used tissues and disposable cleaning cloths) are to be disposed of securely within clinical

waste bags. When full, the plastic bag should then be placed in a second bin bag, tied and put aside for 72 hours before being put in the usual household waste in line with [HTM 07 01 Safe Management of Health Care Waste](#) or returned to base to be disposed of as per normal practice for clinical waste in line with existing local policies and procedures.

Where the consultation is with someone known to have learning disability or autism, carers or parents should be advised to give simplified explanation that PPE will be worn.

2.5 Healthcare settings

2.5.1 Cohort considerations for healthcare settings

A. Confirmed positive or suspected COVID-19 – healthcare settings

Administration and caseload management

- Administrative teams should prompt patients when appointments are being made using the screening questions in Section 2.1.
- Case management software/ clinical information systems should be adapted to identify patients with COVID-19.
- Careful management of people entering the premises should be undertaken.
- Services with text messaging (SMS) systems may use these to prompt patients to identify issues. Providers should update their websites with information to the public including that they will be asked the screening questions and where to access additional support such as NHS.uk, [Every Mind Matters](#) and PHE [guidance](#).
- Ensure patient information posters are displayed where they can be seen before a patient enters the premises, in waiting areas and at patient access points to clinical areas. Posters are available [here](#).
- Careful appointment planning should be used to minimise waiting times as much as possible. As a general principle, patients should only be brought to the service once an isolation room is prepared and ready.

Segregation and zoning

- Services need to consider the risk and options to mitigate these as much as reasonably practicable. This may include zoning, facility separation and staff

separation/cohorting, keeping in mind the need to access multi-disciplinary support as needed.

- Where possible, separate waiting areas or isolation rooms should be used for patients with signage used to warn patients of the segregated area/zone. Where possible, these areas should be separated by closed doors.
- Consider separating clinics into possible COVID-19 and non COVID-19 at different times of the day. This could be developed alongside other local facilities and GP practices.
- If this is not possible, determine whether the patient is clinically stable and able to wait outside the facility. If able to wait outside the service:
 - advise the patient to wait in a private vehicle if possible.
 - advise the patient to wait outside and keep a distance of at least two metres away from others to prevent droplet spread, where waiting in a private vehicle is not possible.
 - contact the patient when an isolation room is ready.
- Patients who cannot wait outside should be advised to wait in the waiting room, keeping a distance of at least two metres away from others.
- Consultation rooms need to be prepared in the standard way including:
 - De-clutter and remove non-essential furnishings and items to assist decontamination.
 - Retain a telephone in the room for calling for assistance.
 - Brief all staff on the potential use of the rooms/areas and actions required, in the event if it is necessary to vacate rooms/areas at short notice.
 - Identify toilet facilities designated for the sole use of patients with possible COVID-19.
 - Rooms and toilet facilities should be cleaned between patients with possible COVID-19.
 - Prepare appropriate space/room signage to be used if the space/room is occupied and for the toilet facilities.
 - Prepare a patient 'support pack' (to be held in reserve). This may include items such as bottled water, disposable tissues, clinical waste bag and fluid-resistant surgical mask.

Conducting the consultation

- If the patient becomes critically ill and requires an urgent ambulance transfer to a hospital, the practice should contact 999 and inform the ambulance call handler of COVID-19 concerns.

- Where available this could mean an isolation zone/area is pre-identified, alternatively a clinical room might be temporarily taken out of action in order to isolate the suspected case, whilst the necessary follow up actions are undertaken.

B. Shielded ‘extremely clinically vulnerable’ patients– healthcare settings

- Shielded patients are extremely vulnerable to COVID-19 and have been asked to self-isolate for a 12 week period beginning 23 March 2020. This remains the case despite the location in which they are currently residing, ie community hospital, rehabilitation unit. Risk assessments need to be completed and documented for shielded patients before attending any healthcare setting during the COVID-19 incident or whilst temporarily residing within a healthcare setting in the community.

C. Other ‘at risk’ patients – healthcare settings

- Extremely clinically vulnerable and at risk patients should be risk assessed before attending a healthcare setting during the COVID-19 incident.

D. All other community patients – healthcare settings

- All other community service patients (in line with the Prioritisation within Community Services [guidance](#)) should be assessed for remote or home consultation before attending a healthcare setting during the COVID-19 incident.

2.5.2 Infection Control for healthcare settings

Clinic

- Follow General Practice [guidance](#)

Care home – In-reach

- Staff going into a care home setting should use personal protective equipment (PPE) in line with [PPE Guidance](#)

Intermediate care / community hospital

- Use the guidance for care homes or wards, whichever is the most appropriate based on the location and layout of the facility.

Schools

Comply with local schools recommendations and the [guidance](#) for schools and other educational settings including safeguarding and vulnerable children and young people.

Where the consultation is with someone known to have a learning disability or autism, carers, parents or clinician should give simplified explanation that PPE will be worn.

2.6 Other key considerations

Community Services 'In Reach' to Care Homes

Community teams should coordinate with GPs, and other health and care professions, to ensure care continues to be provided in care and nursing homes in line with respective service specifications and the COVID-19 Prioritisation within Community Health Services [guidance](#). Regular care home rounds by GPs and/or their multi-disciplinary teams (MDTs) should be delivered virtually unless physical presence is required for clinical reasons.

All health and care professionals that deliver care to these patients will need to follow new guidance specifically for [Care Homes](#) and PPE [Guidance](#).

Proactive care planning

It is important to encourage sensitive and timely proactive discussions around advance care planning, treatment escalation planning and advance decisions, so that individual person-centered holistic care can be maintained. These conversations require immediate documentation and liaison with General Practice and the patient's relatives. (see Appendix 4).

It is unacceptable for advance care plans to be applied to groups of people of any description. These decisions must continue to be made on an individual basis according to need.

End of life care

The health, care and support needs of those people at the end of life should be delivered remotely where clinically possible, and as a general principle the number of health and care professionals entering into someone's home should be kept to an absolute minimum. To achieve this, GPs should work with providers of community services and specialist palliative care teams to coordinate those interactions (See Appendix 5). Strict infection control and decontamination protocols will need to be in place for those health and care professionals that carry out a home visit. To help manage the health needs of people at the end of life, GPs have 24/7 access to local specialist palliative care advice, as per their current local arrangements (in some places patients will be able to access this directly). Further guidance on end of life care will be set out in Coronavirus (COVID-19) Guidance for Community Palliative and End of Life Care during Coronavirus Pandemic.

Precautions following a death are included in the infection prevention and control [guidance](#).

The principles of Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) continue to apply whilst deceased individuals remain in the care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living patients. Where the deceased was known or possibly infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted.

Following a risk assessment of the potential post-mortem risk pathways, PHE has developed this advice in line with the principles set out in the HSE guidance for droplet transmission risk as set out in: ['Managing infection risks when handling the deceased'](#)

Safeguarding

The [COVID-19 Prioritisation with Community Services Guidance](#), [The COVID 2020 Act](#), [Changes to the Care Act 2015](#) and the variety of [COVID 19 Guidance](#) all indicating that safeguarding children and adults is as critical during

COVID-19 as it is statutory at other times. Staff across the health and care sector are advised to:

1. Download the free [NHS Safeguarding App](#), which has local safeguarding contacts
2. Follow #COVIDSafeguarding via @NHSsafeguarding who will be posting daily updates and key messages
3. Join the [COVID Safeguarding digital community of practice](#)

Wellbeing of community staff

This pandemic will increase the probability of either providing care and support to those at the end of life or finding patients who have deceased. Staff support should be provided locally including clinical supervision and access to other support services. Resources and [guidance](#) is also available from NHS Employers.

Volunteer Responders and Social Prescriber Link Workers

Referrals should be made via the [NHS Volunteer Responders referrers' portal](#) or by calling 0808 196 3382. Further guidance for health professionals can be found [here](#). Support can also be enabled by PCN Social Prescriber Link Workers.

3. Working differently to keep staff and patients safe

3.1 Overview of Infection control and personal protective equipment (PPE)

Always check for the latest Public Health England [infection control guidance](#) for and [PPE guidance](#). Information is available for a range of scenarios and settings.

PPE supply

Please see [letter](#) on supply and use of PPE

Supply distribution helpline: 0800 915 9964 (Lines open 24 hours)

3.2 Changes to local teams and cross-organisational working

Community teams should be strictly adhering to local agile working guidance and consider the following adjustments:

- Teams should start and finish their day from home rather than a community base where possible.

- Virtual team meetings and handovers should be implemented immediately.
- There should be staggered entry to a community base to collect consumables and equipment.
- Community health service providers should ensure that there is a high level of support and a focus on staff health and wellbeing during this unprecedented time of high anxiety. To support staff, access the [NHS Employers online resources](#).
- Ensure teams and individuals have access to regular clinical supervision

Interdisciplinary and cross-organisational adjustments as below are to be considered:

- Clinicians should be flexible in terms of their approach and the expectations of routine requirements.
- Teams should collaborate to mitigate transmission using care-coordination across Primary Care Networks and multi skilled triage.
- Shared care records and interoperability should be accelerated across health, social care and the voluntary sector to maximise communication across communities and reduce multiple interactions with people
- Voluntary Community and Social Enterprise (VCSE) organisations should be involved in local planning to respond to COVID-19 in community health services.
- VCSE organisations should be funded to cover costs and meet unplanned costs and community health services should work with local authorities to support this.
- Community capacity building organisations such as volunteer centres and hubs should be engaged to support increased volunteer engagement.
- Social prescribing link workers in Primary Care Networks should be engaged to ensure joined up support for patients.

Appendix 1: Communication and information

How we plan to communicate with you:

At urgent times of need:

- Central Alerting System (CAS): NHS trusts already have systems and processes in place to manage CAS alerts and these will remain in place. Ensure that you have registered for receiving [CAS alerts directly from the Medicines and Healthcare products Regulatory Agency \(MHRA\)](#).

For less urgent COVID-19 communications, organisations will be emailed by a local commissioner.

- Ensure you have dedicated a Senior Responsible Owner (SRO) responsible for communications within your organisation and that they are known within any on-call arrangements in the organisation or local system.
- Organisations may wish to consider a dedicated person to receive COVID-19 alerts once the organisation has signed up to [COVID-19 alerts](#) online.

Supportive additional information:

A variety of additional methods to keep you informed of the emerging situation, alongside royal colleges, regulators and professional bodies, through formal and informal networks, including social and wider media. You can follow these Twitter accounts to keep up to date:

- NHS England and NHS Improvement: [@NHSEngland](#)
- The Department for Health and Social Care: [@DHSCgovuk](#)
- Public Health England: [@PHE_uk](#)

Register online with PHE to download COVID-19 resources:

<https://campaignresources.phe.gov.uk/resources>

Resources:

<https://campaignresources.phe.gov.uk/resources/campaigns/101-coronavirus->

Review and update the contact details for:

- Regional/local health protection teams: www.gov.uk/health-protection-team

- NHS regional infection prevention and control team.
Search: 'infection prevention control + your NHS region'
- NHS local medical network (LMN), local medical committee (LMC)
- NHS regional medical director clinical advisory team
- Local NHS commissioning team

Care Quality Commission Notifications during the COVID-19 Pandemic

The CQC has had made changes to how they work during this period.
Keep up to date with this [guidance](#).

Appendix 2: Advice on support for children and young people in the community

- Children, young people and families may experience additional pressures and stresses during the coronavirus pandemic, particularly the most vulnerable or those who require additional support. It is important to continue to deliver support through a universal and targeted offer during this time. This will enable parents, children and young people to access timely advice and support to keep them well.
- Health visitors and school nurses continue to deliver the Healthy Child Programme. This helps to identify vulnerabilities in early childhood development and readiness for school. It provides opportunities to deliver public health messages for example; parental stress and anxiety, support for breast feeding, avoidable accidents and illness, childhood immunisation and screening, offering support to children, young people and families to improve health and wellbeing outcomes and reduced inequalities.

Key factors

- Children and families will be anxious and pressured at this time, particularly the more **vulnerable and at risk**.
- For some the **transition to parenthood** places pressure on relationships, and there is the potential for domestic violence and abuse to escalate.
- **Mental health** problems in the perinatal period are common including antenatal and postnatal depression.
- **Adverse childhood experiences** are stressful events occurring in childhood, and may have lifelong impacts on health and wellbeing.
- **Unintentional injuries** for the under-fives tend to happen in the home and are linked to the physical environment in the home, the availability of safety equipment and consumer products.
- Good **health and emotional wellbeing** are associated with improved attendance and attainment in school.
- Identifying **vulnerable children and young people** who are at risk of health inequalities is challenging and they are at risk of poorer outcomes.
- **Young carers** and other vulnerable groups, including children in care become vulnerable when the level of care giving, and responsibility, becomes excessive or inappropriate for that child.

Specific support

- Children, young people and families at times feel isolated, frightened and forgotten. Health visitors and school nurses play a significant role in **supporting** children, young people and families, working with them to address barriers to good health, identifying the most appropriate level of support for individual need.
- **Advice and guidance** includes allaying fears, anxiety and timely sign posting to support or medical attention or additional support where there is an additional health need or disability.
- **Support in the community** and local health visiting and school nursing teams provide technology services to keep in touch.
- **Safeguarding and protecting children from harm.** It is important to identify and keep in contact with vulnerable children and families.
- There will be an **additional stress for young carers**, and services can help support and plan so that friends/relatives/volunteers keep daily phone or other contact. This should reduce the need for calls on the NHS and social care
- There will be children and young people who have **clinical and long-term conditions** where services may also need to help support and plan so that friends/relatives/volunteers keep daily phone or other contact. This should reduce the need for calls on the NHS and social care.
- **Social isolation** may have a negative impact on children, young people and their family's **emotional health** and **wellbeing**, services may signpost to safe websites providing accurate messages and support communication between friends and families.
- **Parent conflict and family stress:** social isolation can negatively impact on family relationships, and there are support lines available which parents, children and young people can be sign posted to offer support.

Appendix 3: Advice on support for people with dementia in the community

- 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 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. This guidance is equally applicable to anyone with cognitive impairment resulting from conditions which affect the brain.

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 and other cognitive impairments may have difficulty understanding **complex instructions** about self-isolation or handwashing – keeping information accessible and repeatable is key.
- People with dementia and other cognitive impairments may lack awareness of and be less able to report symptoms because of **communication difficulties** – be alert to the presence of signs as well as symptoms of the virus (“look beyond words”).
- People with dementia may have **swallowing difficulties**, putting 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](#) and [Dementia UK](#) 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 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.

Appendix 4: Advance care plan: guidance notes and template

Guidance notes for completing 'My COVID-19 Advance Care Plan'

- A page of information developed by you, with your family or friends (or somebody else if you need help). It outlines the decisions you have made about your treatment and the support you need if you develop severe COVID-19 symptoms and need to contact emergency services or be admitted to hospital. In these circumstances you are likely to be separated from people who usually support you or speak on your behalf, or COVID-19 may make you too breathless to speak. This plan is a way to capture and share, in an urgent situation, the advance decisions you have made around the care and treatment you would like.

What information is required for a COVID-19 Advance Care Plan?

- You only need to note down brief information about the key things you want people to know under the following headings.

My name, NHS number, I like to be known as	Basic information about your name, NHS number and what you like to be known as
Summary of my health conditions	Briefly list any underlying health conditions you have
Who am I?	Let us know a few things about you as a person e.g. things you do when you are well, like drawing and painting or cycling. Or you are a mother of 3 and a grandmother of 5, or whether you are generally very active etc.
Three important things I want you to know	This is one of the most important sections as it is a place for you to indicate the preferences you have for treatment if you have COVID-19. <ul style="list-style-type: none">• If you do not want to be admitted to hospital, please record this at number 1 in this section.

	<ul style="list-style-type: none"> • You can indicate here if your priority is comfort i.e. managing symptoms, rather than prioritising sustaining your life, which may involve more invasive treatment. • Other things to record under this section might be: <ul style="list-style-type: none"> - that you usually have low blood pressure or body temperature (tell us what they are) - or that you have a phobia of needles or sickness. • Other helpful information would include how you react if you are very stressed as well as treatment that you have decided to decline.
Medication I take	A list of your medication, doses and frequency
How my medication is administered	How you take your medication e.g. orally or through a PEG etc.
How I communicate	It may be that you don't usually use words to speak, or English isn't your first language and a family member interprets for you. It might be useful to know how you would indicate distress or discomfort if you are unable to speak.
My emergency contacts	List the names and numbers of people you would like us to contact in an emergency.
Who has a copy of this plan?	Please tell us who knows about your plan and who we can contact about it if we need to.

My COVID-19 Advance Care Plan

My name:	NHS number:
I like to be known as:	
Summary of my health condition(s) ...	
Who am I? Things I do when I am well / something about me as a person ...	
Three important things I want you to know ...	
1.	
2.	
3.	
Medication I take ...	
How my medication is administered...	
How I communicate ...	
My emergency contacts	
Who has a copy of this plan? Name:	
1 Name:	2 Name:
Relationship to me:	Relationship to me:
Telephone number:	Telephone number:

Appendix 5: Advice on support for people with palliative and end of life care needs in the community

People with palliative and end of life care needs rely on the coordinated support of primary care teams, community health and care services and specialist palliative care teams. During the coronavirus pandemic, there will be more people dying of coronavirus at home who will also require care and support at the end of their lives.

If the person remains at home, in supported living accommodation or residential care homes:

The anticipated increase in demand and stretch in workforce availability means that there will have to be a greater reliance on family members, unpaid carers and those who are with these patients, to help provide the care. They may have to administer medication more than they are used to. GPs, community services and specialist palliative care teams will continue to support these individuals, remotely wherever possible, and face-to-face if required. Information to support these carers is being developed and will be made available. In the meantime, there are some useful resources on: <https://helixcentre.com/project-end-of-life-toolkit>.

If the person is in a care home or hospice:

Guidance for care homes and community palliative care, including hospices, are being developed.

Useful tips:

- People who have an advance care plan should be encouraged to review this with the question “*If I become ill with coronavirus, would this change anything about views, preferences and priorities that I have previously recorded?*” If so, they should amend their advance care plan and make sure this is known to those closest to them.
- People who do not have an advance care plan should be encouraged to consider thinking about, discussing with those closest to them and writing down their views on the extent to which they would want treatment escalated, e.g. would they want to be admitted to hospital, if they were admitted to hospital would they want to limit that to supportive treatments (e.g. oxygen,

intravenous fluids, antibiotics if needed) but not intensive care? Whilst these are clinical judgements that have to be made at the time, knowing the person's views means that these can be taken into account in decision making if the person is too unwell to participate in these conversations at the time.

- Discussions about cardiopulmonary resuscitation are important to have, though advance care plans and treatment escalation plans should not be limited to this one issue. However, if the person has made a decision that he/she would not want cardiopulmonary resuscitation attempted, should this situation arise, it is important that this is clearly documented and made visible to in-house staff and emergency services, e.g. through the message in a bottle system, notice on the back of the front door, etc.

Appendix 6: Community Musculoskeletal services

Aligned with musculoskeletal guidance within the [Prioritisation within Community Services guidance](#) community MSK service planning should

- Sustain segmentation of MSK services to align with rheumatology and orthopaedic planning whilst releasing the majority of staff to assist with prioritised community or secondary care provision.
- Telephone / virtual triage to enable continued referral of urgent or emergency MSK conditions to secondary care informed by published speciality [guidance](#) must be prioritised
- Rehabilitation MUST prioritise patients who have had recent elective surgery, fractures or those with acute and/or complex needs (including carers) with a focus on virtual delivery to enable self-management. An NHS England & NHS Improvement supported electronic information resource regarding the self-management of common musculoskeletal conditions, to sign post patients to, is available through the following [link](#)

Appendix 7: Summary of Related Guidance and Useful Links

This document is to be used in conjunction with the following documents:

General:

- **NHS England and Improvement COVID-19 Prioritisation within Community Health Services Guidance -**
https://www.england.nhs.uk/coronavirus/publication/covid-19-prioritisation-within-community-health-services-with-annex_19-march-2020/
- **NHS England and Improvement COVID-19 Hospital Discharge Service Requirements -** <https://www.england.nhs.uk/coronavirus/publication/covid-19-hospital-discharge-service-requirements/>
- **HM Government and NHS England and Improvement: Hospital Discharge Service Requirements -**
<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/covid-19-discharge-guidance-hmg-format-v4-18.pdf>

For the Public:

- **Public Health England Stay at Home: Guidance for Households with possible coronavirus (COVID-19) infection -**
<https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection>
- **Information for where to get coronavirus support as a clinically extremely vulnerable person -**www.gov.uk/coronavirus-extremely-vulnerable
- **Public Health England Guidance on Social Distancing for everyone in the UK -** <https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults>
- **Helix Centre: End of Life Toolkits for Carers at Home -**
<https://helixcentre.com/project-end-of-life-toolkit>

For Health and Social Care Staff:

- **NHS England and Improvement: Community based health and social care and ambulance services -**
<https://www.england.nhs.uk/coronavirus/community-social-care-ambulance/>
- **Public Health England COVID-19 Guidance: investigation and initial clinical management of possible cases -**

<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>

- **NHS England and Improvement Clinical guide for front line staff to support the management of patients with a learning disability, autism or both during the coronavirus pandemic – relevant to all clinical specialities** - https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0031_Specialty-guide_LD-and-coronavirus-v1_-24-March.pdf
- **Easy Read Guidance** <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/clinical-guide-for-staff-supporting-patients-with-a-learning-disability-autism-or-both-easy-read.pdf>
- **NHS England and Improvement Urgent and Emergency Guide for Musculoskeletal Conditions Requiring Onward Referral** - <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-emergency-msk-conditions-requiring-onward-referral-23-march-2020-updated.pdf>
- **All health and social care staff can refer people to receive the support of an NHS Volunteer Responder via** <https://www.goodsamapp.org/home>
- **For Safeguarding concerns there is a free NHS App** - <http://www.myguideapps.com/projects/safeguarding/default/> or join the digital community of practice - <https://future.nhs.uk/connect.ti/safeguarding/view?objectID=18981104>
- **To receive Central Alerting System alerts directly from the Medicines and Healthcare products Regulatory Agency (MHRA) such as medicines register here** - <https://www.cas.mhra.gov.uk/Help/CoronavirusAlerts.aspx>
- **Chartered Society of Physiotherapy COVID-19: guide for rapid implementation of remote consultations** - <https://www.csp.org.uk/publications/covid-19-guide-rapid-implementation-remote-consultations>
- **NHS Employers: Health, Safety and Wellbeing Guidance** - <https://www.nhsemployers.org/covid19/health-safety-and-wellbeing>
- **The Queen’s Nursing Institute Resources** <https://www.qni.org.uk/resources/>

Infection Control & Personal Protective Equipment (PPE):

- **Public Health England COVID-19: Guidance for infection prevention and control in healthcare settings -**
<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>
- **Correspondence on the supply of PPE from NHS England and Improvement, Academy of Medical Royal Colleges and Public Health England 28 March 2020 -** <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/personal-protection-equipment-letter-28-march-2020.pdf>

Information Governance:

- **NHSX COVID-19 Information Governance Guidance -**
<https://www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance>

New 'Act Like You've Got It, Anyone Can Spread It' assets

- A new set of assets featuring a revised creative (red and yellow) are now available on the Campaign Resource Centre.
<https://campaignresources.phe.gov.uk/resources/campaigns/101/resources/5096>

Other Resources

- <https://www.england.nhs.uk/coronavirus/community-social-care-ambulance/other-resources/>

Workforce

- <https://www.england.nhs.uk/coronavirus/workforce/>