

Operating framework for urgent and planned services in hospital settings during COVID-19

Purpose

- The NHS has created unprecedented surge capacity, including HDU and ITU, to treat and care for patients with confirmed COVID-19 infection.
- The challenge now facing the NHS as it begins the second phase of its response to the outbreak is to maintain the capacity to provide high quality services for patients with COVID-19, whilst increasing other urgent clinical services and important routine diagnostics and planned surgery.
- Local healthcare systems and individual providers have already started planning for this. A key objective in executing these plans must be to minimise the transmission of COVID-19 infection within hospitals, also referred to as hospital-onset infection or nosocomial transmission.
- Delivery against the national expectations and principles set out in this framework will require strong and focussed leadership from local healthcare systems, underpinned by excellent clinical judgment and patient communication.
- Whilst this guidance is intentionally focussed on hospital settings, including acute, community and mental health, many of the principles will be relevant to other healthcare settings and connecting services, including ambulance, primary and community care.

Framework

- 1 Careful planning, scheduling and organisation of clinical activity
- 2 Scientifically guided approach to testing staff and patients
- 3 Excellence in Infection Prevention and Control (IPC)
- 4 Rigorous monitoring and surveillance
- 5 Focus on continuous improvement

Planned & Elective and **Urgent & Emergency** care pathways present different opportunities and challenges for minimising hospital transmission of COVID-19 requiring careful planning, scheduling and organisation of clinical activity.

Planned & Elective Care

- Patients should only be required to attend hospital where clinically necessary- maximise all opportunities for remote, multi-professional virtual consultations.
- *Admission:* only patients who remain asymptomatic having isolated for 14 days prior to admission and, where feasible, tested negative prior to admission (see next page on testing).
Outpatient: only patients who are asymptomatic should attend, ensuring they can comply with normal social distancing requirements.
- Enhanced planning and protection for patients who are clinically extremely vulnerable (shielded) from COVID-19.
- Ensure any patient who subsequently tests positive or shows symptoms can be immediately isolated.

Urgent & Emergency Care

- On arrival, ensure patients are immediately identified as either i) asymptomatic; ii) symptomatic for COVID-19; iii) COVID+ and apply appropriate Infection Prevention and Control procedures.
- Ensure within the Emergency Department and Urgent Access Clinics asymptomatic patients can comply with normal social distancing requirements.
- Ensure any patient who subsequently tests positive or shows symptoms can be immediately isolated or managed in a COVID+ cohorted area.
- Enhanced planning and protection for patients who are clinically extremely vulnerable (shielded) from COVID-19, identified from Summary Care Record or by referring clinician pre-arrival where possible.

Maximise opportunities for creating physical and / or visible separation between clinical and non clinical areas used by patients on a Planned & Elective care pathway and those on an Urgent & Emergency care pathway. Solutions must be flexible and sustainable as demand and activity levels change over the next few months.

Maintain consistency in staff allocation where possible and reduce movement of staff and the cross over of care pathways where feasible between Planned & Elective care pathways and Urgent & Emergency care pathways.

Ensure planned activity aligns with other dependencies, inc. testing capacity, medicines supply, consumables and PPE.

A scientifically guided approach to **testing the right patients and staff, at the right time and frequency** (updated as the evidence evolves) will underpin efforts to minimise COVID19 transmission in hospitals.

The testing approach described below follows advice from the Chief Medical Officer for England and will be kept under constant review during the early stages of the second phase of the NHS response to COVID-19.

Patients

Emergency Admissions: all patients should be tested on admission. For patients who test negative, a further single re-test should be conducted between 5-7 days after admission.

Elective Admissions (including day surgery): patients should isolate for 14 days prior to admission along with members of their household. As and when feasible, this should be supplemented with a pre-admission test* (conducted a maximum of 72 hours in advance), allowing patients who test negative to be admitted with IPC and PPE requirements that are appropriate for someone who's confirmed COVID status is negative.

Inpatients: any inpatient who becomes symptomatic, who has not previously tested positive, should be immediately tested as per current practice

Other day interventions: testing and isolation to be determined locally, based on patient and procedural risk.

Discharge: all patients being discharged to a care home or a hospice should be tested up to 48 hours prior to discharge.

Staff

Symptomatic: all staff or members of their household who are symptomatic should be tested as per current practice.

Asymptomatic: additional available NHS testing capacity should be used to routinely and strategically test asymptomatic frontline staff as part of infection prevention and control measures. Local health systems should work together with their labs and regions to agree the use of available capacity.

Serology

Access to **antibody testing**, as part of the government's testing programme, will also begin to be made available to NHS staff and patients during this next phase. The results will be used to build our understanding and knowledge of COVID-19 and inform the clinical approach. More details will be set out in due course.

* Pre-admission testing should not require a patient to break isolation requirements - the Department of Health and Social Care is leading the rollout of home testing.

Excellent implementation of **Infection Prevention and Control (IPC)** procedures is paramount in reducing healthcare associated infections, including nosocomial transmission of COVID-19.

- **Follow the [national IPC guidance](#)**: evidence based, web accessible and printable: associated checklists and compendium of all relevant IPC resources, including training resources, available in one central place (maintained in 'real time'). And use the [IPC Board Assurance Framework](#) to ensure that recommended IPC measures are being reliably implemented within & across the organisation.
- **Use the appropriate level of Personal Protective Equipment (PPE)**, in line with the latest guidance from Public Health England.
- **Minimise potential COVID-19 Health Care Worker (HCW) transmission** (including HCW to HCW) through supporting staff with:
 - Good hand and respiratory hygiene; keeping hands away from face when wearing any face protection.
 - Declaring all COVID-like symptoms, however mild, and not attending clinical areas for work.
 - Wherever possible, reducing movement between different areas.
 - Social distancing (2 metres) inside & outside of clinical areas e.g. during work breaks and when in communal areas.
 - Understanding the risk of surface contact transmission and frequently cleaning any shared equipment e.g. mobile phones, desk phones and other communication devices, tablets, desktops, keyboards etc

Rigorous monitoring and surveillance will be central to understanding COVID-19 transmission within hospitals, providing transparency on performance and supporting a focus on continuous improvement.

- **Public Health England and NHS Digital are establishing routine data collection systems on COVID-19**, including standard definitions of ‘hospital onset’, at Trust level. This will enable rates of nosocomial transmission to be identified and tracked weekly.
- **Routine data to be available to Trusts by end May 2020**, with data linkage with Spine and Hospital Episode Statistics (HES) planned, enabling:
 - ✓ Sub-group analysis/patient stratification to identify patient risk factors;
 - ✓ Previous hospital episode stays to be identified.
- Surveillance to be underpinned through system level and regional oversight.

5 Focus on continuous improvement

Measure for Improvement

Capture organisational data and measure for improvement

Improvement Methodology

Use an established improvement methodology to identify changes and measure their impact

Clinically Led Pathway Improvements

Ensure a focus on clinically led pathway improvements / redesign to eliminate unnecessary hospital attendances and further reduce risks for patients requiring hospital care and treatment

Build Local Learning Systems

Build local learning systems to capture and share best practice and support the use of peer review