NHS Lothian Board Meeting

24 September 2020, 10:00 to 11:00
MS TEAMS

Agenda

Declaration of Interests

1. Declaration of Interests

Verbal

Martin Hill

Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. It is also a member's duty under the Code of Conduct to ensure that changes in circumstances are reported within one month of them changing. Please notify changes to Georgia.Sherratt@nhslothian.scot.nhs.uk

For further information around declarations of interest please refer to the code of conduct section of the Board Members' Handbook.

Items for Approval or Noting

2. Items proposed for Approval or Noting without further discussion

Verbal

Martin Hill

2.1. Minutes of Previous Board Meeting held on 12 August 2020

For Approval

Martin Hill

12-08-20 Public Board (draft to Board 240920).pdf (16 pages)

Items for Discussion

3. Four-Country Infection Prevention Guidance for the Remobilisation of Health and Care Services

40 minutes
Discussion

Alex McMahon

Report - Four Country Guidance (170920).pdf (4 pages)

3.1. Appendix 1: COVID 19 Guidance for the Remobilisation of Services within Health and Care Settings: Infection Prevention and Control Recommendations August 2020

Appendix 1- COVID-19 Guidance.pdf (22 pages)

3.2. Appendix 2: Pathways

Appendix 2- Pathways.pdf (3 pages)

3.3. Appendix 3: NHS Scotland COVID 19 Remobilisation - Built Environment incl. social distancing support diagrams - 28 August 2020

Appendix 3- NHS Scotland COVID-19 remob- Built Environment.pdf (12 pages)

3.4. Appendix 4: Staff Communications

Appendix 4- Staff Communications.pdf (4 pages)

4. Future Board Meetings

Verbal

Martin Hill

- 14 October 2020
- 09 December 2020

5. Any Other Business

Verbal

Martin Hill

6. Invoking of Standing Order 5.23 - Resolution to take items in closed session

Decision

Martin Hill

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 12 August 2020 using Microsoft Teams.

Present:

Non-Executive Board Members: Mrs E Roberton (Chair); Mr M Hill (Vice-Chair); Mr M Ash; Mr M Connor; Dr P Donald; Cllr G Gordon; Ms C Hirst; Ms F Ireland; Mrs K Kasper; Mr A McCann; Cllr D Milligan; Cllr J McGinty; Mr W McQueen; Mrs A Mitchell; Mr P Murray; Cllr F O'Donnell; Mr T Waterson; Dr R Williams and Professor M Whyte.

Executive Board Members: Mr C Campbell (Chief Executive); Ms T Gillies (Executive Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health & Health Policy); Professor A McMahon (Executive Director, Nursing, Midwifery & AHPs – Executive Lead REAS & Prison Healthcare).

In Attendance: Mr C Briggs (Director of Strategic Planning); Mrs J Butler (Director of HR & OD); Mrs J Campbell (Chief Officer, Acute Services); Mr J Crombie (Deputy Chief Executive); Mr P Lock (Director of Improvement); Mrs J Mackay (Director of Communications & Public Engagement); Mr A Payne (Head of Corporate Governance); Mr D A Small (Director of Primary Care Transformation) and Mr D Weir (Business Manager, Interim Chair, Chief Executive and Deputy Chief Executive's Office).

Declaration of Financial and Non-Financial Interest

42. The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

42.1 There were no declarations of interest.

43. Chair's Introductory Comments

43.1 The Chair extended a warm welcome to Mr T Waterson as the Board's new Employee Director. She also congratulated Mrs Kasper on her pregnancy. The Chair reported that Mr Ash and Mrs Mitchell would remain on the Board as their membership had been extended, however they have stood down from chairing the Audit & Risk Committee and the Staff Governance Committee respectively. The Chair thanked both Mr Ash and Mrs Mitchell for their leadership and contributions in those roles.

43.2 The Chair also extended the Board's thanks to Ms Joanne Brown for her work on the internal audit of the Royal Hospital for Children and Young People / Department of Clinical Neurosciences.

44. Items for Approval

44.1 The Chair reminded those present that the Board agenda was made up of two separate sections. The first was the section for approval commonly referred to as the 'consent agenda'. The Chair reminded members that they had the opportunity to advise in advance if they wished matters to be moved out of this section. The Chair advised that paper 2.2 'Appointment of Committee Members' would be discussed separately.

44.2 The Board agreed items 2.1 and 2.3-2.8 on the agenda without further discussion.

Items for Discussion

45. Appointment of Committee Members

45.1 The Chair advised that the circulated paper had proposed that Mrs Mitchell would join the Edinburgh Integration Joint Board (IJB). However, on reflection Mrs Mitchell concluded that she could not undertake this role. The Board approved the recommendations in the report except the appointment of Mrs Mitchell to the IJB. The position would be reviewed and alternative proposals would be brought to a future Board meeting.

46. Approach to Future Board Meetings

46.1 The Chair commented that the recommendation in the Board paper was that the Board would continue not to convene its Board meetings in public up to and including its meeting on 9 December 2020. This is for the 'special reason' of protecting public health, and the health and wellbeing of anyone who would have otherwise attended the meeting. Meetings would therefore continue to be held by Teams or in any other manner which did not require the members or staff to physically meet.

46.2 Ms Hirst commented that although she was content to have meetings on Teams that she had concerns about the lack of opportunity for members of the general public to observe the Board's business. She questioned what other Boards were doing and whether this included recording meetings in order to have a public record.

46.3 The Board noted that the national Corporate Governance Group was looking at how to take Board meetings out of lockdown, and considering the various options. The Board noted that in NHS Fife the media was allowed to attend meetings via Teams.

46.4 Mr Payne advised that the intention was to develop and implement a consistent approach across Scotland.

46.5 The point was made that the Edinburgh and Midlothian IJB meetings were already streamed. The Chief Executive, Mr Payne and Mrs Mackay would look at opportunities around streaming and also inviting the media to join the meeting. Cllr Milligan reported that councils had been advised of the need to move back to public meetings by mid-September.

46.6 The Board agreed the recommendations contained in the circulated paper and in particular the need to continue to schedule six public Board meetings per year. Mr Connor advised that in a previous role in an English NHS Trust development sessions had been held in the afternoon of the public Board meeting.

47. Opportunity for Committee Chairs or IJB Leads to Highlight Material Items for Awareness

47.1 The Vice Chair advised that at the Finance and Resources Committee meeting held on 22 July 2020, the Committee had reviewed the entry on the corporate risk register for RHCYP/DCN. The committee had also considered the appointment of counsel to the public inquiry, and the role of the Finance and Resources Committee in that process.

48. Board Executive Team Report

48.1 The Chief Executive advised that the production of a Board Executive Team report to the Board was something that he had done in previous Boards. He advised that he had agreed with colleagues that a similar report would be produced for NHS Lothian for a short period and then reviewed to consider its added value.

48.2 The Chief Executive advised in respect of his own section that it was important that the Board were aware that the Annual Review of the Board had been set for 16 November 2020 and further clarity would be provided once this was available. This would include whether non-executive Board members would be asked to actively participate as had been the case in some previous years.

48.3 Professor McCallum advised that it had been her intention to draft a paper for the Board meeting in respect of the Lothian testing strategy. This had been put on hold as she had received a copy of a confidential draft of the Scottish Government's national strategy. It has been agreed not to progress with the Lothian document until it could be clarified that a common approach was being proposed in both documents. Professor McCallum advised that she had responded offline to a number of questions raised by Mr McQueen in respect of environmental testing.

48.4 Mr Murray asked what the intended use was for Patient-Level Information and Costing Systems (PLICS). His understanding was that the original purpose was to help access IJB data, and asked whether there were any intentions for wider use. Mrs Goldsmith advised that there had been a requirement to change supplier and as a result the system had been paused. She commented it would probably be the next financial year before the system was fully up and running, and this would be used to provide actual data for IJBs to use.

48.5 Mrs Mitchell welcomed the report and commented she would like a bit more structure around the paper to demonstrate how to map activity into strategic objectives, and to explain where issues would be developed. The Chair reported that a similar report was used in NHS24, and this mapped to the corporate objectives. The Chair advised she will explore this further.

48.6 The Chief Executive agreed that future iterations of the report should include contributions from IJB Chief Officers. This had been the practice in his previous roles. He reminded the Board that the development of the report was still in its evolutionary stages.

48.7 Professor McMahon, in response to a question from Mr McCann, advised that the healthcare associated infection report had shown positive progress in respect of sabs and c-diff, and that the issue was about sustaining this position into the future.

48.8 Mr Connor sought an update on the indicative date when the elective centre at St John's Hospital would come on stream. Mr Crombie advised that the Covid delay had allowed the system to revisit the design and planning assumptions around the elective centre. There will be an impact on the construction timeline, and we will develop a better understanding of this over the next few months. Mr Crombie advised that the timeline for the submission of the Full Business Case to the Scottish Government in February 2021 still remained, however this depended on the construction timeline. .

48.9 Mr Small in response to a question from Cllr O'Donnell around the flu vaccination provided details on the different approaches being proposed by each of the IJB areas.

48.10 The Vice-Chair commented that the Finance and Resources Committee often reflected on the relative inflexibility of revenue, partly because of PPP contracts. This had been considered in respect of looking at other funding routes for the replacement Eye Pavilion. The Committee has considered how to respond to alternatives to a traditional capital funding model.

48.11 The Vice-Chair commented that whilst he understood the position around the car parking situation at the Royal Infirmary of Edinburgh, the issue added to existing environmental concerns. He sought assurance that final proposals would include proper provision for cyclists and the charging of electric cars. The Chief Executive confirmed that these issues would be considered, and he

accepted that the car parking proposals were in direct opposition to strategic objectives, but were necessary.

48.12 Mr Crombie reported in respect of the Eye Pavilion, that there had been a clear signal from the Scottish Capital Investment Group that no capital would be available. So other funding sources should be considered and this process was currently underway, with nothing having yet been agreed. He commented that further discussion around this would be held at the Finance and Resources Committee. Mrs Goldsmith will prepare a report which considers the implications and associated risks of different funding models.

48.13 It was pointed out that in other organisations the Board receives separate reports from the Chief Executive and the Chair. The Chair advised that she would normally produce a report to the Board, and confirmed she would do so moving forward. She provided the Board with details of individual discussions that she and the Chief Executive had held with MSPs.

48.14 Mr Small responded to a question from Mr Waterson, and advised that for flu vaccinations there is a national fee structure in place. Any charges made by GP practices and the payment of these were not within the gift of NHS Lothian. Professor McMahon provided an update on national work in respect of band 3 nurses and healthcare support workers in relation to the vaccination process. He commented that bank usage would only be utilised for weekend working and this position that would be kept under review. Mr Waterson agreed that he would continue these discussions separately and offline with both Professor McCallum and Professor McMahon.

48.15 The Board noted that regular routine eye care had recommenced on 3 August 2020.

48.16 The Chair reminded Board members that they were now receiving regular press summaries on a trial basis and invited feedback on the effectiveness of this process.

48.17 The Chief Executive thanked Board members for the positive feedback to the Board Executive Team report. He confirmed that he would review its structure, noted the suggestion that future reports should be grouped around themes rather than directors, and that the report should include contributions from the four IJB chief officers. The Chair welcomed the report and asked Board members in the future if they had issues of interest to make contact with the appropriate director offline.

49. Covid-19 – Public Health Update

49.1 Professor McCallum advised the Covid position was still an evolving picture. She commented that in Lothian there had been low levels of community transmission and that some signals of individual cases were being investigated. In terms of asymptomatic cases for workers in care homes it was noted that to date there had been no sign of infection or other issues in

the care home environment. The Board were advised that venue specific issues were being addressed.

49.2 Ms Hirst updated on discussions held at the Midlothian IJB in respect of the impact of flu vaccinations, and also the opportunities around this to do other contacts while patients were receiving their vaccination. She felt there was a need to deliver more locally, and ensure services were easily accessible to members of the public in order to reduce the need for people to travel. She also questioned the position in respect of the variation in local authority areas in terms of infection and death rates.

49.3 Professor McCallum concurred that moving into winter there would be opportunities to undertake extra contact, and that this would be done as much as possible to ensure needs were being addressed. Additionally interventions would be put in place with the third sector, housing and local authorities for vulnerable populations. With regard to variations by local authority, Professor McCallum advised there was a lot of work ongoing with partnerships and the University of Edinburgh and Datatech around this issue, and she would provide details once they were available.

49.4 Mrs Mitchell expressed concerns in terms of contact tracing in relation to efficiency and delays in passing data between the national and local centres. She commented that it appeared there were different ways of notifying people of their results. Professor McCallum reported that Mr McQueen had also asked related questions and she had responded to him offline. She reported that there was a two-tier system in Scotland, and this was different from the approach used in England. The Board was provided with details of how the Scottish system worked. It was noted that basic contact tracing could be undertaken by the national centre, although at the moment because of the lower numbers involved, the local system was providing support around individual cases. The use of text messaging was important, with it being noted for clinical tests, the clinician needed to take responsibility for ensuring patients received their results. It was noted however that in some instances the use of automatic text messaging was not appropriate. The need for a fail-safe system was stressed to ensure people did not get lost in the system. The Chair commented that she was reassured that the local system was able to provide assistance nationally and hoped that this was a reciprocal arrangement.

49.5 Professor McCallum advised that NHS Lothian was working with the Scottish Government to explain why Lothian figures looked higher than the position for the rest of Scotland, and to develop a new matrix. Possible reasons for the Lothian position was provided to the Board. Cllr Gordon felt there was a need to make the public aware of the reasons for the higher Lothian return. It was agreed that Professor McCallum and Mrs Mackay would discuss this offline. Cllr O'Donnell questioned whether travel restrictions would be applied at times of increased lockdowns and whether the tourist sector would be advised not to take bookings from these areas. Professor McCallum commented that if her advice was taken, and there was ability under the Public Health Act, then she would prefer bookings not to be accepted. It was pointed out however

there were exceptions and that the tourist sector had been fantastic in helping the system find safe places for people to self-isolate. Professor McCallum was keen that the existing partnership between local authorities, NHS Lothian, the tourist industry and the third sector continued.

49.6 Cllr O'Donnell further questioned in terms of care homes and a possible second wave whether patients would only be discharged to a care home following a Covid-19 negative test result. Professor McCallum advised that this was always a finely balanced clinical decision underpinned by public health principles. The position would depend on the risk assessment and what was best for the patient.

49.7 Cllr O'Donnell highlighted that in respect of education, it would be important to recognise that older staff like domestics etc, and not just teachers, might be at great risk following the re-opening of schools. Professor McCallum confirmed that this issue was now covered by the guidance. Public engagement and feedback from patients would be added into a future iteration of the Board paper.

49.8 Mr McQueen questioned what was being done to protect black ethnic minority (BME) staff from avoidable exposure, and whether there was a need for a national risk assessment tool. He sought advice on the timescale for the completion of any work and how this would be handled with appropriate staff. Professor McCallum commented on the emerging relationship with Public Health Scotland. She suggested there would be merit in adopting a 'Once for Scotland' approach with both Public Health Scotland and the Scottish Government to reach an aligned position. Professor McCallum reported that Directors of Public Health met weekly, there were no issues about a lack of integration, and relationships were developing in a positive way. A wider community planning relationship was also developing.

49.9 Professor McCallum updated the Board on the developing BME network. She and the Chief Executive along with the Director of the Occupational Health Service had met with BME colleagues to talk through the issues. It was noted that it would be important to ensure that BME specific issues were not lost in the wider risk assessment. Mrs Butler advised that the assessment tool that had been developed was for all staff and not just BME staff, as there were also other risk factors and groups of vulnerable people. The risk assessment in the first instance has been about shielding staff. It was recognised that further work was needed around communications. The Chief Executive concurred with the points made about vulnerable groups including age, obesity and gender, whilst accepting the need to minimise anxiety amongst BME staff.

49.10 Professor Whyte updated on what was being done by the University of Edinburgh in respect of the anticipated influx of students in the summer. It was noted that local and national discussions were taking place. At the moment the system was not testing asymptomatic contacts. Professor Whyte questioned whether it would be possible to influence that agenda. The Chair advised that she was aware of one university that was looking at testing all

staff and students. The point was made that some groups were more at risk than others.

49.11 Dr Donald suggested in terms of the complexity of testing, that communications were important in respect of how to obtain access to a test, how to receive results and any necessary follow-up. She felt that there would be benefit in providing a summary sheet, as currently people were not aware of the nuances. This could be an iterative document that would change over time.

49.12 The Chair commented that the points made had been important and would be taken into account when the Lothian strategy was produced in conjunction with the Scottish Government wide publication. Dr Donald advised that she would be happy to work with colleagues in the development of the strategy.

49.13 The Board agreed the recommendation contained in the circulated paper.

50. Test Strategy

50.1 The Board agreed this issue had been discussed elsewhere on the agenda.

51. Scheduled and Unscheduled Care Performance / Clinical Prioritisation

51.1 The Board agreed to take the above items together given the linkages between the issues.

51.2 Scheduled Care and Unscheduled Care Performance – Mrs Campbell reported in terms of scheduled care that outpatient services were experiencing continued pressure. The level was lower than pre-Covid although urgent suspicion of cancer was up to pre-Covid levels. There had been a reduction in activity and capacity because of the need for physical distancing. The Board noted that a detailed risk assessment had been undertaken to reduce distancing from 2 metres down to 1 metre for outpatient services, and this would be considered at the Corporate Management Team the following week. If this proposal which would have clinical support was signed off then this would have a positive impact on service delivery. A visit had been made to the Louisa Jordan Hospital in Glasgow to consider the capacity that they might be able to provide. The position was being risk assessed as there would be a need to move staff to Glasgow to support the capacity.

51.3 The Board were advised that there were around 39,000 patients waiting more than 12 weeks for treatment. In terms of the treatment time guarantee (TTG) the main focus was about remobilising theatre capacity. There remained reduced capacity because of the requirement to undertake enhanced cleaning and the need to don and doff PPE.

51.4 Mrs Campbell reported in terms of inpatient day cases that the focus was on urgent and suspicion of cancer. It was noted that 31 day and 62 day cancer performance was being monitored. There was currently a specific pressure in urology with work underway to explore how services could be increased using both the Western General Hospital (WGH) and private providers. It was reported that additional non-recurrent funding had been received to support endoscopy by using facilities in Fife, as well as the WGH enhancements.

51.5 Unscheduled Care Performance – The Board was advised that performance for July was at 95%, with the system continuing to maintain red and green pathways. It was noted there were real pressures at the Royal Infirmary of Edinburgh, with activity especially on Mondays being up to pre-Covid levels, partly as a result of increased requirements for resuscitation. The current focus remained on winter and how to schedule unscheduled care, with a focus on diverting self-presenting patients to more appropriate services.

51.6 Clinical Prioritisation – Ms Gillies advised that the remobilisation plan sought the adoption of a unified Scottish approach. The plan followed guidance which the four surgical colleges in the UK developed, and therefore had a level of professional endorsement. It was noted that learning from Grampian had also been useful. Ms Gillies advised that the current issue was that there were increased pressures from new patients waiting for treatment that the system did not have capacity to provide. The Board was advised that waiting resulted in a poor experience for patients, particularly those with urgent needs who would experience a poorer outcome, as explained in the paper.

51.7 The Board received a brief summary of how patients on the waiting list were broken down. It was noted that the split between urgent and routine was the same as for the rest of Scotland (20% - 80% split). It was reported that category 1 patients were not on the waiting list, and were admitted in an unplanned way and would be the first call on resources.

51.8 Ms Gillies reported that national work was underway looking at data submitted via remobilisation plans. The focus remained on those with most urgent needs first. This approach was currently only endorsed for surgical specialties although discussions were being rolled out elsewhere. The Board noted the importance of maintaining communication with patients who were on the waiting list and this was partly being done via ‘keep in touch’. There was a need to have a process to escalate patients and this was being drawn out in the review of Grampian work.

51.9 The Board was advised that in all likelihood the system would see an increase in the number of patients presenting with urgent conditions (categories 1 & 2), with there already being some evidence of this in cancer services. This meant that some people might have to wait longer and it was important that there was clear communication around this. Ms Gillies commented that although this was an unpalatable message, it was important this was communicated in a transparent manner and that a route for escalation was maintained. The Chair advised there had been a clear message at the Chairs Group about the need for both national and local messaging.

51.10 Mrs Campbell, in response to question from Mr McCann about theatre output, advised that ongoing work was underway around theatres. The position pre-Covid had been 200-250 elective sessions per week, moving down to 75, although the position was now recovering to 100 theatre sessions. It was hoped to move to a position of 84% with there already being evidence of increases in activity. A similar exercise was being done for outpatient activity. The Board noted there had been a significant reduction in the number of 'face to face' consultations with initiatives like 'near me' having been deployed. Work was underway looking at how to mitigate the loss of activity, including the use of patient initiated follow-up. The diagnostic capacity had been affected in relation to the need for physical spacing and using PPE, leading to increased turnaround between patients. The Board was advised that consideration was being given to increasing productivity by reducing the 2-metre distancing position to 1 metre, supported by appropriate mitigating actions and clinical sign-off.

51.11 Dr Donald commented that positive feedback had been received in respect of communication with patients. She stressed the importance of also communicating to GPs in order that they were aware of the process for accessing services. Dr Donald felt there were significant opportunities to schedule unscheduled care either locally or nationally. She questioned whether there was anything that the Board could do to facilitate this process. The Board was advised that the access team were updating patient letters to emphasise that access to services would look different, and these messages would continue to be developed.

51.12 Mrs Campbell reported that work around scheduling unscheduled care was a national initiative, and the Scottish Government has communicated its expectations. NHS Lothian has established a Programme Board to look at the local requirements and actions. The Chief Executive advised that he and the Chief Executive of NHS24 co-chaired the National Group to make scheduling unscheduled care a reality. He advised that by the end of October 2020, all heath boards would be required to have system in place to have self-presenters using 111, establish a flow centre, and develop 'call Mia' or steps to put people into hot clinics and then to the Emergency Departments. It was accepted that the clinical triage process would not be perfect by the 31 October 2020, and this would be an issue for the Scottish Government to address. The Chief Executive stressed the need to have robust arrangements in place before the onset of winter. The Chair commented that what was being described represented a significant shift in the way services were delivered.

51.13 Ms Hirst commented in terms of the clinical prioritisation paper and other Board papers that there was a need for a standard paragraph in particular to reflect the impacts of recommendations and policies. She was concerned that in all instances impact assessments had not been carried out. Ms Hirst was clear that there was a need for transparency and communication in terms of clinical prioritisation, and the need to explain to patients why there were not

getting treated. The Chair concurred that there was an ongoing need for this to happen both nationally and locally.

51.14 Mr Murray questioned the Scottish Government position in respect of the TTG target, given that the targets were not capable of being met, and on that basis, health systems should not be held to account. He questioned in terms of the ability to satisfy demand, whether scenario planning was in place to alter the profile of people with most need against less urgent requirements. He commented there would be an increase in demand for care in the community, and therefore a need to reflect on the balance of service provision between the community and the acute sectors.

51.15 Ms Gillies commented that discussions were ongoing with clinicians about referral advice, for both new referrals and repeats. It was noted that it would not be possible for the system to be too purist in its approach. The other point that needed to be considered was the position in respect of patients already on the waiting list. It was noted that since the onset of Covid, some patients' appetite for treatment might have changed, and people might exercise their personal choice and right not to come forward for treatment.

51.16 Mr McQueen commented that the paper suggested that it was not yet possible to quantify the number of patients who presented with urgent conditions. He questioned whether it would be of benefit to the system if this was possible. He also questioned in terms of theatres whether the loss of pre-operative tests was insurmountable. Ms Gillies commented in respect of the second point that the position was currently limited to patients requiring transplantation. Testing might improve over the next few months. Guidance was already in place around red and amber pathways and any patient that had a negative test. Ms Gillies advised that she was keen to move back to a position of having a pool of patients able to attend hospital to be treated in 'quick time'.

51.17 Ms Gillies commented in terms of theatre capacity set aside for category 1 patients that more needed to be allocated because each case was taking longer. She concurred that there was a need to use theatre sessions better and as effectively as possible. Ms Gillies commented that she could not state specifically how much capacity had been put aside although the position that would continue to be monitored.

51.18 Professor Whyte advised that she was grateful to Ms Gillies for highlighting the importance of looking at other specialties other than cancer and urgents. She was concerned in respect of outpatients and the inability to review patients on a 'face to face' basis. She felt that the use of the telephone and video calling was a holding measure rather than a permanent solution. She was keen that consideration was given to how to review patients in person in order that proper examinations could be undertaken.

51.19 Ms Kasper commented that the paper made sobering reading. She advised that she was concerned about the underlying assumption that there was a need to make do with the capacity available and questioned to what degree

that was being challenged. She was concerned that at the moment the discussion was about doing things better and smarter and scaling down the services available. The point was made that for some people there was no alternative to the NHS especially from an inequality perspective. Ms Kasper felt there might be a need to increase capacity to sustain the health of the population. The Chair commented that this was a fair point and that IJBs would also be seeking to increase capacity in the community.

51.20 Ms Campbell commented that she agreed with the points made and advised the Board that there had been positive feedback from a significant number of patients about telephone and 'near me' experiences. She commented however that there was still a need to build capacity to provide a 'face to face' service wherever possible and appropriate. The Board was reminded that discussions about how patients were contacted and treated was clinically led. The Chair commented that the positive feedback from patients was gratifying although it was important to remember that this had been during a period where options were severely restricted.

51.21 The Chief Executive commented that the points made by Ms Kasper were fair. His view was that it is clear there was a need for Lothian to obtain its fair NRAC (National Resource Allocation Committee) share and this had been rehearsed with the Scottish Government. He stressed however that NHS Lothian would need to live within budget and that Scottish Government resources and funding would be under pressure. The Chief Executive advised in that regard he would anticipate difficult times ahead.

51.22 Cllr O'Donnell reminded the Board that within the NHS Lothian area there are the two fastest growing local authority areas by population. The Board acknowledged this point and the challenges it brought. Mrs Campbell undertook to pick up a number of issues around the paper with Mr Murray offline.

51.23 The Board agreed the recommendations contained in both of the circulated papers.

52. St John's Hospital Paediatric Services – Follow up to Royal College of Paediatrics and Child Health (RCPCH) Second Review Report

52.1 Ms Campbell referred to the circulated report and reminded the Board that the RCPCH had been invited to undertake a further review with the report having been received in May 2020. The key issues of the report were outlined to the Board.

52.2 The Board noted that the Paediatric Programme Board had met and taken cognisance of the effect of the report on the middle grade rota. Ms Campbell advised that the rota had been clinically reviewed and positive feedback had been received that the rota could be sustained and would cope with normal variations in demand and annual leave. On this basis the Paediatric Programme Board had recommended that the paediatric inpatient ward at St

John's Hospital (SJH) should reopen on a 24/7 basis from 19 October 2020. Issues around paediatric services would form part of the clinical strategy for the Board that was under development.

52.3 The Chair thanked the Paediatric Programme Board for their considerable efforts in moving the position to a satisfactory and positive conclusion. The Vice Chair also added his personal thanks as Chair of the Programme Board to colleagues who had put in considerable work over the previous 4 years. He was confident that the clinical management team would be able to progress the recommendations effectively.

52.4 Mr Connor commented in respect of the proposed disbandment of the Paediatric Programme Board and the further recommendations that further work should be progressed by the Children's Clinical Management Team that there was a need for this to be effectively communicated. He noted that the recommendation had been specific about the Paediatric Programme Board overseeing some of the recommendations. The Board agreed that future communications should be through the St John's Hospital Stakeholder Group and this would allow the Paediatric Programme Board to be stood down. The Board agreed that the Chief Executive and his team would consider how best to communicate this position.

52.5 Cllr McGinty advised that the report had been helpful and set the way forward. He echoed the thanks of others whilst recognising the services ongoing fragility.

52.6 The Board agreed the recommendations contained in the circulated paper.

53. June 2020 Financial Position

53.1 Mrs Goldsmith advised that she was in the unusual position of reporting an overspend of £19m at this point in the year. This included an estimated £31m in respect of Covid costs. She advised that this related in a large part to staffing costs and new recruits, with it being anticipated that these costs would reduce as students and others were subsumed into permanent posts. Mrs Goldsmith reported that a lot of work was underway to obtain a full understanding of the financial implications of Covid. The Chair commented that a significant issue would be the ability to draw down Scottish Government funding to cover the costs.

53.2 Mr McQueen questioned whether the Scottish Government was joined up in respect of the mobilisation plan, and whether it was realistic about the application of the overspend. Mrs Goldsmith reported that there was a heavy reliance on the finance community to determine the Covid impact and to provide an interpretation of the mobilisation approach. It was recognised that it would be useful for there to be a system-wide recognition of the financial consequences.

53.3 Mrs Goldsmith reported that a quarter 1 financial review would be undertaken and work would continue with Scottish Government colleagues, whilst recognising the need to maintain local control.

53.4 The Chair commented that her understanding was that NHS Lothian was not out of line with other Boards in terms of the financial position around Covid. The Board noted that the Chair, Chief Executive and Mrs Goldsmith would maintain appropriate focus on financial control.

53.5 The Board agreed the recommendations contained in the circulated paper.

54. Corporate Risk Register

54.1 Ms Gillies advised that the circulated paper was self explanatory and proposed the addition of the following two new risks onto the corporate risk register; -

1. Care homes, as recommended by the Healthcare Governance Committee
2. Legionella in terms of controls around water safety premises that had been used less frequently than in previous pathways, including primary care premises

54.2 Ms Gillies commented that some premises were owned by GPs rather than NHS Lothian. There were potential issues about temperature control and regular flushing of water systems, with the current position being unclear. This would remain an important focus of the Water Safety Group.

54.3 The Board noted that following review by the Finance and Resource Committee it was being recommended that the 'facilities fit for purpose' risk should be downgraded. Mr Murray commented that the paper appeared to be focusing on aspects of care homes where the risk should be overseen by IJBs and HSCPs. He questioned whether there should be a component in the risk register for IJBs to fill the gap. Professor McMahon reported that the IJB Chief Officers would be reporting to the Healthcare Governance Committee in respect of care homes in areas that they had responsibility for. He advised that national work streams were underway to tease out lines of responsibility in respect of care homes. It was noted that the risk register focused on NHS Lothian's responsibility. The Board was advised that the Scottish Executive Nurse Director Group discussed this issue on a weekly basis. Professor McMahon advised if the current Executive Nurse Director responsibilities extended beyond 31 November 2020 as anticipated, then it was appropriate to spend time resolving responsibility issues.

54.4 Dr Williams commented in respect to legionella that he believed one of the main actions was to run water for a prolonged period of time and this did not fit with the environmental agenda. He questioned whether other options were available. Ms Gillies commented that currently temperature issues and

flushing were statutory requirements, and that NHS Lothian followed health and safety guidance.

54.5 The Board agreed the recommendations contained in the circulated paper.

55. Audit and Risk Committee Consideration of the Internal Audit of Royal Hospital for Children and Young People / Department of Clinical Neurosciences (RHCYP/DCN)

55.1 Mr Ash as Chair of the Audit and Risk Committee reminded Board members of the background to NHS Lothian commissioning the internal audit report.

55.2 Mr Ash advised that it was proper that the Audit and Risk Committee provided assurance to the Board that the Committee had carried out its remit.

55.3 The Board noted that further discussion would be held in private session later in the day.

55.4 The Board agreed the recommendations contained in the circulated paper.

56. Royal Hospital for Children and Young People, Department of Clinical Neurosciences and Child Adolescent Mental Health Services (RHCPY, DCN & CAMHS)

56.1 Mrs Goldsmith provided the Board with a verbal update on the RHCYP/DCN & CAMHS project. The Board noted that Supplemental Agreement 2 (SA2) had now been signed. A review is being carried out in relation to why it had taken so long to conclude. It was hoped that this would improve processes for future changes. As SA2 had been signed it would be possible for estimated costs to be produced. The Board noted that the programme was still on target and work had progressed in advance of SA2 having been formally signed. Mrs Goldsmith advised that she expected work would be completed within the timeline of the critical care and haematology / oncology enhancements. The Board noted the ventilation equipment was now onsite.

56.2 Mrs Goldsmith reported that it was gratifying to see the hospital being used in the way it had been intended. The Chair concurred that it was important to put on record that all of DCN and 70% of outpatient services for the Royal Hospital of Sick Children had now moved on to the new site. The Board recorded its thanks to Mrs Goldsmith and her team for concluding SA2 and also to clinical teams for their efforts in populating the building.

56.3 The Chair commented that she would liaise with IHSL about bringing forward the indicative programme if this were at all possible. She felt that lessons learned from this project would be important for the wider public sector.

56.4 The Board welcomed the positive update report.

57. Future Board Meetings

57.1 The Board agreed the September Board meeting would be a development session followed by a formal Board meeting in October.

58. Standing Order 5.23 Resolutions to take Items in Closed Session

58.1 The Board agreed to invoke Standing Order 5.23 to allow a meeting of Lothian NHS Board to be held in Private. The reason for this was due to the commercial and confidential nature of the business to be discussed.

Chair's Signature ……

Date ……

Mrs Esther Roberton
Interim Chair – Lothian NHS Board

NHS LOTHIAN

Board Meeting
Thursday 24th September 2020

Executive Director Nursing, Midwifery and AHPs
Executive Medical Director

FOUR COUNTRY INFECTION PREVENTION CONTROL GUIDANCE FOR THE REMOBILSATION OF HEATH AND CARE SERVICES

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note the publication of the four country guidance, as set out in appendix 1, that was published on the 21st August with the expectation that it was enacted from the 7th September. NHS Boards have been undertaking risk assessments in relation to how best to safely introduce the guidance. Of particular note and challenge has been the issue of fully complying with 2 metres physical distance between patients in an inpatient setting and the introduction of new patient pathways.

2 A process has been undertaken within NHS Lothian to work through the three patient pathways green, amber and red, and how we would make this work within the constraints of our local estate and clinical services.

Any member wishing additional information should contact the Executive Lead in advance of the meeting.

3 Recommendations

3.1 Accept that NHS Lothian should, where possible, work within the 2 metres guidance as set out in the guidance at appendix 1

3.2 Service areas that require to undertake a risk assessment, using the hierarchy of control as set out in appendix 3 are intensive care units, respiratory services, endoscopy, theatres with some work required in mental health, maternity and neonatal units. Each risk assessment will be reviewed and signed off by the Executive Leadership Group

3.3 That the weekly Strategic Group for PPE has oversight of the implementation of the guidance and in turn advises the Executive Leadership Team of any operational challenges

3.4 That the Healthcare Governance Committee is the designated governance committee to have oversight and that routine updates will be taken there as required, and where appropriate to the Board.

3.5 To note the communications to staff that have been developed.

3.6 To note that in relation to the ‘Green’ pathway NHS Lothian may have to introduce a limited or no visiting within this pathway to protect patients and staff and keep the pathway as free of COVID as possible.

4 Discussion of Key Issues

4.1 The guidance was issued jointly by the Department of Health and Social care, Public Health Wales, Public Health Agency Northern Ireland and Health Protection Scotland, Public Health England and NHS England. This guidance supersedes the COVID-19 UK IPC guidance published on the 18th June 2020.

4.2 The guidance does state that "some differences in operational details and organisational responsibilities may apply" and that implementation will require risk assessment.

4.3 The guidance introduces three patient pathways:

4.3.1 High risk (red) where there is no change in the recommendations for use of PPE and infection control procedures

4.3.2 Medium risk (amber) this includes patients who have no symptoms of COVID-19 but do not have a COVID-19 SARS-CoV-2 PCR test result.

4.3.3 Low risk (green) for patients with no symptoms and a negative COVID-19 SARS-CoV-2 PCR test who have self isolated for 14 days prior to admission.

4.4 The guidance also introduces that "physical distancing of 2 metres is considered standard practice in all health and care settings".

4.5 There is a clear disclaimer in the guidance that states "when an organisational adopts practices that differ from those recommendations in this national guidance, that organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment (s) through local governance procedures, for example Health Boards".

4.6 Within NHS Lothian the Medical and Nurse Directors have undertaken a series of workshops and presentations in relation to the guidance and our ability to implement this, including at the Board Development session on the 2nd September and at the Healthcare Governance Committee on the 8th September. The implications of the guidance and the implementation of the pathways was also discussed at the Corporate Management Team on the 15th September. There have also been discussions at national levels. The position that we have come to is that where we have single rooms or the ability to safely cohort patients with the same infection, there is more flexibility to manage the pathways as described and we would work with the three pathways as set out in appendix 2.

4.7 The constraint that NHS Lothian has is that all of our acute hospitals RIE, SJH and WGH have only a small number of single rooms, as well as four and six bedded bays.

4.8 We have used the attached guidance published on the 11th September as part of our risk assessment. Using the hierarchy of control is a helpful way to think about why we have gone with the decisions that we have, which relate to the recommendations at section 3. The hierarchy of control starts with elimination of the problem, through substitution, engineering and administrative controls and finally the use of PPE. What underpins all of these is a constant need to re-enforce and comply with wider infection prevention control measures.

4.9 In looking at the patient pathways, it is our view that all community hospitals and the Royal Edinburgh hospital do not meet the criteria for a green pathway and therefore would automatically fall into amber and red pathways.

4.10 Another feature of our thinking has been the need to provide and sustain capacity in order that we start to treat patients who have been waiting for interventions or surgery deferred or delayed as a consequence of the restrictions associated with the the first wave of COVID-19 infection.. We have a duty to ensure that we try and see and treat as many patients as we can whilst still ensuring that we are keeping patients and staff and others safe. To that end, compliance with Personnel Protective Equipment and maintaining high standards of wider infection prevention and control practices are very important.

4.11 Whilst the work that we have done in NHS Lothian has involved our Partnership colleagues they have continually expressed their concerns that the guidance is explicit in requiring that 2 metres physical distance is maintained at all times. It should be recognised that this forms part of a suite of control measures (in line with the hierarchy of risk) and does not provide full mitigation of risk on its own. Mitigation of risk to staff is also provided through compliant use of fluid resistant surgical face masks in all clinical areas and all clinical care delivery. It is important to highlight again the disclaimer in the guidance as stated at section 4.5. It is our intention to continue to work with Partnership through the implementation of this guidance just as we have throughout COVID-19. As recommended above, the key forum to maintain oversight of this group on behalf of the organisation will be the weekly strategic PPE group chaired by the Executive Nurse Director and the key governance committee will be the Healthcare Governance Committee then to the Board.

4.12 In taking this work forward, communication with our staff is paramount. Attached at appendix 4 are the communications that have been developed for both staff and patients.

5 Key Risks

5.1 The key risk is our ability to work with 2 metres physical distance between patients in our inpatient settings. The caveat here is that the guidance as published provides the disclaimer which we are choosing to use here in NHS Lothian which is set out at 4.5 above.

5.2 The other risk to NHS Lothian is our inability to have the capacity required to enact our remobilisation plan in full, to see patients who need to be seen and treated in a timely manner, whilst also reducing the number of people who have now been waiting in excess of the agreed waiting times.

6 Risk Register

6.1 The risks here relate to patient safety and safety of staff (need to give the right risk register entries).

7 Impact on Inequality, Including Health Inequalities

7.1 An impact assessment will be carried out in those service areas that we have identified at the recommendation set out at 3.2 above.

8 Duty to Inform, Engage and Consult People who use our Services

8.1 A number of discussions and presentations have taken place within the corporate management team and the Executive Leadership Team, as well as a number of meetings with senior clinicians and managers across community, REAS and acute

hospitals. In addition a board development day took place on the 2nd September and a presentation at Healthcare Governance Committee on the 8th September.

9 Resource Implications

9.1 Cleaning regimes will increase across all in patient care areas and a detailed piece of work has been done to calculate this cost. To date this stands at circa £2m per annum and will form part of the risk assessment to be undertaken. Although appropriate use of PPE is set out in the guidance we know from the initial COVID experience that staff anxieties will be heightened with this further change and this may generate over use of PPE which will have to be closely monitored. The real and significant resource challenge will be in further dealing those patients that need to receive surgery and other curative procedures. Our Remobilisation plan sets this it in more detail.

Professor Alex McMahon
Executive Director, Nursing, Midwifery and AHP's
17th September 2020
Alex.mcmahon@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: 4 Country Infection Prevention Control Guidance

Appendix 2: Schematics of Patient Pathways

Appendix 3: Healthcare COVID Remobilisation including Social Distancing Diagrams

Appendix 4: Staff Communications

COVID-19 Guidance for the Remobilisation of Services within Health and Care settings:

Infection Prevention and Control recommendations August 2020

Version History

Version	Date	Summary of changes
1.0	04/08/20	Final version for publication

Key messages:

1. This guidance supersedes the COVID-19 UK IPC guidance (18th June 2020) as we move from a period of high community and hospital prevalence/incidence into a period of low prevalence/incidence with isolated outbreaks identified by each country.

2. Local and national prevalence and incidence data will be used to guide returning services as advised by Country specific/public health organisations.

3. **Patients to be managed in three COVID-19 pathways:**

    a. **High risk:** There is no change in recommendations for IPC or for the use of PPE by staff when managing patients who have, or are likely to have, COVID-19

    b. **Medium risk:** This includes patients who have no symptoms of COVID-19 but do not have a COVID-19 SARs- CoV-2 PCR test result

    c. **Low risk:** Patients with no symptoms and a negative COVID-19 SARs- CoV-2 PCR test who have self-isolated prior to admission for example following NICE guidance

4. Sessional use of single use PPE items has been minimised and only applies to extended use of facemasks for healthcare workers.

5. The use of facemasks/face covering in addition to social distancing and hand hygiene for staff, patients and visitors in both clinical and non-clinical areas (in England and Scotland) to further reduce transmission risk.

6. Physical distancing of 2 metres is considered standard practice in all health and care settings.

7. Patients on a low risk pathway require Standard Infection Prevention & Control Precautions for surgery or procedures.

8. This document applies to all health and care settings including acute, diagnostics, independent sector, mental health and learning disabilities, primary care, care homes, maternity and paediatrics (this list is not exhaustive).

9. This guidance will be updated in line with service need and as the evidence evolves the administrative measures outlined in the guidance are consistent with WHO guidance.

Contents

1. Introduction

1.1 Scope and purpose

This document sets out the infection prevention and control (IPC) advice for health and care organisations as the UK moves to remobilise healthcare services.

This document applies to all health and care settings, including the independent sector for example mental health and learning disabilities, primary care areas, care homes, maternity and paediatrics (this list is not exhaustive, please refer to specific country resources for setting specific guidance). It includes key IPC control recommendations; this includes risk assessed patient pathway scenarios to help guide the implementation of measures to provide safe and effective care locally and is based on the best available evidence.

This revised guidance supersedes the COVID-19 IPC guidance (18th June 2020) on the Gov.UK website and has been drafted to support services to safely restart. The challenge facing the NHS is to remobilise healthcare services and increase NHS capacity whilst providing a safe and equitable service for staff, visitors and patients including those who may present with COVID-19, those who have recovered from COVID-19 and those with no history of COVID-19.

The remobilisation of services requires new ways of working during the continued pandemic and, as COVID-19 becomes endemic; guidance for working in a new healthcare environment will need to be developed and updated based upon emerging evidence, experience and expert opinion.

Whilst this document seeks to ensure a consistent and resilient UK wide approach, some differences in operational details and organisational responsibilities may apply, where current legislation, guidance e.g. clinical definitions, already exists links can be accessed in the resources below.

NB. This document does not provide links throughout the sections, please follow the country specific resources e.g. visiting guidance, testing etc.

IPC COVID-19 resources for:

- England can be found here
- Scotland can be found here
- Wales can be found here
- Northern Ireland can be found here

Further updates may be made to this document as new detail/evidence on COVID-19 emerges and as the pandemic phases/levels change. Link to current Alert Levels

2. Governance and responsibilities

Organisations and employers including NHS Trusts, NHS Boards, Health and Social Care Trusts (Northern Ireland), Local Authorities, Independent Sector providers, through their Chief Executive Officer (CEO) or equivalent must ensure:

- **Monitoring of infection prevention and control practices,** as recommended in this guidance, and ensure that resources are in place to implement good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).
- **Testing and self-isolation strategies** are in place with a local policy for the response if transmission rates of COVID-19 increase.
- **Training in infection prevention and control** measures are provided to all staff, including: the correct use of PPE (including a face fit test if wearing a respirator, filtering face piece (FFP3), and the correct technique for putting on and removing (donning/doffing).
- **Risk assessment(s)** is undertaken for any staff members in at risk or shielding groups, including Black, Asian and Minority ethnic (BAME) staff.
- **Patients at high risk/ extremely high risk of severe** illness are protected from COVID-19. This must include consideration of families and carers accompanying patients for treatments/ procedures.
- **Health and care settings are COVID-19 secure** workplaces as far as practical i.e. that any workplace risk(s) are mitigated maximally for everyone.

DISCLAIMER

Please note that this guidance is of a general nature and that employer should consider the specific conditions of each individual place of work and comply with all applicable legislation including the Health and Safety at Work Act 1974 etc.

When an organisation adopts practices that differ from those recommended/stated in this national guidance, that individual organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment(s) approved through local governance procedures, for example Integrated Care System level, Health Board.

3. Care pathways

These pathways are specific to the COVID-19 pandemic and are **examples** of how organisations may separate COVID-19 risks. Implementation strategies must be underpinned by patient/procedure risk assessment, appropriate testing regimens (as per organisations or country specific) and epidemiological data.

Additional information on specific settings can be found in: NICE (2020) 'COVID-19 rapid guideline: arranging planned care in hospitals and diagnostic services'

Screening and triaging within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases. See Appendix 1 for an example of triage questions. Triage should be undertaken by clinical staff who are trained and competent in the application of the clinical case definition prior to arrival at a care area, or as soon as possible on arrival, and allocated to the appropriate pathway. This should include screening for other infections/multi-drug resistant organisms, including as per national screening requirements.

Infection risk and infection prevention and control precautions e.g. Standard Infection Control Precautions (SICPs) or Transmission Based Precautions (TBPs) must be communicated between care areas.

High-Risk COVID-19 Pathway **Section 9: SICPs & TBPs**	**Medium Risk COVID-19 Pathway** **Section 8: SICPs & TBPs**	**Low Risk COVID-19 Pathway** **Section 6: SICPs**
Any care facility where: a) untriaged individuals present for assessment or treatment (symptoms unknown) OR b) confirmed SARS-CoV-2 (COVID-19) positive individuals are cared for OR c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting test results OR d) symptomatic individuals who decline testing	Any care facility where triaged/ clinically assessed individuals are asymptomatic and are: a) waiting a SARS-CoV-2 (COVID-19) test result and have no known recent COVID-19 contact OR b) where testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR c) asymptomatic individuals who decline testing in any care facility	a) Any care facility where triaged/clinically assessed individuals no symptoms, no known recent COVID-19 contact, who have isolated/shielded AND have a negative SARS-CoV-2 (COVID-19) test within 72 hours of treatment and, for planned admissions, have self-isolated from the point of the test OR b) patients who have recovered from COVID-19 and had at least three consecutive days without fever or respiratory symptoms and a negative COVID-19 test OR c) patients or individuals in any care facility where testing is undertaken regularly (remain negative)
Examples of patient (individual) groups/facilities within these pathways: these lists are not exhaustive.		
• Designated areas within Emergency/Resuscitation Departments. • GP surgeries/walk in centres. • Facilities where confirmed or suspected/symptomatic COVID-19 patients are cared for e.g. ○ emergency admissions to in-patient areas (adult and children). ○ Mental health. ○ Maternity. ○ Critical Care Units. ○ Renal dialysis units.	• Designated areas within Emergency/Resuscitation, GP surgeries and walk-in centres. • Non elective admissions. • Primary care facilities e.g. general dental and general practice. • Facilities where patients are cared for e.g. in-patients; adult and children, Mental health, Maternity, Critical Care Units. • Outpatient depts. including Diagnostics and Endoscopy. • Vaccination clinics. • Care Homes. • Prisons.	• Planned/elective surgical procedures including day cases. • Oncology/chemotherapy patients and/or facilities. • Planned in -patient admissions (adult and children), Mental health, Maternity. • Outpatients including Diagnostics/Endoscopy. • Care homes. • Prisons.

3.1 Administrative measures for the pathways

1. Establish separation of patient pathways and staff flow to minimise contact between pathways. This could include for example, provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas.
    - Hospitals/patient care areas (e.g. ward, clinic, GP practice, care home) may designate, self-contained area(s) or ward(s) for the treatment and care of patients at high, medium and low risk of COVID-19. Temporal separation may be used in clinics/primary care settings.
    - As a minimum in smaller facilities or primary care outpatient settings physical/ or temporal separation of patients/departments at high risk of COVID-19 from the rest of the facility/patients.
2. Ensure that hygiene facilities (IPC measures) and messaging are available for all patients, staff and visitors to minimise COVID-19 transmission such as:
    - Hand hygiene facilities including instructional posters
    - Good respiratory hygiene measures
    - Maintaining physical distancing of 2m at all times (unless wearing PPE due to clinical care)
    - Frequent decontamination of equipment and environment
    - Clear advice on use of face coverings and facemasks by patients, visitors and by staff in non-patient facing areas. This will include:
        - Use of face coverings by all outpatients (if tolerated) and visitors when entering a hospital or GP/dental surgery.
        - Use of a surgical facemask (Type II or Type IIR) by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care, such as when receiving oxygen therapy, to minimise the dispersal of respiratory secretions and reduce environmental contamination.
        - Extended use of facemasks by all staff (England /Scotland) in both clinical and non-clinical areas within the healthcare setting.
        - Where visitors decline to wear face coverings, clinicians should apply clinical judgement and consider if other IPC measures such as physical distancing are sufficient depending on the patient's condition and the care pathway.
3. Where possible and clinically appropriate remote consultations rather than face-to-face should be offered to patients.
4. Ensure restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients, visitors or staff, including patient transfers, communal staff areas (changing rooms/restaurant). As the prevalence/incident rates decline this may not be necessary between pathways providing the IPC measures are maintained.
5. Ensure areas/wards are clearly signposted, using physical barriers as appropriate to ensure patients and staff understand the different risk areas.
6. Ensure local standard operating procedures detail the measures to segregate equipment and staff including planning for emergency scenarios as the prevalence/incidence of COVID-19 may increase and decrease until cessation of the pandemic.
7. Ensure a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital onset cases (staff and patients). Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation.
8. If prevalence/incidence rate for COVID-19 is high where possible, assign teams of medical/nursing and domestic staff to care for individuals in isolation/cohort rooms/areas/pathways. If a member of staff is required to move between sites/hospitals due to the unique function of their role, all IPC measures including physical distancing must be maintained.

9. Providers of planned services should be responsive to local and national prevalence/incidence data on COVID-19 and adapt processes so that services can be stepped-up or down, using weekly COVID-19 surveillance report from the respective countries and depending on the data, the pressure on the healthcare services and local capacity and resources.
10. Safe systems of working including administrative, environmental and engineering controls are an integral part of infection prevention and control measures. Standards for ventilation will apply to specific areas in a healthcare setting e.g. theatres and endoscopy suites.

3.2 Community settings

Areas where triaging for COVID-19 is not possible e.g. community pharmacy:

- Signage at entry points advising of the necessary precautions.
- Staff should maintain 2 metres physical distance with customers / service users, using floor markings, clear screens or wear surgical face masks (Type IIR) where this is not be possible. Patients with symptoms should be advised not to enter the premises.

3.3 Outpatient / primary /day care

- Where possible services should utilise virtual consultation.
- If attending outpatients or diagnostics, service providers should consider timed appointments and strategies' such as asking patients to wait to be called to the waiting area with minimum wait times.
- Patients should not attend if they have symptoms of COVID-19 and communications should advise actions to take in such circumstances for example for patients receiving chemotherapy and renal dialysis.
- Communications prior to appointments should provide advice on what to do if patients suspect they have come into contact with someone who has COVID-19 prior to their appointment.
- Outpatient letters should be altered to advise patients of parking, entrances, IPC precautions and COVID-19 symptoms.
- Patients must be instructed to remain in waiting areas and not visit other parts of the facility.
- Prior to admission to the waiting area, all patients and accompanying persons should be screened for COVID-19 contacts and symptoms and asked to wear a mask / face covering at all times.

4. Standard Infection Prevention Control Precautions (SICPs): all pathways

SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection and are required across ALL COVID-19 pathways.

SICPs must therefore be used by all staff, in all care settings, at all times and for all patients, whether infection is known or not, to ensure the safety of patients, staff and visitors. This section highlights the key measures for the COVID-19 pathways please refer to the practical guide* for additional information on the other elements which remain unchanged.

The elements of SICPs are:

- Patient placement and assessment for infection risk (screening/triaging)
- Hand Hygiene
- Respiratory and cough hygiene
- Personal Protective Equipment **(see below)**
- Safe management of the care environment **(see below)**
- Safe management of care equipment **(see below)**
- Safe management of healthcare linen
- Safe management of blood and body fluids
- Safe disposal of waste (including sharps)
- Occupational Safety: Prevention and exposure management
- Maintaining Social/Physical (term used) distancing (new SICP due to COVID-19)

*Practice guides and literature reviews to support SICPs can be found here for England and Scotland, here for Wales and here for Northern Ireland

4.1 Personal Protective Equipment (PPE)

For the purpose of this document, the term 'personal protective equipment' is used to describe products that are either PPE or medical devices that are approved by the Health and Safety Executive (HSE) and the Medicines and Healthcare products Regulatory Agency (MHRA) as protective solutions in managing the COVID-19 pandemic.

Local or national uniform policies should be considered when wearing PPE.

All PPE should be:

- located close to the point of use (where this does not compromise patient safety, e.g. mental health/learning disabilities). In domiciliary care PPE must be transported in a clean receptacle.
- stored safely and in a clean, dry area to prevent contamination
- within expiry date (or had the quality assurance checks prior to releasing stock outside this date)
- single use unless specified by the manufacturer or as agreed for extended/sessional use including surgical facemasks
- changed immediately after each patient and/or after completing a procedure or task
- disposed into the correct waste stream depending on setting e.g. domestic waste/offensive (non-infectious) or infectious clinical waste
- discarded if damaged or contaminated
- safely doffed (removed) to avoid self-contamination. See here for guidance on donning (putting on) and doffing (removing)
- decontaminated after each use following manufactures guidance if reusable PPE is used, such as non-disposable goggles/face shields/visors.

Gloves must be:

- worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely
- changed immediately after each patient and/or after completing a procedure/task even on the same patient
- never decontaminated with Alcohol Based Hand Rub (ABHR) or soap between use
- double gloving is NOT recommended for routine clinical care of COVID-19 cases.

Aprons must be:

- worn to protect uniform or clothes when contamination is anticipated or likely
- worn when providing direct care within 2 metres of suspected/confirmed COVID-19 cases
- changed between patients and/or after completing a procedure or task.

Full body gowns or fluid repellent coveralls must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids
- worn when undertaking aerosol generating procedures
- worn when a disposable apron provides inadequate cover for the procedure or task being performed
- changed between patients and immediately after completing a procedure or task unless sessional use is advised due to local/national data.

Eye or face protection (including full-face visors) must:

- be worn if blood and/or body fluid contamination to the eyes or face is anticipated or likely – e.g. by members of the surgical theatre team and always during aerosol generating procedures . Regular corrective spectacles are not considered eye protection
- not be impeded by accessories such as piercings or false eyelashes
- not be touched when being worn.

Fluid resistant surgical facemask (FRSM Type IIR) masks must:

- be worn with eye protection if splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa (nose and mouth) is anticipated or likely (Type IIR)
- be worn when delivering direct care within 2 metres of a suspected/confirmed COVID-19 case
- be well-fitting and fit for purpose, fully cover the mouth and nose (manufacturers' instructions must be followed to ensure effective fit and protection)
- not touched once put on or allowed to dangle around the neck
- be replaced if damaged, visibly soiled, damp, uncomfortable or difficult to breathe through.

Surgical face masks Type II must be:

- worn for extended use by healthcare workers when entering the hospital or care setting, a Type IIR is also suitable. Type I are suitable in some settings refer to the guidance.

Head/footwear:

- Headwear is not routinely required in clinical areas (even if undertaking an AGP) unless part of theatre attire or to prevent contamination of the environment such as in clean rooms
- Headwear worn for religious reasons (e.g. turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in e.g. theatres
- Foot/shoe coverings are not required or recommended for the care of COVID-19 cases.

NB. Personal protective equipment may restrict communication with patient groups and other ways of communicating to meet their needs should be considered.

5. Aerosol Generating Procedures: procedures that create a higher risk of respiratory infection transmission

An Aerosol Generating Procedure (AGP) is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route.

This is the list of medical procedures for COVID -19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

- Tracheal intubation and extubation
- Manual ventilation
- Tracheotomy or tracheostomy procedures (insertion or removal)
- Bronchoscopy
- Dental procedures (using high speed devices e.g. ultrasonic scalers/high speed drills
- Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Flow Nasal Oxygen (HFNO)
- High Frequency Oscillatory Ventilation (HFOV)
- Induction of sputum using nebulised saline
- Respiratory tract suctioning
- Upper ENT airway procedures that involve respiratory suctioning
- Upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs
- High speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

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 humidified oxygen, Entonox or medication via nebulisation.

The New and Emerging Respiratory Viral Threat Assessment Group (NERVTAG) advised that during nebulisation, the aerosol derives from a non-patient source (the fluid in the nebuliser chamber) and does not carry patient-derived viral particles. If a particle in the aerosol coalesces with a contaminated mucous membrane, it will cease to be airborne and therefore will not be part of an aerosol. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks. In addition, the current expert consensus from NERVTAG is that chest compressions are not considered to be procedures that pose a higher risk for respiratory infections including COVID-19.

Literature review for AGPS during COVID-19 can be found here:

6. Low Risk Pathway: key principles

This pathway applies to:

a) Individuals triaged/clinically assessed prior to treatment (inpatient/outpatient) with no COVID-19 contacts or symptoms who have isolated/shielded

AND

Patient has had a negative SARS-CoV-2 (COVID-19) test result within 72 hours of care and, for planned admissions, has self-isolated since point of testing

OR

b) Individuals who have recovered from COVID-19 AND have had at least 3 consecutive days without fever or respiratory symptoms AND a negative COVID-19 test result

OR

c) Patients or individuals in any care facility where testing is undertaken regularly (remains negative)

Clinicians should advise people who are at greater risk of getting COVID-19, or having a poorer outcome from it, that they may want to self-isolate for a longer period before a planned procedure. The length of self-isolation will depend on their individual risk factors and requires individualised care and shared decision making.

6.1 Maintaining Physical Distancing

All staff and other care workers must maintain social/physical distancing of 2 metres where possible (unless providing clinical care and wearing PPE).

6.2 Personal Protective Equipment **

Personal Protective Equipment required for SICPs is as follows: this includes the use of a surgical face mask for extended use.

SICPS/PPE (all settings/all patients)	Disposable Gloves	Disposable Apron/Gown	Face masks	Eye/face protection(visor)
If contact with blood and/or body fluids is anticipated	Single use	Single use apron (gown if risk of spraying / splashing)	Surgical mask Type II for extended use* FRSM Type IIR for direct patient care *	Risk assess and use if required for care procedure/task where anticipated blood/body fluids spraying/splashes

*extended use of facemasks in England/Scotland for HCW when in any healthcare facility

**Airborne precautions are NOT required for AGPs on patients in the low risk COVID-19 pathway, providing the patient has no other infectious agent transmitted via the droplet or airborne route.

6.3 Safe management of environment/equipment and blood/body fluids

During the pandemic, the frequency of cleaning of both the environment and equipment in patient areas should be increased to at least twice daily, in particular, frequently touched sites/points.

In the low risk COVID-19 pathway organisations may choose to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants (with the exception of blood and body fluids, where a chlorine releasing agent (or a suitable alternative) solution should be used).

Operating theatres and procedure rooms

Within the low risk COVID-19 pathway, standard theatre cleaning and time for air changes provides appropriate levels of IPC and there is no requirement for additional cleaning or theatre down time unless the patient has another infectious agent that requires additional IPC measures.

6.4 Aerosol Generating Procedures (AGPs): procedures that create a higher risk of respiratory infection transmission

Airborne precautions are NOT required for AGPs on patients in the low risk COVID-19 pathway, providing the patient has no other infectious agent transmitted via the droplet or airborne route.

There is no additional requirement for ventilation or downtime in this pathway, providing safe systems of work, including engineering controls are in place.

Critical care areas: as numbers of COVID-19 cases decline, providing suspected/confirmed COVID-19 cases can be cared for in single rooms or isolation rooms, the department should no longer be classified as an AGP “hot spot” or “high risk area” This should be defined locally depending on prevalence/incidence data and subsequent pathway assigned. This negates the requirement for the routine wearing of airborne PPE including a respirator in the low risk COVID-19 pathway.

Operating theatres: patients in the low risk COVID-19 pathway do not need to be anaesthetised or recovered in the operating theatre if intubation/extubation (AGP) is required.

6.5 Visitors

As outlined in Section 3.1 (2), Hand hygiene and the wearing of a face covering along with social distancing should be promoted/maintained therefore, visitors require no additional PPE.

6.6 Discharge

There is no restriction on patient discharge unless the patient is entering a long-term care facility and testing may be required.

7. Transmission Based Precautions (TBPs)

Transmission Based Precautions (TBP) are **additiona**l measures (to SICPs) required when caring for patients/ individuals with a known or suspected infection such as COVID-19.

Transmission Based Precautions are based upon the route of transmission and include:

a) Contact precautions

Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment). This is the most common route of cross-infection transmission. **COVID-19 can be spread via this route.**

b) Droplet precautions

Used to prevent and control infections spread over short distances (at least 3 feet/1metre) via droplets (>5µm) from the respiratory tract of individuals directly onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. **COVID-19 is predominantly spread via this route and the precautionary distance has been increased to 2 metres.**

c) Airborne precautions

Used to prevent and control infection spread without necessarily having close patient contact via aerosols (≤5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. **COVID-19 has the potential to spread via this route when Aerosol Generating Procedures (AGPs) are undertaken**

Transmission Characteristic

Transmission of SARs-CoV-2 implications for infection prevention precautions is contained within the WHO scientific briefing paper

Literature reviews to support TBPs can be found here

8. Medium Risk Pathway: key principles

This pathway applies to the following

a) any facility where triaged/ clinically assessed individuals are asymptomatic and are waiting a SARS-CoV-2 (COVID-19) test result and have no known recent COVID-19 contact

OR

b) where testing is not required or feasible on asymptomatic individuals and therefore infectious status is unknown

OR

c) asymptomatic individuals who declines testing (care facility)

8.1 Maintaining physical distancing and patient placement

- Maintain physical distancing of 2 metres at all times (unless the member of staff is wearing appropriate PPE to provide clinical care) and advise other patients/visitors to comply.
- Ensure cohorted patients are physically separated from each other e.g. use screens, privacy curtains between the beds to minimise opportunities for close contact, this should be locally risk assessed to ensure patient safety is not compromised.
- Suspected COVID-19 cases (asymptomatic) must be separately isolated (or cohorted where isolation facilities are limited) until results are known.

8.2 Personal Protective Equipment

DROPLET/CONTACT PPE	Disposable Gloves	Disposable Apron/Gown	Face masks	Eye/face protection (visor)
SUSPECTED COVID-19 PATIENTS	Single use	Single use apron (gown required if risk of spraying / splashing)	FRSM Type IIR for direct patient care[1]	Single use or re-usable
AIRBORNE	**Disposable Gloves**	**Disposable Apron/Gown**	**Respirator**	**Eye/face protection (visor)**
WHEN UNDERTAKING AGPS ON SUSPECTED COVID-19 PATIENTS	Single use	Single use gown	FFP3 or Hood for AGPs	Single use or re-usable

[1] FRSM can be worn sessionally if providing care for COVID-19 cohorted patients

8.3 Safe management of care environment/equipment/blood and body fluids

Equipment:

- Patient care equipment should be single-use items where practicable.
- Reusable (communal) non-invasive equipment should be allocated to an individual patient or cohort of patients.
- All reusable (communal) non-invasive equipment must be decontaminated:
  - between each patient and after patient use;
  - after blood and body fluid contamination; and
  - at regular intervals as part of equipment cleaning.
- Decontamination of equipment must be performed using either:
  - A combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
  - A general-purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm av.cl.

- Alternative cleaning agents/disinfectant products may be used with agreement of the local Infection Prevention and Control Team/HPT.

Environment

- Cleaning of care equipment as per manufacturers guidance/instruction and recommended product "contact time" must be followed for all cleaning/disinfectant solutions/products
- An increased frequency of decontamination should be considered for all reusable non-invasive care equipment when used in isolation/cohort areas.
- The use of fans in high and medium risk pathways should be risk assessed. Refer to Estates guidance
- Cleaning frequencies of the care environment in COVID-19 care areas must be enhanced and single rooms, cohort areas and clinical rooms (including rooms where PPE is removed) cleaned at least twice daily
- Routine cleaning must be performed using either:
    - A combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
    - A general-purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm av.cl.
- Alternative cleaning agents/disinfectant products may be used with agreement of the local Infection Prevention and Control Team/HPT.
- If there are clusters or outbreaks of COVID-19 (two or more cases linked by time and place) with significant respiratory symptoms in communal settings this frequency should be increased to a minimum of twice daily.
- The increased frequency of decontamination/cleaning should be incorporated into the environmental decontamination schedules for all COVID-19 areas, including where there may be higher environmental contamination rates, including for example:
    - toilets/commodes particularly if patients have diarrhoea;
    - “frequently touched” surfaces such as medical equipment, door/toilet handles, locker tops, patient call bells, over bed tables, bed rails, phones, lift buttons/communal touch points and communication devices (e.g. mobile phones, tablets, desktops, keyboards) particularly where these are used by many people, should be cleaned at least twice daily with solution of detergent and 1000ppm chlorine or an agreed alternative when known to be contaminated with secretions, excretions or body fluids;
- Dedicated or disposable equipment (such as mop heads, cloths) must be used for environmental decontamination.
- Reusable equipment (such as mop handles, buckets) must be decontaminated after use with a chlorine-based disinfectant or locally agreed disinfectant.
- Single (isolation) rooms must be terminally cleaned as above following resolution of symptoms, discharge or transfer (this includes removal and laundering of all curtains and bed screens).

8.4 Aerosol Generating Procedures (AGPs) procedures that create a higher risk of respiratory infection transmission

AGPs should only be carried out when essential and only staff who are needed to undertake the procedure should be present, wearing airborne PPE/ RPE precautions (See section 9: High Risk Pathway).

Critical care areas: Droplet precautions apply. However, consideration may need to be given to the application of airborne precautions where the number of cases of suspected/confirmed COVID-19 requiring AGPs increases and patients cannot be managed in single or isolation rooms.

Operating Theatres: should anaesthetise and recover patients in the operating theatre if intubation/extubation (AGP) is required. For local, neuraxial or regional anesthesia the patient is not required to be anaesthetised/ recovered in theatre.

8.5 Duration of transmission based precautions

Transmission based precautions should only be discontinued in consultation with clinicians and should take into consideration patient test results and clinical symptoms. If test results are not available (for example the patient declines) TBPs can be discontinued after 10 days (inpatients) depending on contact exposure and providing the patient remains symptom free.

8.6 Visitor guidance

Visiting has been limited during the peak of the pandemic however as cases decline and restrictions ease, visitors should be permitted to enter the facility and be educated in the infection prevention and control measures required as outlined in Section 3. Point 7.

This include accompanying individuals when attending outpatient appointments such as, antenatal appointments and therapy groups.

8.7 Discharge / Transfer

There is no restriction on discharge if the patient is well, unless the patient is entering a long-term facility and testing may be required.

Advice on any self-isolation post discharge will be provided by the clinician if this is required.

Discharge information for patients should include patient understanding of their need for any self-isolation and/or quarantine, as well as their family members.

Ambulance services and the receiving facilities must be informed of the infectious status of the individual.

9. High Risk Pathway: key principles

This pathway applies to any emergency/urgent care facility where:

a) untriaged individuals present for assessment or treatment (symptoms unknown*)

OR

b) confirmed COVID-19 positive patients are cared for

OR

c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a (COVID-19 case) who have been triaged / clinically assessed and are waiting test results

*Once assessed, if asymptomatic with no contact history, patients may move to the Medium risk pathway awaiting test result.

9.1 Patient placement

- If the patient has symptoms or a history of contact with a case, they should be prioritised for single room isolation until their test results are known **OR** cohorted (if an isolation room is unavailable) until the result are known. e.g. use privacy curtains between bed spaces to minimise opportunities for close contact between patients. This should be locally risk assessed to ensure this does not compromise patient safety.
- If single rooms are in short supply, priority should be given to patients with excessive cough and sputum production, diarrhoea or vomiting and to those in the high risk/extremely high risk of severe illness.
- Local risk assessments and clinical decisions must be made regarding placement of surgical patients with availability of single rooms taken into consideration.

9.2 Personal Protective Equipment

DROPLET/CONTACT PPE	Disposable Gloves	Disposable Apron/Gown	Face masks	Eye/face protection (visor)
IF SUSPECTED/ CONFIRMED COVID-19 PATIENT	Single use	Single use apron (gown required if risk of spraying / splashing)	FRSM Type IIR for direct patient care[1]	Single use or re-usable
AIRBORNE*	**Disposable Gloves**	**Disposable Apron/Gown**	**Respirator**	**Eye/face protection (visor)**
WHEN UNDERTAKING AGPS ON CONFIRMED OR SUSPECTED COVID-19 PATIENTS	Single use	Single use gown	FFP3 or Hood for AGPs	Single use or re-usable

[1] FRSM can be worn sessionally if providing care for COVID -19 cohorted patients

*Consideration may need to be given to the application of airborne precautions where the number of cases of COVID-19 requiring AGPs increases and patients cannot be managed in single or isolation rooms.

Respiratory protective equipment (RPE) FFP3 (filtering face piece or hood):

Respirators are used to prevent inhalation of small airborne particles arising from AGPs.

- Respirators should:
  - be well fitting, covering both nose and mouth
  - always worn when undertaking an AGP on a COVID-19 confirmed or suspected patient

- not be allowed to dangle around the neck of the wearer after or between each use
- not be touched once put on
- be removed outside the patient room or cohort area or COVID-19 ward

- Respirators can be single use or single session use (disposable or reusable) and fluid-resistant.
- Valved respirators are not fully fluid-resistant unless they are also 'shrouded'. Valved non-shrouded FFP3 respirators should be worn with a full-face shield if blood or body fluid splashing is anticipated.
- All staff who are required to wear an FFP3 respirator must be fit tested for the relevant model to ensure an adequate seal or fit (according to the manufacturers' guidance). Fit checking (according to the manufacturers' guidance) is necessary when a respirator is put on (donned) to ensure an adequate seal has been achieved.
- Where fit testing fails, suitable alternative equipment must be provided, or the healthcare worker moved to an area where FFP3 respirators are not required.
- Respirators should be compatible with other facial protection used (protective eyewear) so that this does not interfere with the seal of the respiratory protection.
- The respirator should be discarded and replaced and NOT be subject to continued use if the facial seal is compromised, it is uncomfortable, or it is difficult to breathe through.
- Reusable respirators can be utilised by individuals if they comply with HSE recommendations. Reusable respirators should be decontaminated according to the manufacturer's instructions.

Literature on RPE can be found here

Full body gowns or fluid repellent coveralls must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids;
- worn when undertaking aerosol generating procedures;
- worn when a disposable apron provides inadequate cover for the procedure or task being performed;
- changed between patients and immediately after completing a procedure or task unless sessional use is advised due to local/national data.

9.3 Safe management of care environment/equipment/blood and body fluids

Please refer to Section 8.3

9.4 Aerosol Generating Procedures that create a higher risk of respiratory infection transmission and Operating Theatres (including day surgery)

Critical Care: Droplet precautions would apply however, consideration may need to be given to the application of airborne precautions where the number of cases of COVID-19 requiring AGPs increases and patients cannot be managed in single or isolation rooms.

Operating Theatres: Patients should be anaesthetised and recovered in the theatre if intubation/extubation (AGP) is required using airborne precautions. This is not required for regional, neuraxial or local anaesthesia.

Ventilation in both laminar flow and conventionally ventilated theatres should remain fully on during surgical procedures where patients have suspected/confirmed COVID-19. Air passing from operating theatres to adjacent areas will be highly diluted and is not considered to be a risk.

9.5 Duration of precautions

Patients should remain in isolation/cohort with TBPs applied for at least 10 days after onset of symptoms and at least three consecutive days without a fever or respiratory symptoms. For asymptomatic patients, TBPs may be discontinued 10 days after initial positive result. The decision to modify the duration of, or 'stand down' TBPs (Contact/Droplet/Airborne) should be made by the clinical team managing the patient(s) care.

Step down of TBPs for COVID-19 for home discharge may require some individual clinical assessment at local level depending on the severity of the disease and underlying conditions, including testing requirements.

9.6 Visitor guidance

In this pathway, visiting should continue to be limited to only essential visitors e.g. birthing partner, carer/parent/guardian.

The need for visitors to wear PPE should be assessed.

9.7 Discharge/Transfer

Discharge from an inpatient facility can occur when the individual is well enough with advice for self -isolation post discharge provided by the clinician, which may include:

- Self-isolation for 14 days from the date of SARS-CoV-2 PCR test (providing symptoms resolve).
- Individuals with underlying health conditions, severe disease or in a care facility may be required to isolate for a longer period e.g. 14 days (providing symptoms resolve).

Discharge to another care area may be dependent on testing and/or isolation facilities available.

Discharge information for patients should include the patients understanding of their need for any self-isolation as well as their family members.

Ambulance services and the receiving facilities must be informed of the infectious status of the individual.

Appendix 1. Sample triage tool

Example of triage questions for COVID-19
If No to all questions proceed with treatment/testing and follow low risk pathway.

	YES	NO
1. Do you or any member of your household/ family have a confirmed diagnosis of COVID-19? If yes wait the agreed period of time depending on date of onset (7-14 days) before treatment or if urgent care is required, follow the High/Medium pathway.		
2. Are you or any member of your household/family waiting for a COVID-19 test result? If yes ascertain if treatment can be delayed until results are known. If urgent care is required, follow the High/Medium risk pathway.		
3. Have you travelled internationally in the last 14 days? If yes, confirm where and if this is a country that has been agreed as safe for travel by the government, if this is not on the list then 14 days quarantine will apply. If urgent care is required, follow the High/Medium risk pathway.		
4. Have you had contact with someone with a confirmed diagnosis of COVID-19, or been in isolation with a suspected case in the last 14 days? If yes wait the agreed period of time depending on what date of the isolation period the patients is at (ideally, 14 days) before treatment or if urgent care is required, follow High/Medium risk pathway.		
5. Do you have any of the following symptoms? • High Temperature or Fever • New, Continuous Cough • A loss or alteration to taste or smell If yes provide advice on who to contact GP/NHS111 or, if admission required, follow High/Medium risk pathway		

RED PATHWAY – ALL CARE SETTINGS

RED PATHWAY – HIGHEST RISK

COVID +ve/Suspected

1. Confirmed +ve (community)
2. Symptomatic (meets case definition)
3. Symptomatic (clinical suspicion)
4. Symptomatic (case contact)
5. Care home resident (ongoing outbreak in home)

Patient Placement

- **Suspected cases – test pending**: ISOLATE or COHORT (only if isolation not available) -2M physical distancing required
- **Confirmed cases:** ISOLATE or COHORT with other confirmed COVID +ve pts only
- **Suspected cases -test negative**– Move to Amber high risk path -ISOLATE if -ve **AND** alternative infection diagnosis **OR** cohort with others based on organism (e.g. Flu cohort, RSV cohort)
- COHORT as per Amber high risk path if -ve and alternative diagnosis excludes infection and no other indication for isolation

Ward based management*

- ALL staff to wear FRSM all times
- Maintain 2M physical distancing
- Apron -within 2M of patient
- Gloves - within 2M of patient
- Eye protection - within 2M of patient
- FFP3 for all ward based AGP
- Limit Patient visiting – face covering & 2M physical distance
- Patients to use face masks (if tolerated) when not seated/lying
- Equipment cleaning – chlorine 1000ppm
- Domestic cleaning –full clean twice daily with chlorine 1000ppm
- Terminal clean –all spaces/rooms

*see surgical path for theatre management

RED PATHWAY – HIGH RISK

Asymptomatic contact of confirmed case

Patient Placement

Isolate from RED HIGHEST RISK patients

DO NOT COHORT (unless with existing in-patient cohort from the same exposure e.g. new +ve in multibed Amber room)

Maintain full ward based precautions 14 days even if COVID test -ve in this period

If contact tests +ve – continue to ISOLATE or COHORT in **Red Covid cohort**

Ward based management*

- ALL staff to wear FRSM all times
- Maintain 2M physical distancing
- Apron -within 2M of patient
- Gloves - within 2M of patient
- Eye protection - within 2M of patient
- FFP3 for all ward based AGP
- Limit Patient visiting – face covering & 2M physical distance
- Patients to use face masks (if tolerated) when not seated/lying
- Equipment cleaning – chlorine 1000ppm
- Domestic cleaning –full clean twice daily with chlorine 1000ppm
- Terminal clean –all spaces/rooms

*see surgical path for theatre management

ALL NON SURGICAL ADMISSIONS– ALL SETTINGS

NO

Patient has a negative COVID test result (this admission)

YES

MEDIUM RISK AMBER PATHWAY

LOWER RISK AMBER PATHWAY

Patient placement

Assess patient for isolation need – prioritise in rank order:

- Alert infection
- Ward based AGP planned
- Shielding patient
- BAME patient

Cohort/patient placement based on clinical need & capacity as per standard practices

Cohort other alert organism cases (e.g. Flu)

Aim to meet 2M physical distancing at all times – reduce only on risk assessment

Patient Placement

Assess patient for isolation need – prioritise in rank order:

- Alert infection
- Ward based AGP planned
- Shielding patient
- BAME patient

Cohort/patient placement based on clinical need & capacity as per standard practices

Cohort other alert organism cases (e.g. Flu)

Aim to meet 2M physical distancing at all times – reduce only on risk assessment

Ward based management

- ALL staff to wear FRSM all times
- Apron -on risk assessment/task
- Gloves -on risk assessment/task
- Eye protection -on risk assessment/task
- FFP3 for all ward based AGP
- Patient visiting permitted – face covering & 2M physical distance
- Aim to maintain 2M physical distance for patients at all times
- Patients to use face masks (if tolerated) when not seated/lying
- Domestic cleaning –full twice daily with detergent (chlorine in sanitary areas) - in-patient areas. Reduce as per amber low risk path only on risk assessment
- Equipment cleaning – detergent between each use
- Discharge clean – unless other 'alert infection' (e.g. MRSA) present

Ward based management

- ALL staff to wear FRSM all times
- Apron -on risk assessment/task
- Gloves -on risk assessment/task
- Eye protection -on risk assessment/task
- FFP3 for all ward based AGP
- Patient visiting permitted – face covering & 2M physical distance
- Aim to maintain 2M physical distance for patients at all times
- Patients to use face masks (if tolerated) when not seated/lying
- Domestic cleaning – minimum daily clean PLUS 2nd high touch surface clean /check clean – detergent (chlorine in sanitary areas)
- Equipment cleaning – detergent between each use
- Discharge clean – unless other 'alert infection' (e.g. MRSA) present

Elective (planned) surgical pathway (GREEN)

Patient has self-quarantined 14 days **AND** COVID test negative within 72 hours of surgery **AND** maintained quarantine from test date

Patient Placement

Assess patient for isolation need – prioritise in rank order:

- Alert infection
- Shielding patient
- BAME patient

Cohort/patient placement based on clinical need & capacity as per standard practices

Minimum 1M physical distancing at all times

Surgical management

Follow 'standard' perioperative care & management (use of all theatre spaces)

Green (Elective) theatre list & staff

No requirement for FFP3 unless ALERT organism risk as per APPX 11

Ward based management

- Follow SICPs at all times
- ALL staff to wear FRSM all times
- Follow TBPs as per NIPCM where indicated (Alert organism)
- Domestic cleaning – minimum daily clean PLUS 2nd high touch surface clean /check clean – detergent (chlorine in sanitary areas)
- Patient visiting NOT permitted – pre-operative patients
- Patient visiting post-operative -face covering & 2M physical distance
- Aim to provide 2M distance – risk assess & apply mitigation
- Provide patients with face mask if requested

All other surgery pathway (AMBER)

Patient **HAS NOT** self-quarantined 14 days - irrespective of test results

Patient Placement

Assess patient for isolation need – prioritise in rank order:

- Alert infection
- Ward based AGP planned
- Shielding patient
- BAME patient

Cohort/patient placement based on clinical need & capacity as per standard practices

Cohort other alert organism cases (e.g. Flu)

Aim to meet 2M physical distancing at all times – reduce only on risk assessment

Surgical management

Induction of anaesthetic – in theatre

Recovery – in theatre

Amber/Red theatre list & staff

FFP3 & full PPE ensemble required -all AGP (refer to Surgical/Theatre guidance)

Ward based management

- ALL staff to wear FRSM all times
- Apron -on risk assessment/task
- Gloves -on risk assessment/task
- Eye protection -on risk assessment/task
- FFP3 for all ward based AGP
- Patient visiting permitted – face covering & 2M physical distance
- Aim to maintain 2M physical distance for patients at all times
- Patients to use face masks (if tolerated) when not seated/lying
- Domestic cleaning –full twice daily with detergent (chlorine in sanitary areas) - in-patient areas.
- Equipment cleaning – detergent between each use
- Discharge clean – unless other 'alert

NHS Scotland COVID-19 remobilisation –Built Environment incl. social distancing support diagrams -28 Aug 20

- Scottish Government www.gov.scot/collections/coronavirus-covid-19-guidance/
- Health Protection Scotland (HPS) www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/infection-prevention-and-control-ipc-guidance-in-healthcare-settings/
- UK Government www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control
- National Institute for Health and Care Excellence (NICE) https://www.nice.org.uk/covid-19
- Healthcare Improvement Scotland (HIS) www.healthcareimprovementscotland.org/our_work/coronavirus_covid-19
- World Health Organisation (WHO) www.who.int/.../technical-guidance & www.who.int/.../sars-cov-2-implications-for-infection-prevention
- European Agency for Safety & Health at Work (OSHi) https://osha.europa.eu/en
- Health & Safety Executive (HSE) www.hse.gov.uk/coronavirus/social-distancing/index.htm
- Hierarchy of Risk Controls //en.wikipedia.org/wiki/Workplace_hazard_controls_for_COVID-19 & www.youtube.com/watch?v=FyBMpdaEaD4
- Designing facilities: www.designingbuildings.co.uk/wiki/Coronavirus_and_the_construction_industry & www.cibse.org/Coronavirus-(COVID-19)
- NHSScotland NSS supporting info in msTeam: NSS - HFS/ARHAI Covid-19 FAQs and Supporting Documentation

> *"In indoor places and where physical distancing is difficult and where there is a risk of contact within 2m with people who are not members of your household, you are expected to wear a face covering".*
>
> *"Physical distancing, hand hygiene and respiratory hygiene are the most important and effective things we can all do to prevent the spread of coronavirus. The wearing of face coverings must not be used as an alternative to any of these other precautions".*

www.gov.scot/publications/coronavirus-covid-19-phase-3-staying-safe-and-protecting-others/pages/face-coverings/ (24 Aug 2020)

> "The extended use of face masks does not remove the need for other key *bundles* of measures to reduce the risk of transmission of SARS-CoV-2, including social/physical distancing, optimal hand hygiene, frequent surface decontamination, ventilation and other measures where appropriate. Reliance on individual (as opposed to bundles of) measures to reduce the risk of virus transmission is not sufficient."

www.gov.uk/government/publications/.../new-government-recommendations-for-england-nhs-hospital-trusts-and-private-hospital-providers (21 Aug 2020)

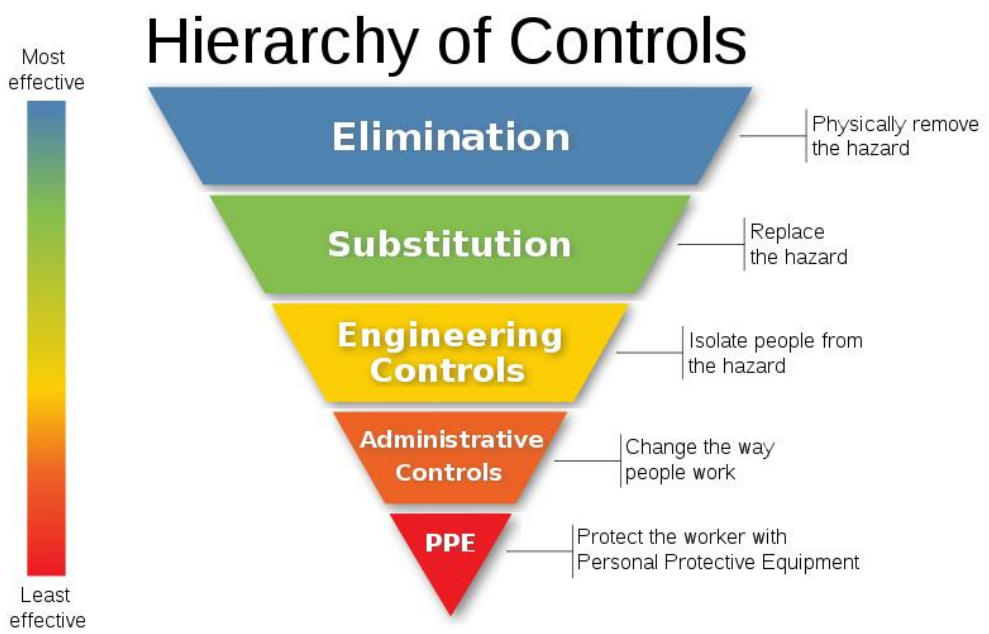
> *"The use of face masks (for staff) or face coverings[1] (England and Scotland) is recommended in addition to social distancing and hand hygiene for staff, patients/individuals and visitors in both clinical and non-clinical areas to further reduce the risk of transmission. ([1]You must wear a face covering by law in some public places unless you are exempt…)"*
>
> *"The IPC principles in this document apply to all health and care settings including acute, diagnostics, independent sector, mental health and learning disabilities, primary care, care homes, care at home, maternity and paediatrics (this list is not exhaustive)."*

//assets.publishing.service.gov.uk/government/.../COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf (21 Aug 2020)

Built Environment: considerations for application of the above COVID Infection Prevention Control (IPC) Guidance (21 Aug 20)

Manage transmission risk by **Hierarchy of Risk Control** as legislated in Management of Health and Safety at Work Regulations 1999, Regulation 4, Schedule 1.

- Elimination: e.g. clinical consultations via secure telephone or video; staff working from home.
- Substitution: e.g. outdoor / drive-in clinics for testing; move staff to non-patient facing role;
- Engineering: e.g. single room patient placement; 2m / 6ft social distancing; appropriate ventilation /dilution incl. open windows/ doors; technology to reduce length-of-stay (LoS)/ occupancy/ direct staff contacts;
- Administration: e.g. processes to reduce LoS etc incl opening times; improved cleaning incl fallow times after AGPs; pathways and signage
- Personal Protection: e.g. face covering; hand hygiene; cough hygiene; PPE



Hierarchy of Risk Controls graphic //commons.wikimedia.org/index.curid=90190143
(original version: NIOSH Vector version: Michael Pittman)

People have differing levels of susceptibility and severity; 3 risk groups defined

- Standard (or Lower)- no evidence of additional risk
- Higher- an increased risk e.g. age, obesity, diabetes, pregnancy, ethnicity
- Highest- e.g. cystic fibrosis, renal dialysis, severely immune compromised

Care Zones: UK COVID **High**; **Medium**; and **Low** risk in Care pathways and Standard infection prevention control precautions (SICPs) - all pathways. Diagrams support all 3 care zones/ pathways. IPC AGPs guidance to take precedence

Social distancing is not an isolated factor for COVID transmission control. It is one of many **compounding factors** to be managed in-concert. These include:

- Placement x Social distancing (Proximity x Direction) x Contact time x Ventilation dilution x Vocal projection x Hand hygiene x Face covering x Surface cleaning

Assumptions: mouth, nose & eyes are a COVID transmission key source and receiver. Diagrams show ergonomic Head zone: 0.5m dia circle/person. Plus assume

- Health & care patients to wear face coverings whilst inside, unless exempt, or for agreed task e.g. sleep, rest, washing, drinking, eating, whilst socially distant.
- Health & care facility visitors minimised and to wear face coverings whilst inside, unless exempt; www.gov.scot/.../covid-19-hospital-visiting-guidance/.
- Check Ventilation maintained & operated appropriately, e.g. if Mechanical, clean and confirm at correct airflow, if Natural ventilation check windows, trickle vents etc are operable and utilised. By law, all occupied space must have operable ventilation (Health & Safety at Work Act etc); COVID re-emphasised this.
- Environmental psychology- deploy intuitive layouts & signs, but be aware risky behaviours can be encouraged by over-familiarity/ engineering overreliance

central aisle ≥ 3000 mm

≥ 2500 mm to centre of table / desk

Fig 1A - Corner desk/ table layout:

KEY: Social Spacing:

Any Person in health & care facility (red)
MUST wear a Face Covering unless exempt

A Person exempt for agreed purpose (green)
e.g. sleep, rest, washing, drinking, eating, and
MUST be recumbent/ sitting/ stationary

Inner circle or head zone /person
(**0.5m Dia** / 0.25m Radius)
(blue dotted)

Outer circle /person
(**2.5m Dia** / 1.25m Radius)
(blue dashed)

Physical distancing between persons
(**2m Dia** / 1m Radius)
(green dashed)

Room/ space/ area (dark blue broken)

Partition / screen (dark blue)

Assumes ANY person likely to move within **<2m/ 6ft** of another person wears a Face Covering
Area Calculation of blue outer circle: $\prod R^2$ = 3.14 x 1.25 x 1.25 = min **~5 m²** / person
Room/ space: circa **20 m²** / **4** people (shown 4.5 x 4.4 m & shaded 1.6 x 0.75 m desk /table)
[central aisle **≥3m** shown; to allow non-face-cover movement ≥ 5.5m i.e. min = ~**7 m²** / person]
Layout 1A, with persons facing away, is preferred for Social distancing i.e. Proximity x Direction

Diagram 1A: Corner desk/ table layout

~ 3000 mm to centre of table / desk

central aisle ~ 2750 mm

Fig 1B - Corner desk/ table layout

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A Person exempt for agreed purpose (green)
e.g. sleep, rest, washing, drinking, eating, and
MUST be recumbent/ sitting/ stationary

Inner circle or head zone /person
(**0.5m Dia** / 0.25m Radius)
(blue dotted)

Outer circle /person
(**2.5m Dia** / 1.25m Radius)
(blue dashed)

Physical distancing between persons
(**2m Dia** / 1m Radius)
(green dashed)

Room/ space/ area (dark blue broken)

Partition / screen (dark blue)

Assumes ANY person likely to move within **<2m/ 6ft** of another person wears a Face Covering
Area Calculation for 1 person: ~2.9 x ~2.2 m = min **~6 m²** / person
Room/ space: circa **24 m²** / **4** people (shown 6.0 x 4.0 m & shaded 1.6 x 0.75 m desk /table)
[central aisle **~2.75m** shown; to allow non-face-cover movement ≥ 5.25m i.e. min = **~10 m²** / person]

Diagram 1B: Central desk/ table layout

Fig 1C – Desk/ tables with Screens layout

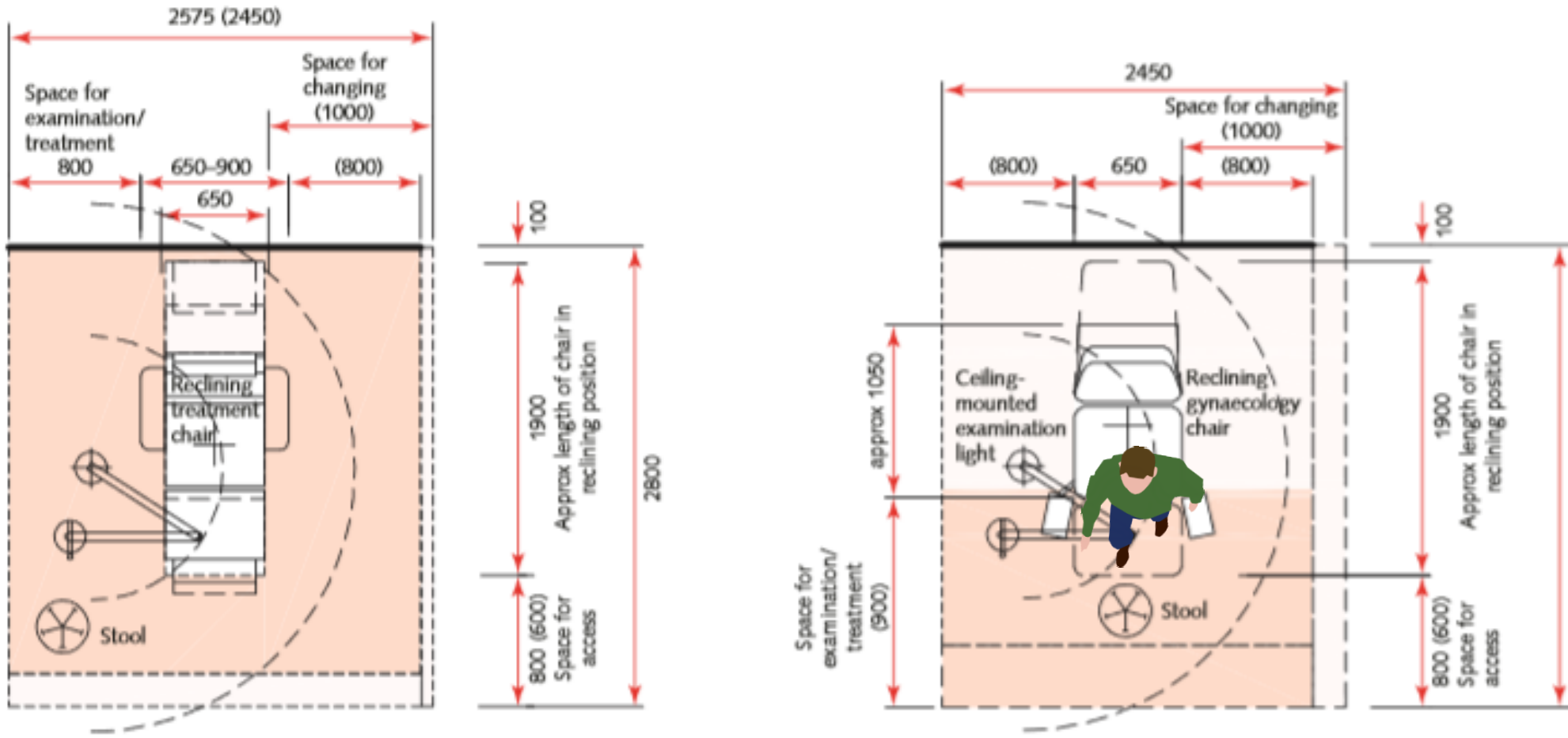
NHS Scotland HBN 00-03: Treatment couch / chair bay layout

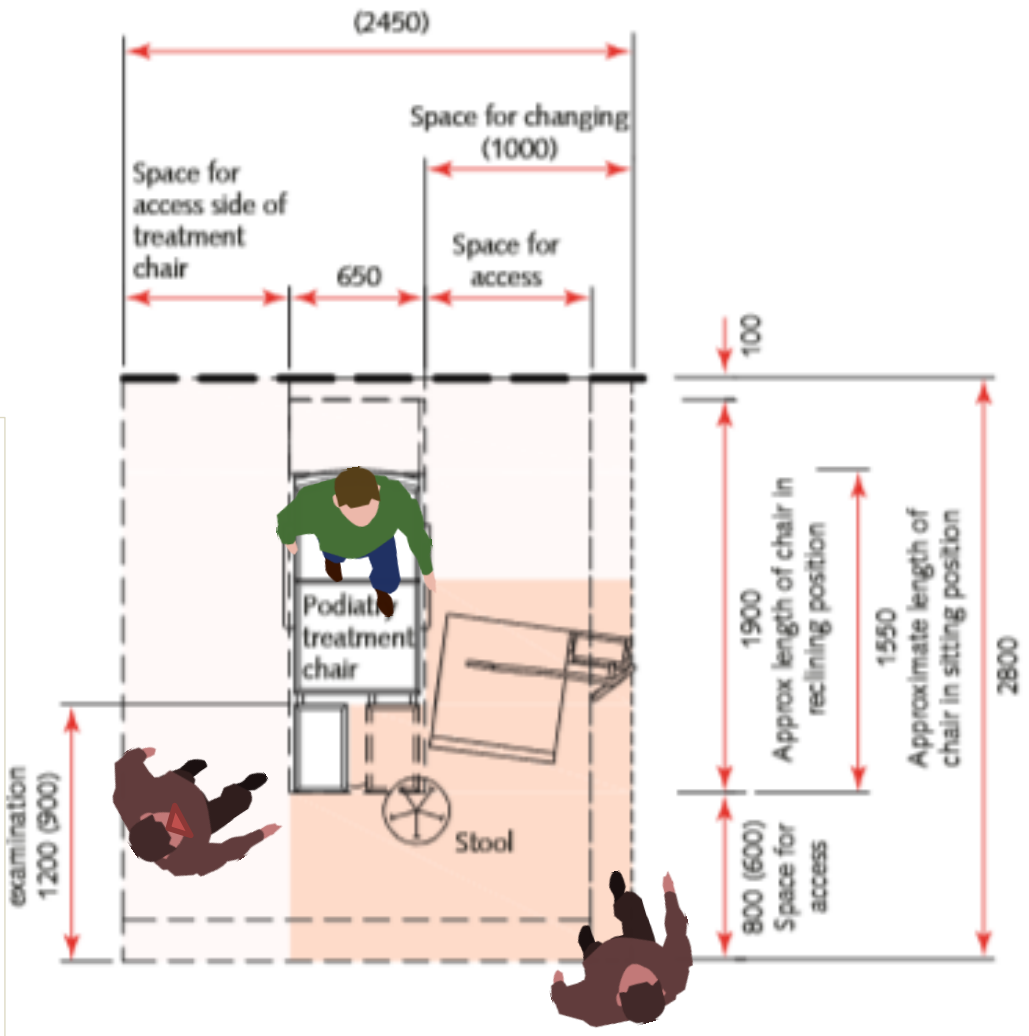
HBN 00-03 states 2.575m preferred, or 2.45m width, each with 2.8m depth. Width is based on a 0.8m space for access either side of chair / couch.
Assume say 0.5m dia for head position allowance on centre line of chair/ couch and starting 0.25m from wall;

- a 2.575m width bay, allows ≥**2.075m** physical distancing to adjacent patient (i.e. ≥ 2m and 6ft)
- a 2.45m width bay, allows ≥**1.95m** physical distancing to adjacent patient (i.e. ≥ 6ft or 1.8m)
- a 2.25m width bay, allows ≥**1.95m** physical distancing to adjacent patient (i.e. ≥ 6ft or 1.8m)
- a 2.8m depth bay plus say a 1.5m aisle, allows **5.5m** physical distancing to patient across aisle; (a 2.6 depth & 1.2m aisle, allows 4.8m distancing)

Extract of Fig 45 is from [Core guidance - Clinical and clinical support spaces (HBN 00-03)]

Figure 45 Space requirements for double-sided access to a variety of treatment chairs





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e.g. sleep, rest, washing, drinking, eating, and
MUST be recumbent/ sitting/ stationary

Inner circle or head zone /person
(**0.5m Dia** / 0.25m Radius)
(blue dotted)

Outer circle /person
(**2.5m Dia** / 1.25m Radius)
(blue dashed)

Physical distancing between persons
(**2m Dia** / 1m Radius)
(green dashed)

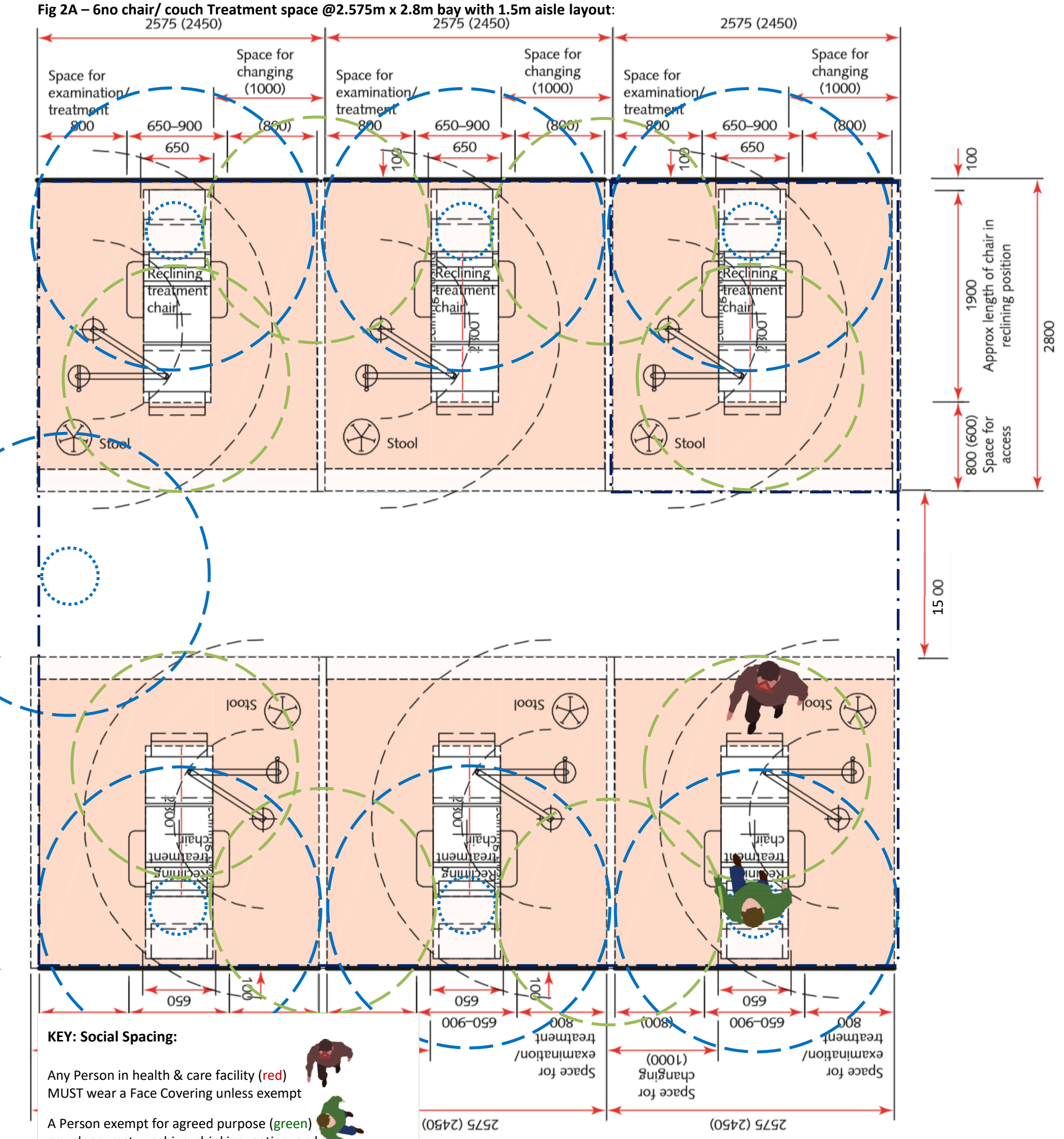
Room/ space/ area (dark blue broken)

Partition / screen (dark blue)

Assumes ANY person likely to move within **<2m/ 6ft** of another person wears a Face Covering
Area Calculation for 1 person bay: 2.575 (or 2.4) x 2.8 (or 2.6) m = **~ 6.5 – 7.5 m²** / bay
Room/ space, incl ≥ 1.2m central aisle: **~ 47 - 55 m²** / **6** patient
[the larger sizes allow non-face-cover movement within central aisle; IF depth = **> 6 m**]

Diagram 2: HBN 00-03 Treatment couch/ chair layout

Fig 2A – 6no chair/ couch Treatment space @2.575m x 2.8m bay with 1.5m aisle layout:



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A Person exempt for agreed purpose (green)
e.g. sleep, rest, washing, drinking, eating, and
MUST be recumbent/ sitting/ stationary

Inner circle or head zone /person
(**0.5m Dia** / 0.25m Radius)
(blue dotted)

Outer circle /person
(**2.5m Dia** / 1.25m Radius)
(blue dashed)

Physical distancing between persons
(**2m Dia** / 1m Radius)
(green dashed)

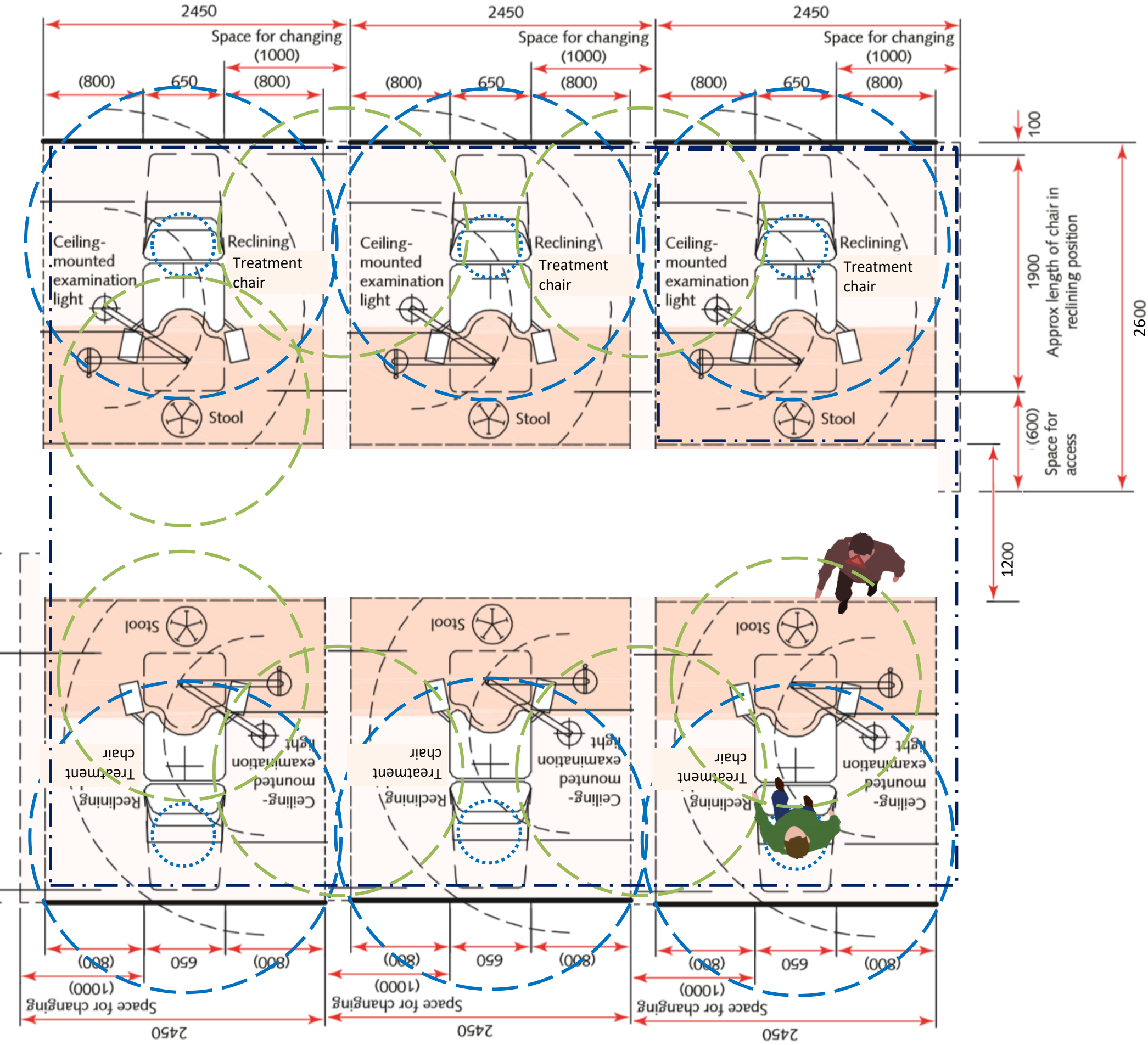
Room/ space/ area (dark blue broken)

Partition / screen (dark blue)

Assumes ANY person likely to move within **<2m/ 6ft** of another person wears a Face Covering
Area Calculation for 1 person bay: 2.575 x 2.8 m = **~7.5 m²** / bay
Room/ space, incl 1.5m central aisle: 7.725 x 7.1 m = **~ 55 m²** / **6** people)
[room depth = **7.1 m**; allows non-face-cover movement, sitting, dining etc within central aisle]

Diagram 2A: 6no chair/ couch Treatment space @2.575m layout

Fig 2B – 6no chair Treatment space @2.45m x 2.6m bay with 1.2m aisle layout:



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e.g. sleep, rest, washing, drinking, eating, and
MUST be recumbent/ sitting/ stationary

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(blue dotted)

Outer circle /person
(**2.5m Dia** / 1.25m Radius)
(blue dashed)

Physical distancing between persons
(**2m Dia** / 1m Radius)
(green dashed)

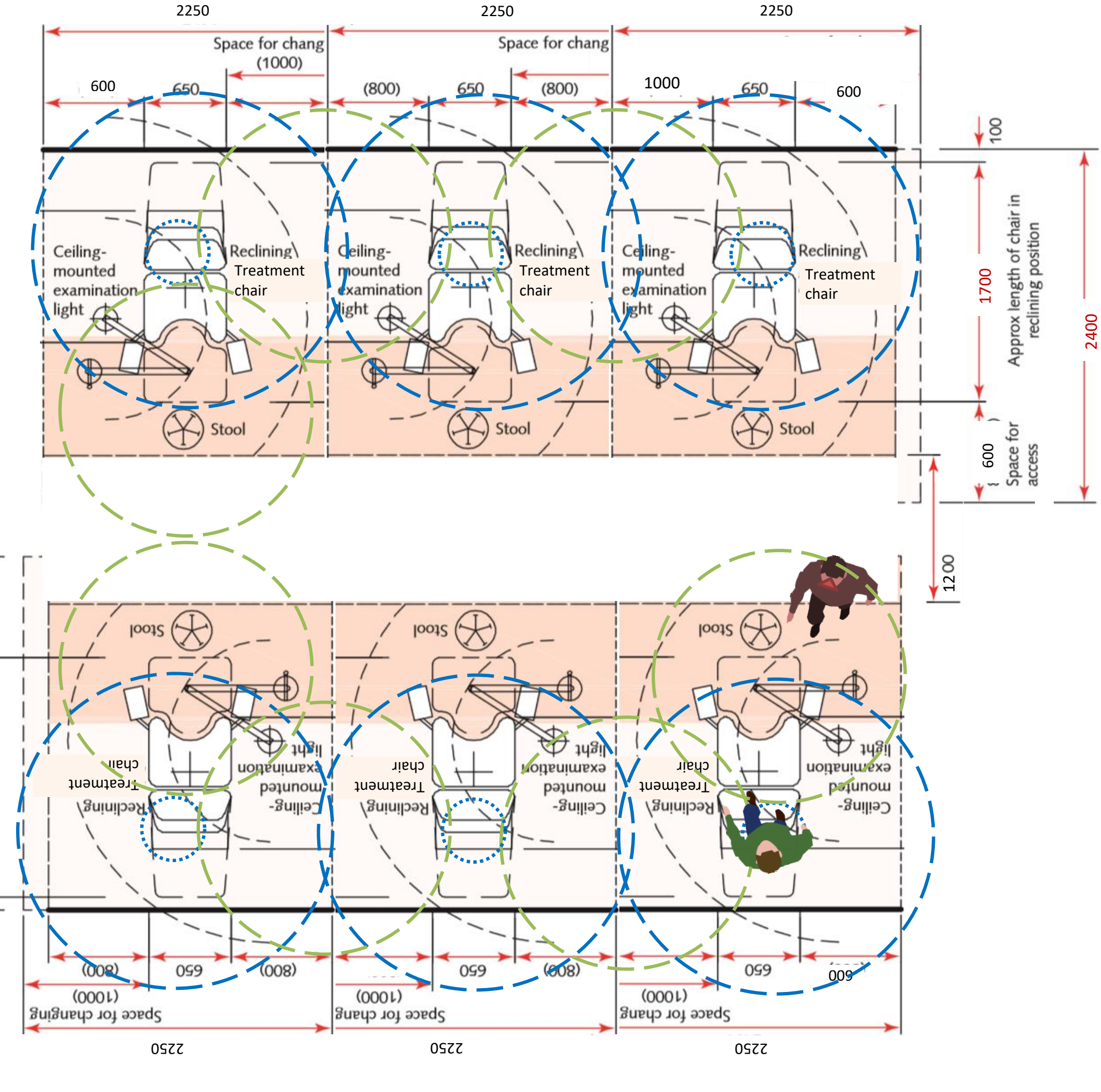
Room / space / area (dark blue)

Partition / screen (dark blue)

Assumes ANY person likely to move within **<2m/ 6ft** of another person wears a Face Covering
Area Calculation for 1 person bay: 2.45 x 2.6 m = **~6.5 m²** / bay
Room/ space, incl ≥ 1.2m central aisle: 7.35 x 6.4 m = **~ 47 m²** / **6** people
[room depth = **6.4 m**; MAY allow non-face-cover movement etc in aisle, dependant on head positions]

Diagram 2B: 6no chair Treatment space @2.45m layout

Fig 2C – 6no chair Treatment space @2.25m x 2.4m bay with 1.2m aisle layout:



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A Person exempt for agreed purpose (green)
e.g. sleep, rest, washing, drinking, eating, and
MUST be recumbent/ sitting/ stationary

Inner circle or head zone /person
(**0.5m Dia** / 0.25m Radius)
(blue dotted)

Outer circle /person
(**2.5m Dia** / 1.25m Radius)
(blue dashed)

Physical distancing between persons
(**2m Dia** / 1m Radius)
(green dashed)

Room / space / area (dark blue)

Partition / screen (dark blue)

Assumes ANY person likely to move within **<2m/ 6ft** of another person wears a Face Covering
Area Calculation for 1 person bay: 2.25 x 2.4 m = **~5.5 m²** / bay
Room/ space, incl ≥ 1.2m central aisle: 6.75 x 6.0 m = **~ 41 m²** / **6** people
[room depth = **6.0 m**; will NOT allow any non-face-cover movement etc in aisle]
[note: recliner chair NOT fully recumbent as depth is reduced to 1.7m]

Diagram 2C: 6no chair/ couch Treatment space @2.25m layout

Fig 2D – 6 - 8no semi-reclining chair Treatment space @2.25m x 2.0m bay with 1.0m aisle layout

8no chairs min area = 9m x 6m = 54m^2 based on Fig 2C layout,
Existing layout of 8no semi-reclining chair treatment space @ 1.7m x 2m bay with 1m aisle in a ~5m x ~7m space
Propose: (i) 6no chair bays or (ii) up to 7no chair bay≤1.5m s, ~ 2.25m x 2.0 with 1m aisle
[A space increase to either 5 x 7.8m or 6 x 7m allows a potential 7th chair drawn in grey]

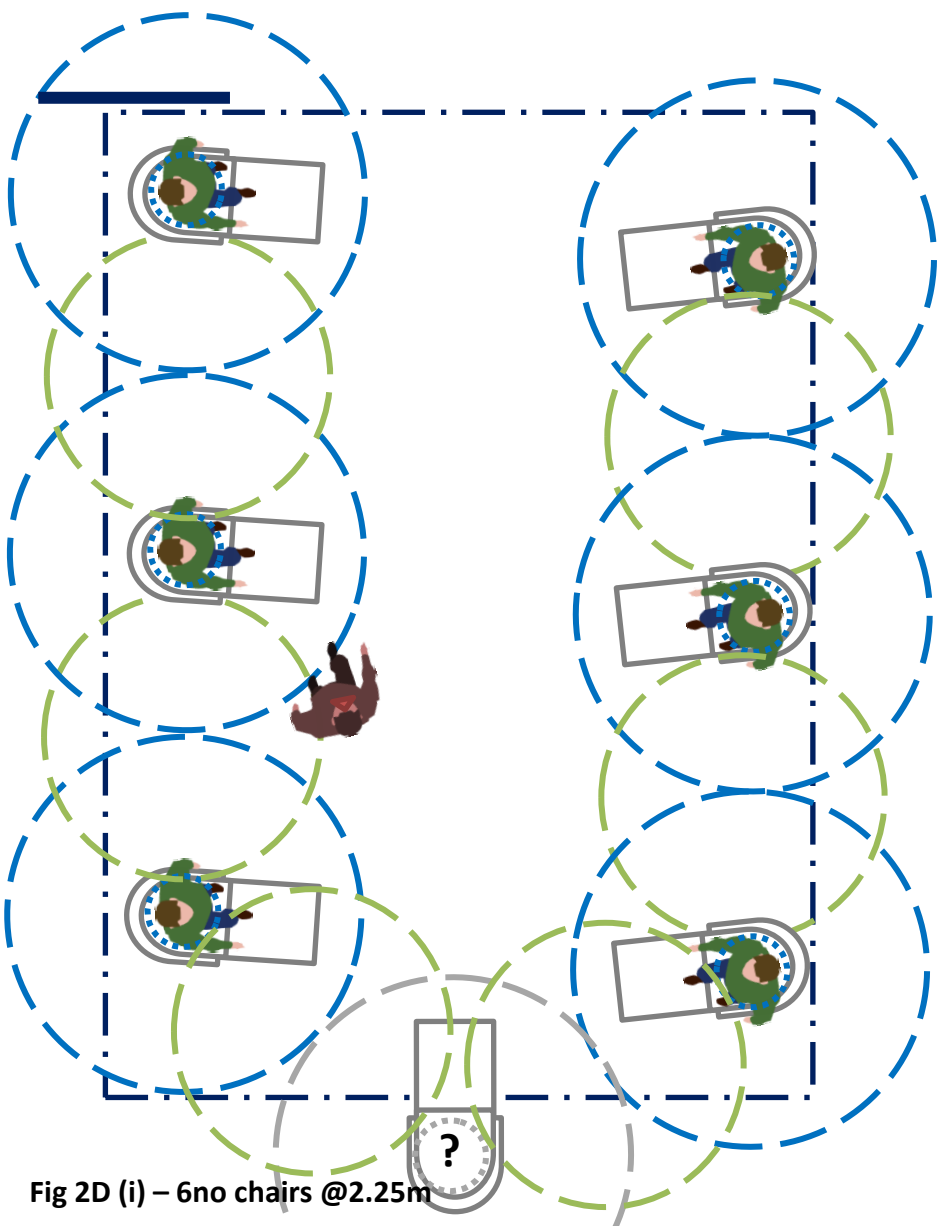


Fig 2D (i) – 6no chairs @2.25m

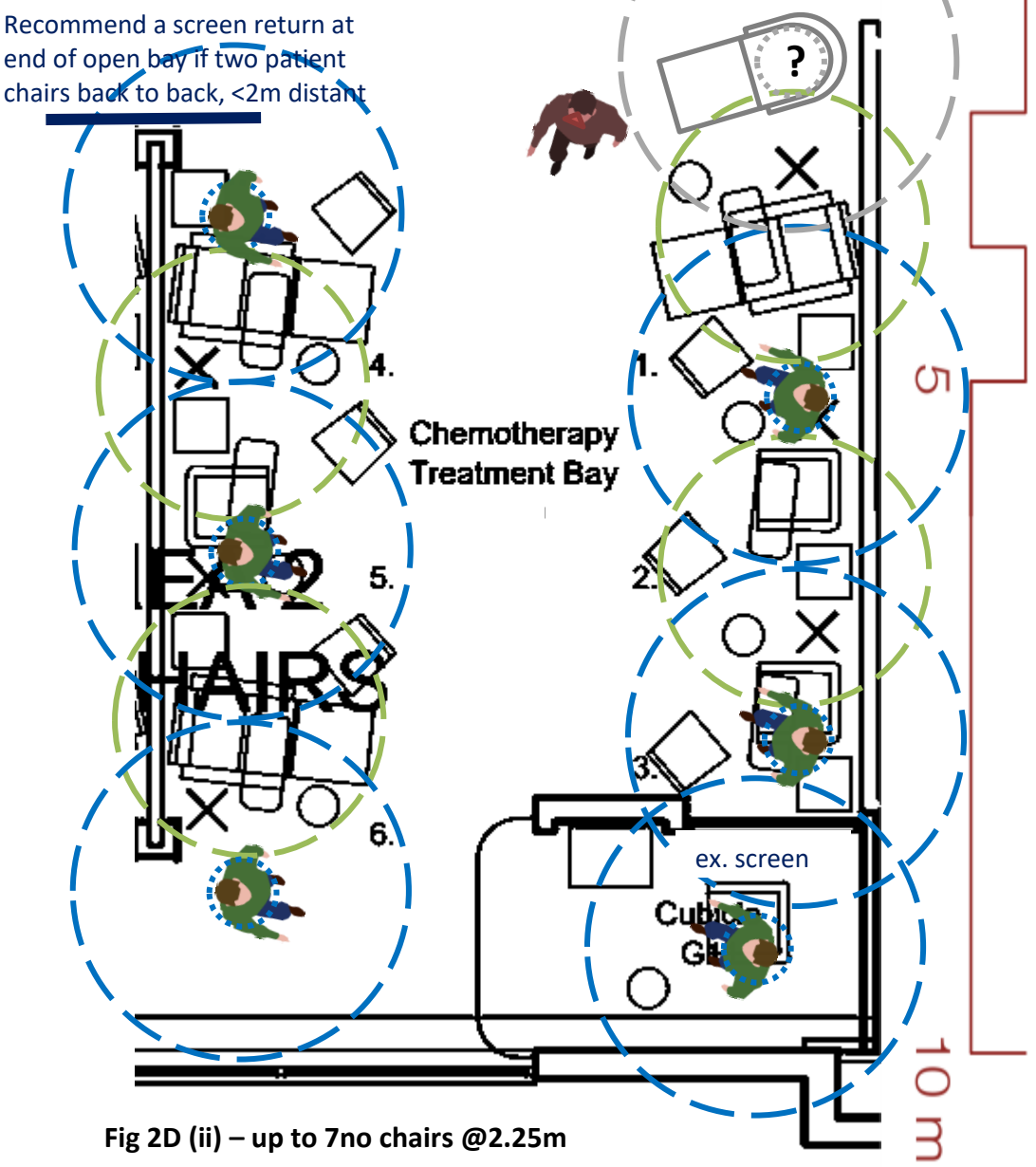
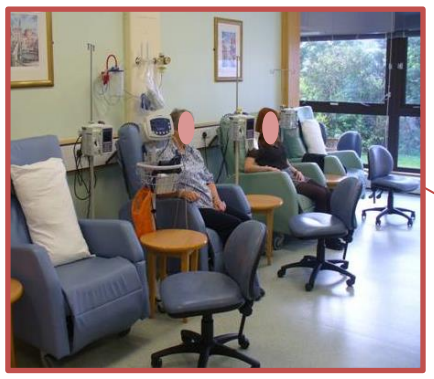


Fig 2D (ii) – up to 7no chairs @2.25m

Note: social distancing for outpatients at limit for a chair bay @2.25m width. ANY bays < 2.25m width to be re-planned or chairs removed / left not occupied. Thereby reducing viral load to space and increasing social distancing to ~2.0m wherever practical.



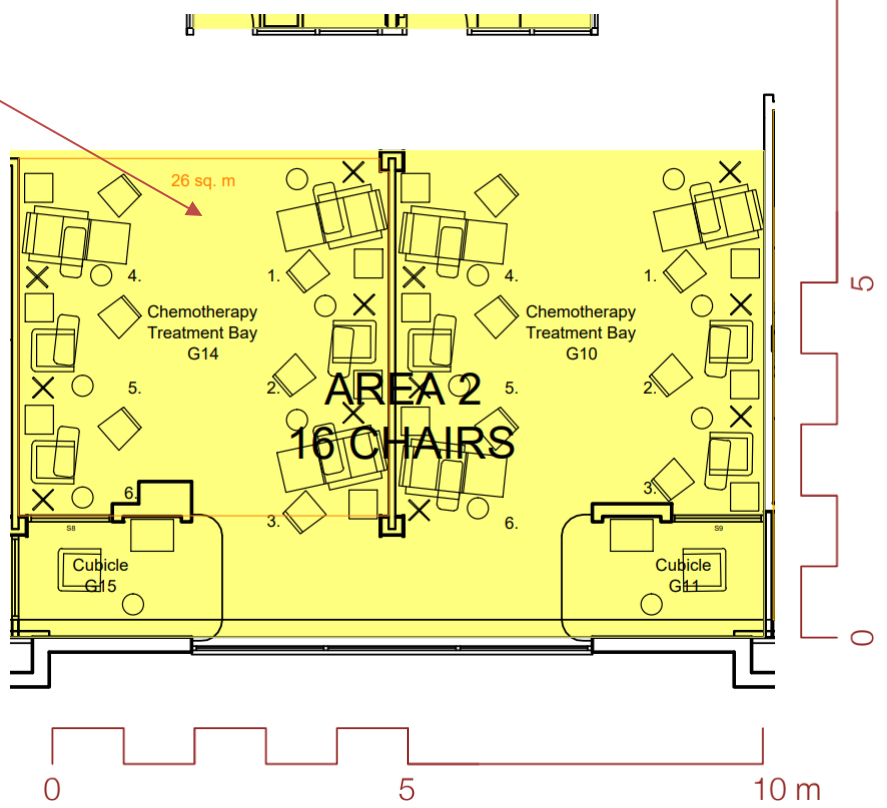


Fig 2D (iii) – existing 8no ≤1.5m chairs @1.7m x 2m bay with 1m aisle

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A Person exempt for agreed purpose (green)
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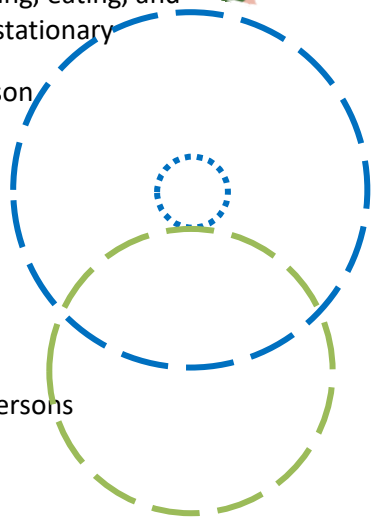
MUST be recumbent/ sitting/ stationary



Inner circle or head zone /person
(**0.5m Dia** / 0.25m Radius)
(blue dotted)

Outer circle /person
(**2.5m Dia** / 1.25m Radius)
(blue dashed)

Physical distancing between persons
(**2m Dia** / 1m Radius)
(green dashed)

Room / space / area (dark blue)

Partition / screen (dark blue)

Assumes ANY person likely to move within **<2m/ 6ft** of another person wears a Face Covering
Area Calculation for a ≤1.5m semi-reclining chair bay: 2.25 x 2.0 m = **~4.5 m^2** / bay
Room/ space, incl ≥ 1.0m central aisle: ~5m x ~7m = **~ 35 m^2** / **6** patients)
[alternatively increase space to either 5 x 7.8m or 6 x 7m to allow a 7th chair = 39 – 42 m^2 / 7 patients]

Diagram 2D: Semi-reclining chair Treatment space @2.25m layout

NHS Scotland HBN 00-03: Multi bed bay bedroom layout

HBN 00-03 states 3.6m preferred width bay with 3.1m to curtain and 3.7m total depth. Central aisle is ≥1.2m between curtains.
Dimensions are based on ergonomic requirements for equipment e.g. wheelchair/ hoist access, & ensuring legal compliance e.g. Equality & Manual Handling

Assume say 0.5m x 0.9m ellipse for patient head zone allowance on centre line of bed and starting 0.25m from wall; plus a 0.5m dia circle if sitting/ standing

- a 3.6m width bay, allows ≥**2.7m** physical distancing to adjacent patient (i.e. ≥ 2m and 6ft)
- a 2.7m width bay, allows **1.8 - 2.0m** physical distancing to adjacent patient (i.e. ≥ 6ft or 1.8m)
- a 2.4m width bay, allows **1.65 – 1.8m** physical distancing to adjacent patient (i.e. ≤ 6ft or 1.8m), consider 1m screening e.g. locker or bed curtain
- a 3.1m depth bay plus say a 1.2m aisle, allows **5.9m** physical distancing to patient across aisle; (a 2.75m depth bay with 0.8m aisle, alllows 4.8m)

Figure below is extract from Core guidance - Clinical and clinical support spaces (HBN 00-03); also in Adult in-patient facilities (SHPN 04-01)

Figure 2 Multi-bed room layout

Fig 3 - HBN 00-03: 4 bay bedroom space @3.6m x 3.1m bay with ≥1.2m aisle layout

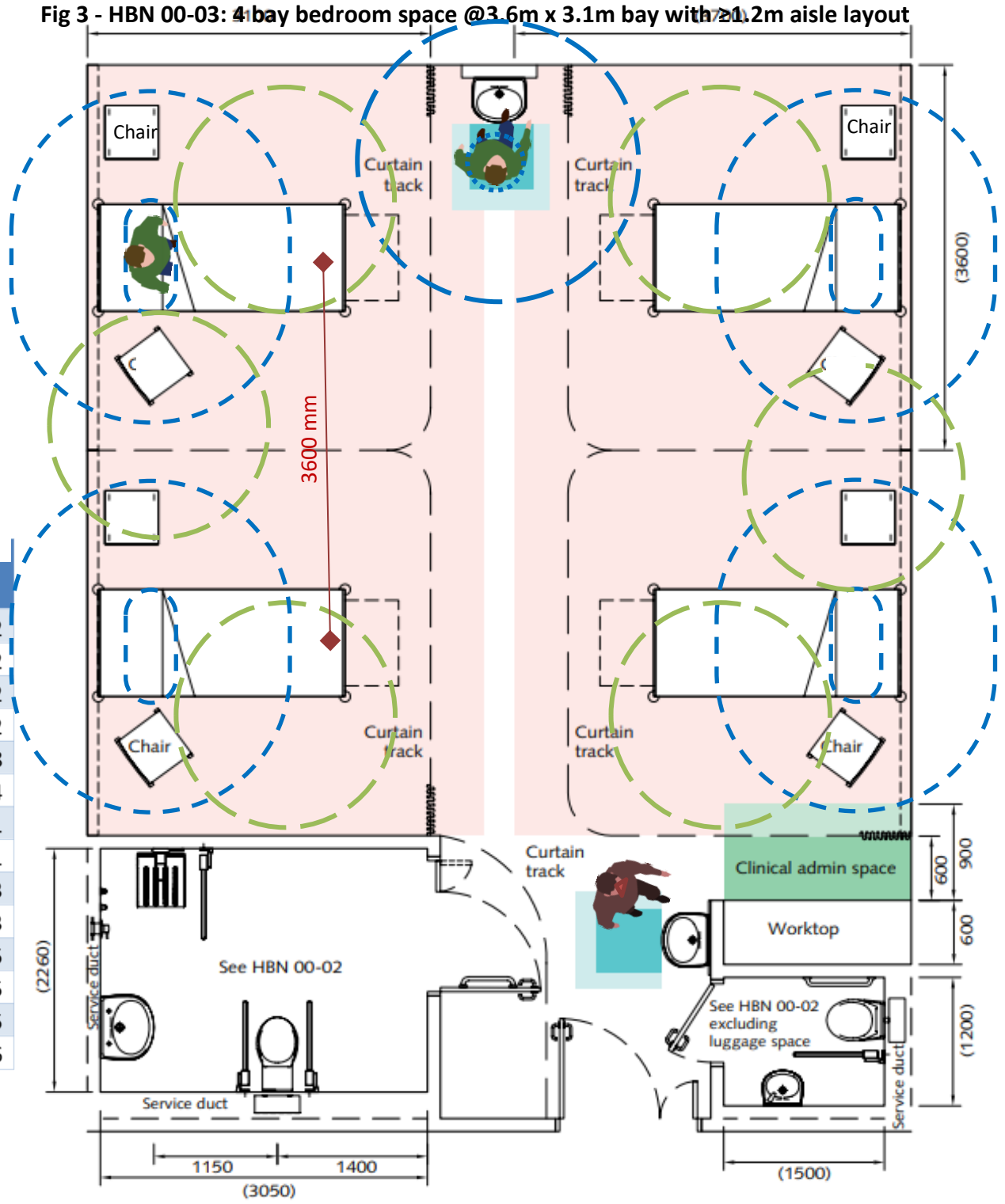
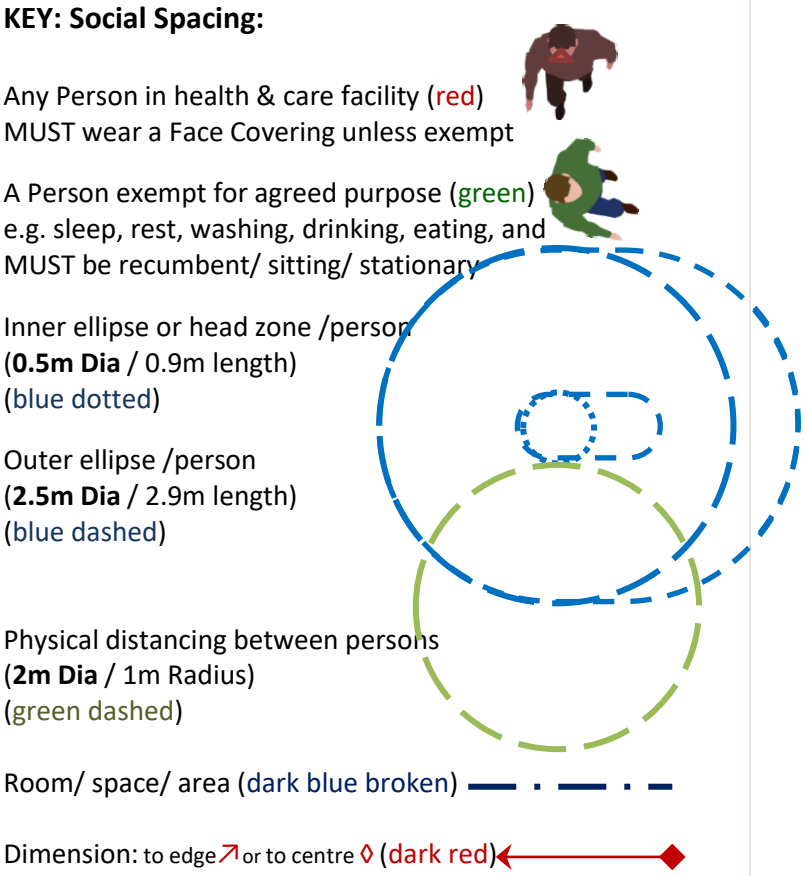


Table 3: NHS Scotland history of Bed Spacing:

Date		(m)	(m)	(sq.m.)
2013	HBN 00-03	3.6	3.7	13.32
2010	CEL(2010)27	3.6	3.7	13.32
2010	SHPN 04-01	3.6	3.7	13.32
2009	HBN 04-01	3.6	3.7	13.32
2008	CEL(2008)48	3.4	3.7	12.58
2002	HFN 30	3.6	2.9	10.44
2000	SHPN 04	2.9	2.9	8.41
1997	HBN 04 vol 1	2.9	2.9	8.41
1996	SHPN 40 Vol5	2.7	2.9	7.83
1995	HBN 40 vol 2	2.7	2.9	7.83
1992	SHPN 4	2.5	2.9	7.25
1990	HBN 4	2.5	2.9	7.25
1986	HBN 40 vol 1	2.5	2.9	7.25
1961	HBN 4	2.4	2.9	6.96

KEY: Social Spacing:



Any Person in health & care facility (red)
MUST wear a Face Covering unless exempt

A Person exempt for agreed purpose (green)
e.g. sleep, rest, washing, drinking, eating, and
MUST be recumbent/ sitting/ stationary

Inner ellipse or head zone /person
(**0.5m Dia** / 0.9m length)
(blue dotted)

Outer ellipse /person
(**2.5m Dia** / 2.9m length)
(blue dashed)

Physical distancing between persons
(**2m Dia** / 1m Radius)
(green dashed)

Room/ space/ area (dark blue broken)

Dimension: to edge ↗ or to centre ◊ (dark red)

Assumes ANY person likely to move within **<2m/ 6ft** of another person wears a Face Covering
Area Calculation for 1 bed bay: 3.6 x 3.1 m ≥ **11 m²** / bay
Room/ space, incl ≥ 1.2m central aisle ≥ **53 m²** / **4** patient
[Room should allow non-face-cover movement within central aisle; as room depth = **> 6 m**]

Diagram 3: HBN 00-03 a Multi bed bay bedroom layout

Fig 3A – a 4 bay bedroom space @3.6m + 2.4m + 2.7m bay width, with 1.2m/0.8m aisle layouts

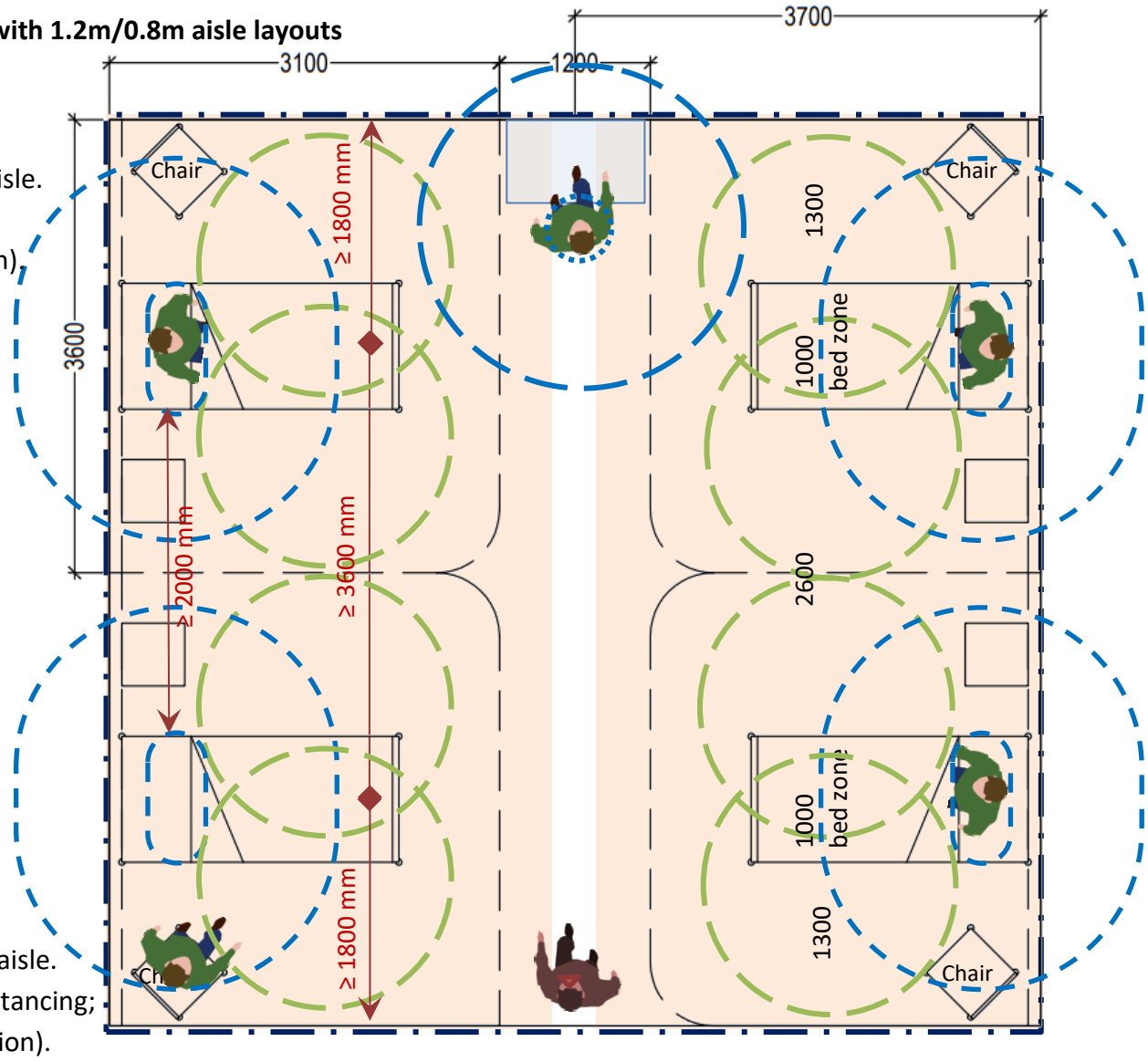
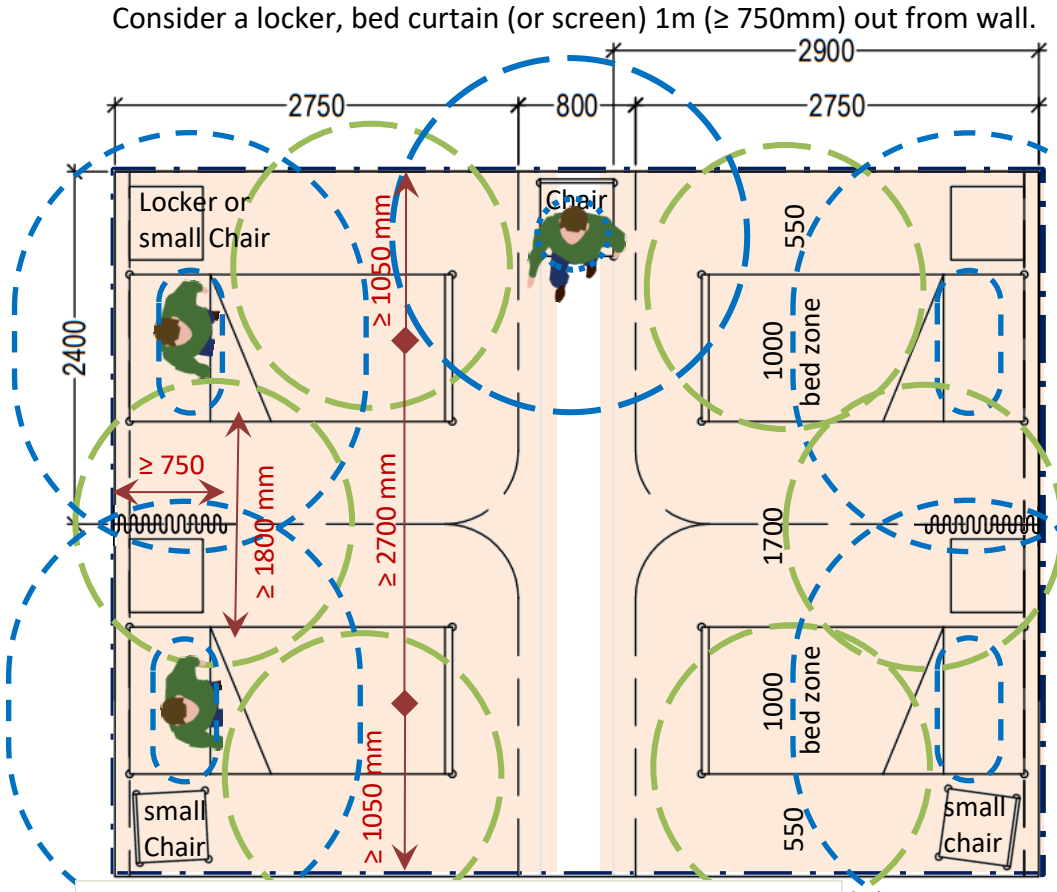
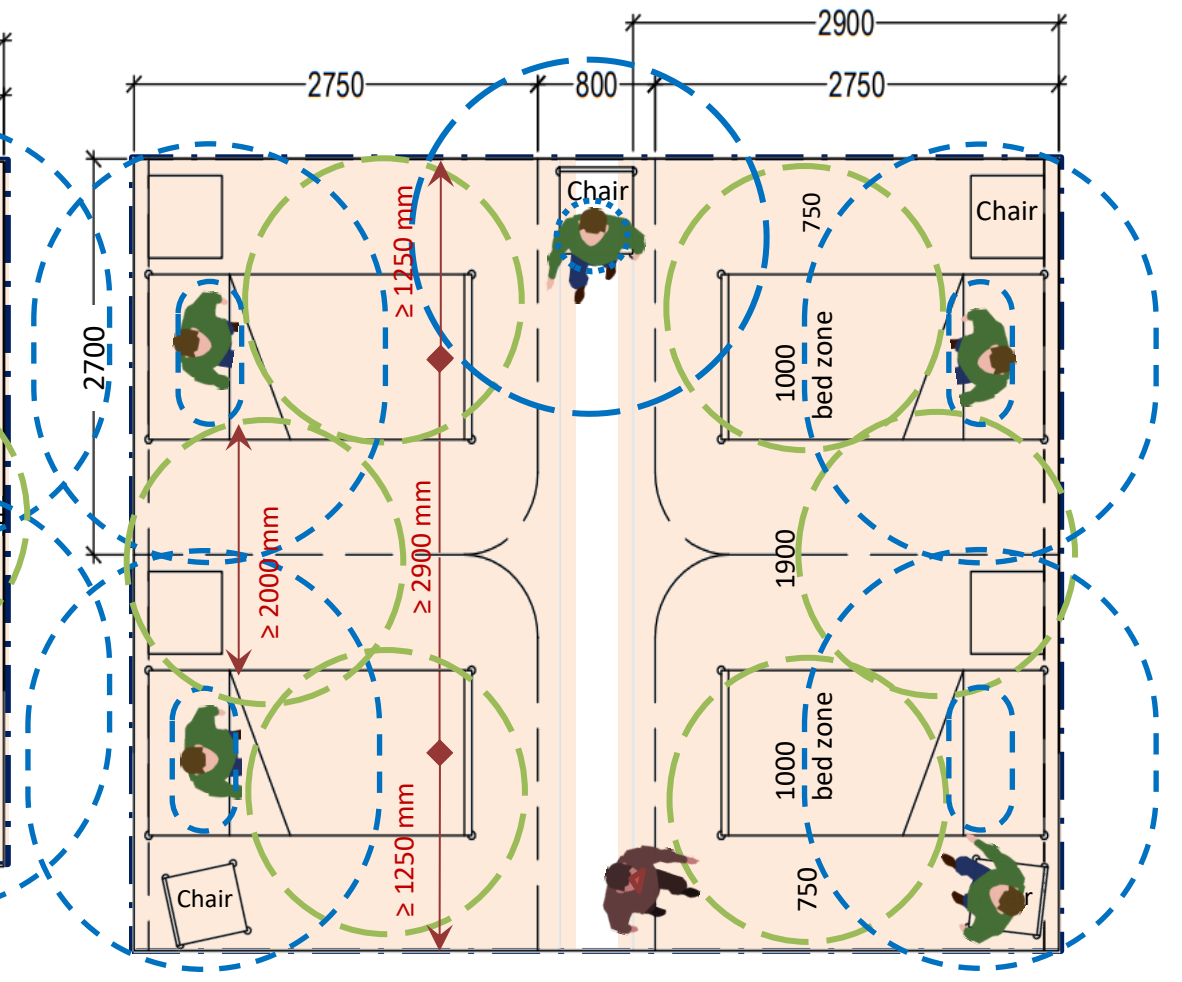


Fig 3A (i) – 4 bed bay @3.6 width x 3.1 depth, with ≥1.2m aisle
Layout achieves **≥2m** patient physical distance for bed/ chairs/ aisle.
(Patient chair shown at bed far-side ensures physical distancing;
but 2m also possible for ≤2 beds in alternative near-side location).

Fig 3A (ii) – 4 bed bay @2.4 width x 2.75 depth, with 0.8m aisle
Layout achieves **≥1.8m** patient physical distance for bed/ chairs/ aisle.
(Small chair (<550mm) shown at bed far-side ensures physical distancing;
larger patient chair (<800mm) option shown at end of aisle location).
Consider a locker, bed curtain (or screen) 1m (≥ 750mm) out from wall.





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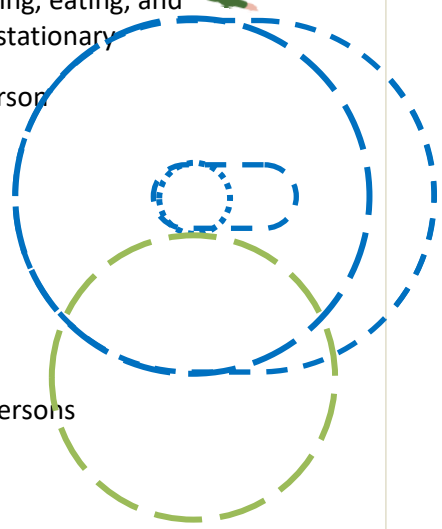

Inner ellipse or head zone /person
(**0.5m Dia** / 0.9m length)
(blue dotted)

Outer ellipse /person
(**2.5m Dia** / 2.9m length)
(blue dashed)

Physical distancing between persons
(**2m Dia** / 1m Radius)
(green dashed)

Room/ space/ area (dark blue broken)

Dimension: to edge ↗ or to centre ◊ (dark red)

Fig 3A (iii) – 4 bed bay @2.7 width x 2.75 depth, with 0.8m aisle
Layout achieves **≥2.0m** patient physical distance for bed/ chairs/ aisle.
(Patient chair shown at bed far-side ensures physical distancing; option for a patient chair/ dining at end of aisle is shown, but near-side not an option).

Assumes ANY person likely to move within **<2m/ 6ft** of another person wears a Face Covering
Area Calculation for 1 bed bay: @2.7m = **7.4 m²** , or @2.4m = **6.6 m²** / bay
Room/ space, incl ≥ 0.8m central aisle: @2.7m = **34 m²** , or @2.4m = **30 m²** / **4** patient
[Room should allow non-face-cover movement within central aisle; as room depth = **> 6 m**]

Diagram 3A: a 4 bay bedroom space @3.6m + 2.7m +2.4m layouts

Fig 3B – a 6 or 8 bay bedroom space @ 2.4m + 2.7m bay width, with 0.8m aisle layouts

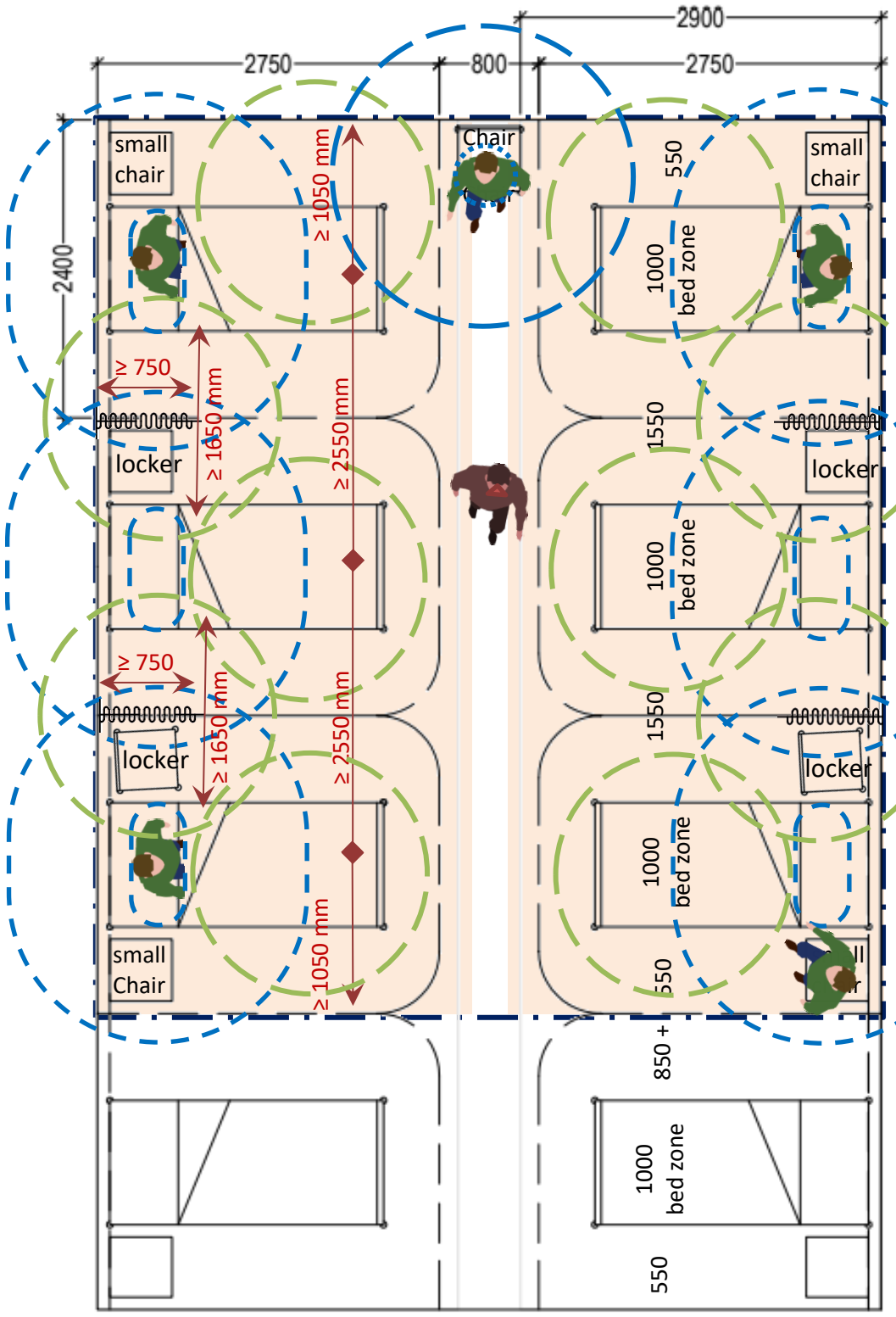

Fig 3B (i) – 6 or 8 bed bay @2.4 width x 2.75 depth, with 0.8m aisle
Layout achieves **≥1.65m** patient physical distance for bed/ chairs/ aisle.
An ensuite or WHB aisle may allow patient distancing increase to ≥1.8m.
(Small chair (<550mm) shown at bed perimeter, but none at centre beds.
Larger patient chair (<800mm) option shown at end of aisle location).
Consider a locker, bed curtain (or screen) 1m (≥ 750mm) out from wall.
For 6 or 8 bed room @2.4m bays, consider reducing or not occupying by 1, or 2 beds, to reduce room total viral load, and to increase distancing.

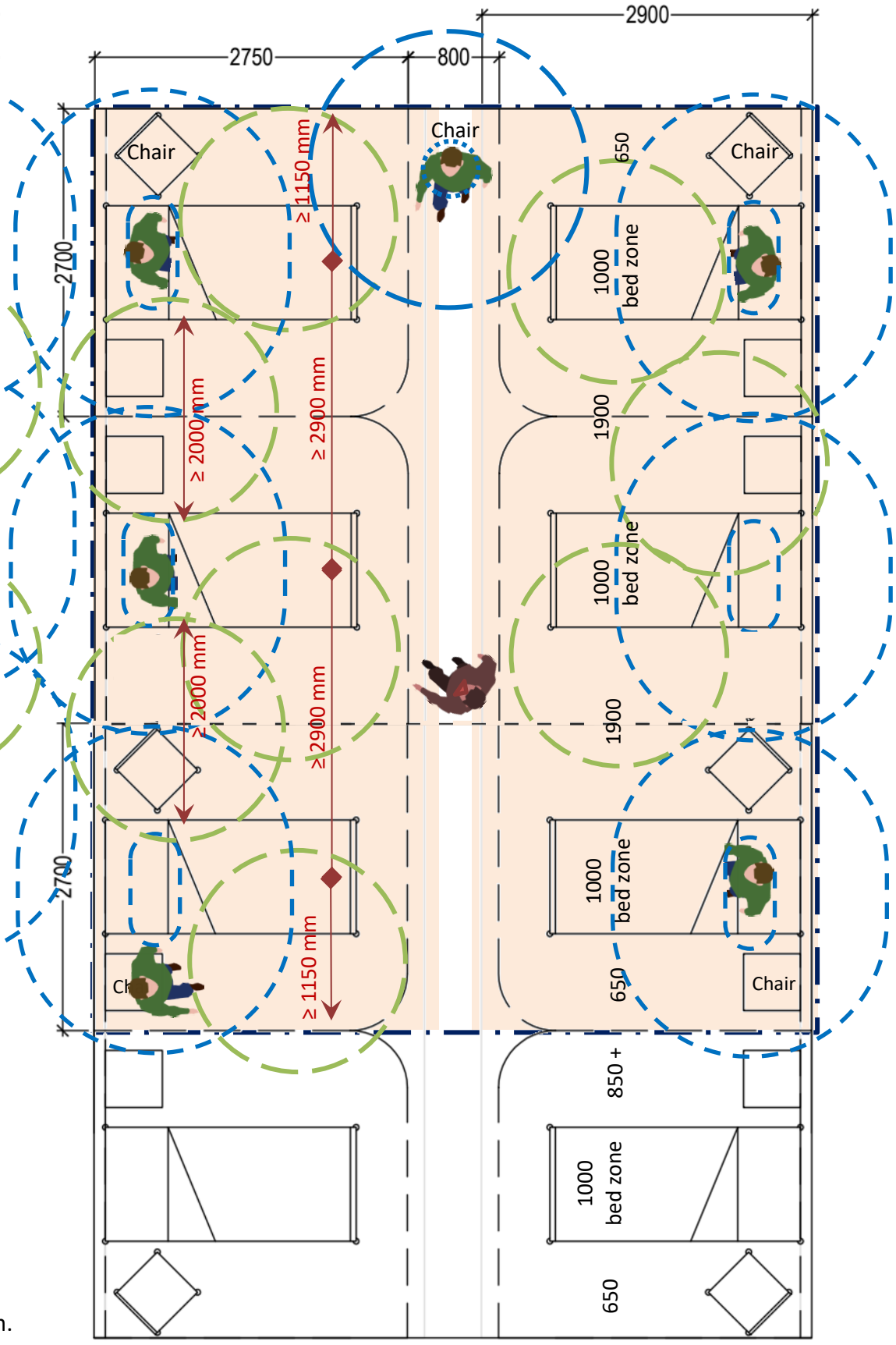

Fig 3B (ii) – 6 or 8 bed bay @2.7 width x 2.75 depth, with 0.8m aisle
Layout achieves **≥2.0m** patient physical distance for bed/ chairs/ aisle.
An ensuite or WHB aisle may allow an increase to patient distancing.
(Patient chair shown at bed far-side ensures physical distancing; option for a patient chair/ dining at end of aisle is shown, but none for centre beds.

KEY: Social Spacing:

Note: social distancing for bedroom at limit for a BED bay @2.4m width. ANY BED bays < 2.4m width to be re-planned or beds removed / not occupied, to reduce viral load and increase social distancing to ~2.0m.
(for couch/ chair bays i.e. head zone: 0.5m Dia, see pages 5 – 9 diagrams)

Assumes ANY person likely to move within **<2m/ 6ft** of another person wears a Face Covering
Area Calculation for 1 bed bay: @2.7m = **7.4 m²** , or @2.4m = **6.6 m²** / bay
Room space, incl ≥ 0.8m central aisle: @2.7m = **51 m²** , or @2.4m = **45 m²** / **6** patient
[Room should allow non-face-cover movement within central aisle; as room depth = **> 6 m**]

Diagram 3B: a 6 or 8 bay bedroom space @2.4m + 2.7m layout

	WHAT advice/action	WHERE does this apply?	WHY?
What has not changed? You should continue to implement/follow existing guidance/protocols or practice	1. Where possible, maintain 2M physical distance between individuals at all times 2. Staff, patients and visitors should decontaminate their hands regularly 3. Equipment and the environment must be cleaned regularly/between patient use and when visibly soiled. 4. All staff must wear a fluid resistant surgical face mask (FRSM) in all clinical areas/during all clinical care for the duration of shift 5. FRSM can be used by staff on a sessional basis 6. Where patients are symptomatic and considered 'infectious' droplet transmission-based precautions should be used (FRSM, apron, gloves and eye protection when within 2M of the patient, and for all direct care) 7. Where patients are asymptomatic and not considered 'infectious' – aprons, gloves and eye protection should be worn where this is appropriate to direct care	All adult and paediatric services All mental health services All community services	Points 1-6: These precautions follow the wider principles of physical distancing, use of face masks to contain respiratory droplets and minimise spread, and hand hygiene to prevent contact transmission. 7. Standard infection control precautions apply – PPE is worn where there is a potential exposure to blood/body fluids, secretions or excretions 8. Where possible, patients with suspected or COVID 19 should be cared for by a dedicated cohort of staff, and physically separated from other patients. 9. The guidance is developed by expert scientific panel and evidence based. The HSE, medical royal colleges and trade union/staff partnerships have also endorsed this guidance. Inappropriate use of PPE may create an unnecessary demand on supply chains and impact on provision where this is required 10. Where there is risk that a patient has had an exposure to

	delivery and the task 8. Patients and visitors should wear a face mask/covering when attending appointments/where 2M physical distancing can't be achieved 9. PPE should be worn up to, but not exceeding, the level specified in UK guidance 10. FFP3 should be used for all aerosol generating procedures (AGP) in Amber and Red pathways 11. An appropriate post AGP fallow period must be observed in any room where an AGP has been carried out – before others should enter 12. Patients should be assessed/triaged before admission and/or treatment. 13. All patients suspected of having COVID 19 should be segregated from others e.g. in a RED ward/zone		COVID 19, could be asymptomatic and/or does not have a negative COVID test result – a precautionary approach to the use of FFP3 still applies during AGP 11. To prevent other staff/patients/visitors from exposure to potentially infectious aerosol 12. To minimise the risk of symptomatic patients mixing with others, to ensure patients are appropriately placed within the care environment with the required IPC precautions. 13. To minimise the risk of transmission
What has changed? Be aware of changes to guidance and how this impacts on your	1. FFP3 is no longer required for any AGP on a patient in a Green elective surgical pathway (unless indicated by another	All elective surgical patients (acute hospitals)	1. Where a patient has had no wider community exposure (quarantined) for 14 days and has tested negative for COVID

practice/care locally	infection) 2. Standard advice on step down of precautions for COVID +ve patients – a. 14 days from sample date if asymptomatic b. 14 days AND at least 3 consecutive days without fever or respiratory symptoms if symptomatic		19 – this gives confidence that the patient is not infectious therefore standard infection control precautions apply
What is still being considered – with further guidance/information available shortly	• Implementation of RED, AMBER and GREEN pathways in all settings & assessing impact on timely/safe and patient centred assessment, care and treatment • Risk assessments and actions required where 2M physical distance cannot be maintained OR where this adversely impacts access to services • Face coverings recommended for all in-patients • Use of anaesthetic and recovery rooms for perioperative management of Amber and Red patients • Implementation of twice daily cleaning in all areas irrespective of activity/service type/patient risk profile • Patient companions & visiting arrangements-all pathways	All health & social care services All hospital care All Mental Health services All OPD/community services	Implementation of these generic guidance requirements is complex, and impact assessment required- to consider wider consequences and exacerbation of non COVID risks. The safety and welfare of staff, patients and the wider public remains the priority for NHS Lothian. Implementation of guidance must be undertaken in collaboration with clinical teams and staff partnership representatives.

	• Implementation of chlorine cleaning in Amber (asymptomatic) patient zones		