To: Chief Executives, Chief Nurses and Medical Directors and HR Directors of all NHS Trusts and Foundation Trusts

Copy: Regional Directors
Regional Chief Nurses
Regional Medical Directors

NHS England and NHS Improvement
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24 June 2020

Dear colleague

Healthcare associated COVID-19 infections – further action

Further to the letter dated 9 June, we want to thank you all for your continued efforts to reduce healthcare associated COVID-19 infections in your organisations.

Tackling this issue is vital to ensure patient safety, maintain public confidence and protect the health and wellbeing of NHS staff. This letter sets out number of important actions that all organisation must take.

Evidence has now shown that people infected with COVID-19 who are either pre-symptomatic[1] or have very mild or no respiratory symptoms (asymptomatic)[2] can transmit the virus to others without knowing so it is important that we take even greater steps to stop the spread of coronavirus in healthcare settings.

A. Inpatient testing

The current inpatient testing programme remains:

(i) all patients at emergency admission, whether or not they have symptoms;
(ii) those with symptoms of COVID-19 after admission;
(iii) for those who test negative upon admission, a further single re-test should be conducted between 5-7 days after admission;
(iv) test all patients on discharge to other care settings, including to care homes or hospices;
(v) elective patient testing prior to admission.

B. Staff testing

(i) NHS testing capacity should also be used to test all staff with symptoms (or the index case if a household member).

(ii) Surplus NHS testing capacity should also be used for testing non-symptomatic staff (in addition to all patients and symptomatic staff) working in situations where there is an untoward incident or outbreak or high prevalence. These terms are explained in more detail in the Annex. For example, if two patients in a ward test positive the whole ward (patients and staff) should be tested. Or, if a healthcare worker tests positive the colleagues who they've been in contact with should be identified and tested. As with

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/890236/s0267-nervtag-assessment-pre-symptomatic-transmission-covid-19-300420-sage30.pdf
[2] Chau NVV, et al. The natural history and transmission potential of asymptomatic SARS-CoV-2 infection. medRxiv 2020.04.27.20082347; doi: https://doi.org/10.1101/2020.04.27.20082347

previous extensions of testing, Trusts should work through their pathology networks and the regional Testing CEOs to ensure additional capacity is distributed where it is most needed.

(iii) It is the view of the CMO that at present periodic staff testing is best done as part of PHE's SIREN study. SIREN is an NIHR urgent public health priority study which has a primary objective of determining if prior SARS-CoV-2 infection in health care workers confers future immunity to re-infection. It will also allow organisations to estimate the prevalence of SARS-CoV-2 infection in healthcare workers and utilise this information to determine wider staff testing[3]. Trusts should support staff in enrolling, and support the study with both PCR and antibody testing (including phlebotomy) from hospital resources, working with pathology networks and support across regions to ensure capacity is available. Trusts should consider supporting a minimum of 10% of staff to enrol in the SIREN study. This study will allow us to determine whether antibody responses are sustained and whether they protect people from re-infection. The SIREN protocol specifies that staff will be tested every 2 weeks, via a venous blood test and by PCR screening. However, frequency may be altered depending on national and regional epidemiology.

As prevalence changes and evidence emerges, we will continue to review the appropriate frequency for asymptomatic testing in the NHS.

C. Staff risk assessment

Trusts are reminded that as part of their responsibilities, all relevant staff including Black, Asian and minority ethnic staff, should be offered a risk assessment. It is an employer's legal duty to protect the health, safety and welfare of their employees and we expect all employers to make significant progress in deploying risk assessments over the next few weeks. Risk assessments should not be viewed in isolation – satisfactory deployment brings organisation-wide benefits including less absenteeism and sickness, fosters a safety-first culture, and helps ensure trust and engagement with staff.

Guidance for NHS employers is available here.

D. Managing healthcare associated COVID-19 cases

Strict application of UK recommended Infection Prevention and Control Guidance remains vital. This includes all staff in hospital wearing a surgical face mask when not in personal protective equipment or in a part of the facility that is COVID-secure, and visitors and outpatients wearing a form of face covering. Guidance is set out here.

Accurate and timely information is also critical, not only to track and respond to outbreaks but also to support wider surveillance efforts on overall Covid infection levels across the country. Daily reported data that are now available on Tableau enable organisations at local and regional levels to understand their own performance and take action. Data can be accessed by NHS Trusts here.

These data are helpful in enabling you to identify both **outbreaks** (as defined in the annex) and **clusters** (commonly referring to the detection of unexpected, potentially linked cases) of healthcare associated COVID-19 infections.

[3] https://www.nihr.ac.uk/covid-studies/study-detail.htm?entryId=284460

Using these data, the expectation at a **local** level is that healthcare associated COVID-19 infection rates should be analysed and reviewed on a daily basis to check for case numbers and particularly to note trends. This review should be led by an executive director.

Where cases are identified, actions should be taken in line with the flowcharts detailing standard procedures for managing outbreaks at a local level, which were circulated as annexes to the 9 June letter. The local Director of Infection Prevention and Control is responsible for overseeing the response to any outbreak in hospitals with appropriate oversight from NHS regional and national teams.

As part of this, we are now asking all organisations to do root cause analyses (RCAs) for every probable healthcare associated COVID-19 inpatient infection i.e. patients diagnosed more than 7 days after admission. In doing this, it will be important that the organisation continues to reference the existing Serious Incident Framework to underpin the next level of investigation, if required to do so.

At an **ICS/STP level**, all organisations providing NHS services in the area, including social enterprises and primary care, should meet as a minimum on a weekly basis to discuss your local infection status. These discussions should allow for the sharing of information and best practice across organisations to enable local improvements and engage peer support.

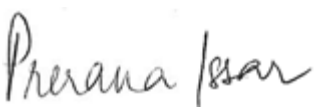
At a **regional level**, further response is required when organisations have remained as 'outliers' for over 7 days. An outlier is defined statistically according to the average numbers of cases aggregated over the preceding 4 weeks. You should undertake a full review of all actions implemented locally and mobilise a **regional IPC support offer** into the organisation.

Thank you once again for all the work you are doing to tackle this issue. As a service we have shown that when we all determinedly focus on infection prevention and control, we can make rapid and effective progress. We need to repeat that success here, at a fast pace.

With best wishes

Ruth May
Chief Nursing Officer for England

Steve Powis
National Medical Director



Prerana Issar
Chief People Officer

Pauline Philip
National Director for Urgent and Emergency Care

Annex – Definitions of terms

- An **untoward incident** in terms of probable healthcare associated COVID-19 is a single inpatient who develops COVID-19 more than 7 days after hospital admission.
- The term **outbreak** is strictly defined in PHE guidance as two or more cases in a single setting (for example, in a single ward or having shared a location) that have become symptomatic or detected on screening on or after day eight of hospital admission.
- The term **cluster** is used commonly when referring to the detection of unexpected, potentially linked cases. PHE notes that some cases and clusters of communicable disease may not require a formal outbreak to be declared. It is important that such cases are appropriately recorded and managed for audit purposes and to support surveillance and any future outbreak management.
- **High prevalence**: Testing will also be expected in those organisations that are identified as outliers in relation to numbers of cases of inpatients diagnosed with COVID-19 more than 7 days after admission. This definition is based on above-average number of cases aggregated over the preceding 4 weeks.