Community Health & Social Care Directorate
Primary Care Division

The Scottish Government
Riaghaltas na h-Alba

Addresses

For Action
GP Practices
Chief Executives NHS Boards

For information
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Practice Manager Network
Practice Nurse Network

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10 April 2020

Dear Colleagues,

ANTICIPATORY CARE PLANS FOR VULNERABLE AND HIGH RISK PATIENTS

As you will know the Chief Medical Officer has recently written to both General Practice and to Hospital Clinicians about the plans for supporting those patients identified as being at the highest risk of mortality and severe morbidity from COVID-19.

In this letter clinicians were advised that patients in the vulnerable patients group would be written to over the next week with advice about Shielding (*Shielding is a measure to protect extremely vulnerable people from coming into contact with coronavirus, by minimising all interaction between them and others*), and where practice capacity allowed, those in the very high risk group would be contacted by their GP practice to have a further discussion.

The letter also recommended as that as part of this discussion with patients, important information, such as key worker, should be captured and included in the electronic Key Information Summary (eKIS). This discussion could be done by a non-clinical person in the team, with the supporting guidance for these discussions shared in Annex C of the letter. Information on how to enter data in KIS was also included Annex D.

This letter to practices also stated:

In addition for some patients in this group it may be appropriate to discuss their Anticipatory Care Plan. This discussion should be done by a clinician but again it doesn't have to be a GP.

In fact, for many of the patients in the very high risk group it would be more appropriate for them to have their ACP conversation with their treating consultant, who may be in

better position to discuss appropriate treatment options based on the patient's individual circumstances.

We are now writing to you with some further information to support the completion of Anticipatory Care plans, and Key Information Summaries, for those patients where the practice and wider multi-disciplinary team feel it is clinically appropriate.

Attached you will find a revised and simplified Anticipatory Care Template (Annex A) which has been developed by Healthcare Scotland (HIS). This template takes into account the guidance previous provided in Annex C of the CMO letter, to try and avoid duplication of more general information gathering and has been designed to capture essential information which should be copied into eKIS.

We would like to take this opportunity to reiterate some key points about completing an ACP. There are four main principles which should be considered:

a) How we identify people from practice lists, MDT and secondary care caseloads.
b) Encouraging all clinical staff to consider and have ACP conversations with patients (this could be face to face, telephone or NHS Near Me consultation).
c) Documenting these conversations on the new Essential ACP template or directly onto eKIS as appropriate, depending who in the team is having the discussion with the patient.
d) Ensuring the information is shared in a way that it can get onto eKIS.

1. GP Practices and members of the wider MDT such as Community Nurses, AHPs, Carers, Community Mental Health, Learning Disability services, Care Home and Secondary Care clinical staff should use their clinical judgement to decide who on their practice list or caseloads should be a priority for having an ACP conversation and completing an ACP. Many of these patients will already have an ACP, and the team should consider whether it needs to be reviewed and updated.

   Where patients are identified on the case-loads (MDT and secondary care) it will be important to have a co-ordinated approach to care planning, with communication between the different teams, a priority to avoid the risk of duplication of effort.

2. That ACP conversation and completion of the form does not always need to be completed by a GP and can be completed by other members of the clinical team eg General Practice Nurse, District Nurses, AHP, Speciality Community Nurses, Care Home staff, Hospital clinician etc.

   When an ACP is completed by a member of the wider Health and Social Care team or a Hospital Clinician a copy should be kept with the patient where possible and a copy sent to the GP practice. When completed by a member of the practice team who has access to the practice clinical system following discussion with the patient it may be entered directly into eKIS.

3. Where the ACP has been completed by somebody out with the practice team, the GP practice could provide support by copying the information into the eKIS. There are a number of ways this could be done, such as allowing external clinical staff to

have access to the practices clinical system, or for an administrative person in the practice to enter the information into eKIS where practice workload and capacity allow. The process for passing completed ACPs to the appropriate practice should be agreed locally eg a generic email address,

4. We recognise that DNACPR discussions are always difficult ones to have, even more so when being done over the telephone. It is also recognised that CPR has a very low chance of success when cardiopulmonary arrest is in the context of severe Covid illness. Therefore we would like to reassure clinicians that there is no specific requirement to have a DNACPR discussion as part of this ACP conversation, unless the patient raises this and wishes to discuss it, or the clinician feels strongly that they need to discuss it. Instead the focus should be on supportive discussions with patients about what matters to them should they fall ill with Covid. The HIS ACP template provides a framework for your discussions, with the option to complete the DNACPR section, if this is discussed. Guidance on having difficult conversations has been developed and is attached in Annex B.

5. We also recognise the importance for both patients and clinicians of ensuring supportive and high-level public messaging around the benefit of anticipatory care planning conversations. This is being developed as a matter of urgency within the Scottish Government to accompany this work. Patient resources are also being developed to help facilitate their conversations with carers and families, and these will be available in the coming days on www.nhsinform.co.uk .

We realise this is challenging work and we intend to support this with clear, high-level public messaging around its importance. We're working to have revised Covid-19 related Anticipatory Care Planning information on NHS Inform by the end of this week.

Please also note the publication on 3 April 2020 of the Covid-19 Ethical Advice and Support Framework and Clinical Advice. The CMO published these documents on 3 April 2020. They are intended to support clinicians with decision making during this pandemic.

As stated by the CMO please accept our sincere thanks for your support, patience and courage during this challenging time. We realise that workload and capacity in General Practice just now is challenging, but we also understand that you put the best interest of your patients to the forefront.

Further resources and information about anticipatory care planning are on Healthcare Improvement Scotland's website.

Yours sincerely,

Dr Gregor Smith
Interim Chief Medical Officer

Having significant conversations to support those most vulnerable to coronavirus

There are particular groups of individuals who are at increased risk of severe illness from coronavirus. These people would benefit from having a 'Key Information Summary' created or updated. Many will also benefit from Anticipatory Care Planning.

There is a second group of people who are at much higher risk of becoming seriously unwell from coronavirus, and are already at greater risk of dying from infections and other health problems. This group should be prioritised for Anticipatory Care Planning. This template can be used to document these discussions and shared on the Key Information Summary.

This is an important opportunity for people to have conversations with carers and loved ones about the type of care that they would like to receive should they become unwell.

We know that treatments for coronavirus focus on supportive measures, and specific care options like ventilation are of low benefit or do not help people who are already in poor health. However, there are many other aspects of care that can be discussed and planned. People may well be worried about the future, and so there is an opportunity to have a helpful conversation about what matters to them if they become very unwell and die.

These discussions can be extremely difficult to start, but they are important and helpful. The aim is to have an open and honest conversation with people and their families and carers so that we can plan future care as well as possible.

The RED-MAP framework can be helpful to guide discussions about ACP

https://www.ec4h.org.uk/covid-19-effective-communication-for-professionals/

R eady:	Can we talk about how coronavirus might affect you?
E xpect:	What do you know? What do you want to ask?
D iagnosis:	We know that coronavirus.... We don't know.....
M atters:	What matters to you if you were to become unwell?
A ctions:	What we can do to help is....
P lan:	Let's plan ahead for 'just in case'

Depending on how the conversation goes, you may consider exploring other relevant aspects of Anticipatory Care Planning. Some people may not be ready for this conversation and it may be necessary to revisit it at another time. Focus on the benefits of having a plan for each person and, if possible, offer another opportunity with you or a colleague.

An essential ACP for those most vulnerable to coronavirus

Name		**Preferred name**	
CHI or DoB		**Phone number**	
Address			

Ask: 'If you were to become seriously unwell due to an infection such as the coronavirus, how would you like to be cared for?
Ask: 'Is there anyone that you would like to be involved in future decisions about your care, if you were to become unwell (e.g. a friend, family member or carer)?

Note: Specific care options e.g. ventilation in intensive care may not be available or appropriate. It may help to explore this further and consider whether comfort options such as symptom control would be a priority.

The things you would like:

The things you do not want:

Any other information around preferences for care:

Discussions about cardiopulmonary resuscitation:

Is this person to have cardiopulmonary resuscitation? YES ☐ NO ☐
If NO, Is a DNACPR form completed? YES ☐ NO ☐

The people you would like to be involved in decisions about your care. (List names and contact info.)

Do any of these people have power of attorney or welfare guardianship? YES ☐ NO ☐
If so, what are their names?

Other important contacts (next of kin / carer / neighbour):

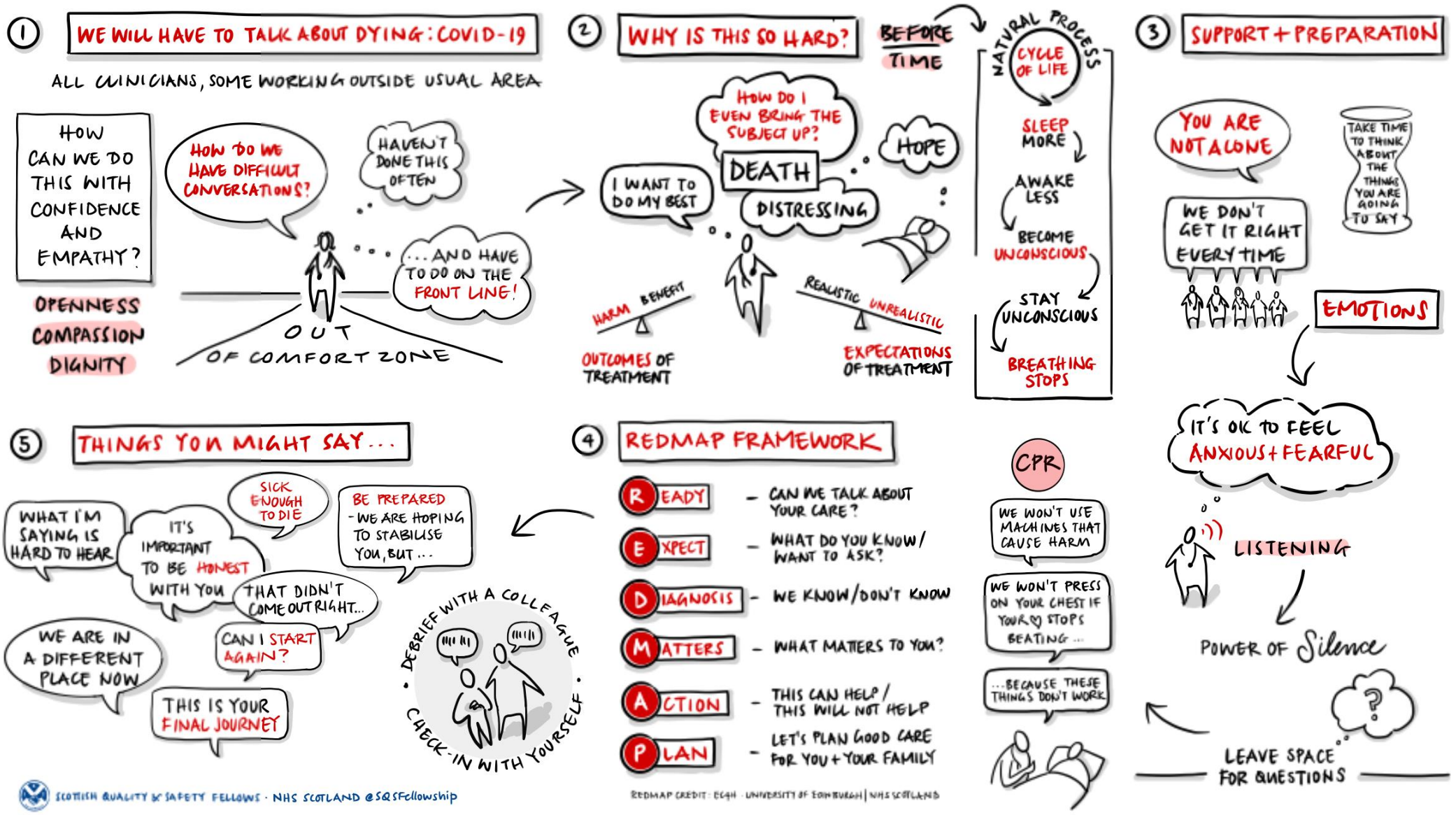
Key worker (social / health care worker/ mental health support/ others)

Name and contact details of Responsible Clinician (Consultant/ GP/ Other)

Name and designation of person who has led this ACP discussion	**Date completed:**

Consent obtained to share in Key Information Summary (good practice but not mandatory)
YES ☐ NO ☐
Please send this completed electronic word document to the GP practice so that the above information can be copied and pasted into the special notes section of the Key Information Summary

ANNEX B


1
WE WILL HAVE TO TALK ABOUT DYING: COVID-19
ALL CLINICIANS, SOME WORKING OUTSIDE USUAL AREA
HOW CAN WE DO THIS WITH CONFIDENCE AND EMPATHY?
OPENNESS
COMPASSION
DIGNITY
HOW DO WE HAVE DIFFICULT CONVERSATIONS?
HAVEN'T DONE THIS OFTEN
...AND HAVE TO DO ON THE FRONT LINE!
OUT OF COMFORT ZONE
2
WHY IS THIS SO HARD?
HOW DO I EVEN BRING THE SUBJECT UP?
I WANT TO DO MY BEST
DEATH
DISTRESSING
HOPE
HARM
BENEFIT
OUTCOMES OF TREATMENT
REALISTIC
UNREALISTIC
EXPECTATIONS OF TREATMENT
BEFORE TIME
NATURAL PROCESS
CYCLE OF LIFE
SLEEP MORE
AWAKE LESS
BECOME UNCONSCIOUS
STAY UNCONSCIOUS
BREATHING STOPS
3
SUPPORT + PREPARATION
YOU ARE NOT ALONE
TAKE TIME TO THINK ABOUT THE THINGS YOU ARE GOING TO SAY
WE DON'T GET IT RIGHT EVERY TIME
EMOTIONS
IT'S OK TO FEEL ANXIOUS + FEARFUL
LISTENING
POWER OF Silence
LEAVE SPACE FOR QUESTIONS
4
REDMAP FRAMEWORK
READY – CAN WE TALK ABOUT YOUR CARE?
EXPECT – WHAT DO YOU KNOW/ WANT TO ASK?
DIAGNOSIS – WE KNOW/DON'T KNOW
MATTERS – WHAT MATTERS TO YOU?
ACTION – THIS CAN HELP / THIS WILL NOT HELP
PLAN – LET'S PLAN GOOD CARE FOR YOU + YOUR FAMILY
REDMAP CREDIT: ECSH · UNIVERSITY OF EDINBURGH | NHS SCOTLAND
CPR
WE WON'T USE MACHINES THAT CAUSE HARM
WE WON'T PRESS ON YOUR CHEST IF YOUR ♡ STOPS BEATING ...
...BECAUSE THESE THINGS DON'T WORK
5
THINGS YOU MIGHT SAY...
WHAT I'M SAYING IS HARD TO HEAR
IT'S IMPORTANT TO BE HONEST WITH YOU
SICK ENOUGH TO DIE
BE PREPARED - WE ARE HOPING TO STABILISE YOU, BUT...
THAT DIDN'T COME OUT RIGHT...
CAN I START AGAIN?
WE ARE IN A DIFFERENT PLACE NOW
THIS IS YOUR FINAL JOURNEY
DEBRIEF WITH A COLLEAGUE
CHECK-IN WITH YOURSELF
SCOTTISH QUALITY & SAFETY FELLOWS · NHS SCOTLAND @SQSFellowship

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IJB Chief Officers
Local Authority Chief Executives
IJB Chief Social Work Officers
Scottish Care
Coalition of Care and Support Providers in Scotland
Care Inspectorate
Scottish Social Services Council

13 March 2020

Dear Colleague,

Coronavirus (COVID-19) social care response

I am writing to provide an update on recent discussions around Coronavirus and the social care sector.

As I write this, you will be aware that Scotland has seen 85 confirmed cases of Coronavirus (COVID-19). We understand that these patients are currently well and are receiving appropriate care.

We do not underestimate the challenges COVID-19 presents for us, but Scotland is well equipped to deal with infections of this kind. The Scottish Government, local government and NHS Scotland have a proven track record for responding to disease outbreaks and follow tried and tested procedures. These follow the highest safety standards possible, for the protection of our staff, people accessing health and social care support, and the wider public.

Health Protection Scotland (HPS) has developed specific guidance for social or community care and residential settings on COVID-19 to support those working in the social care sector. It is based on the National Infection Prevention & Control Manual and includes advice on how to prevent spread of all respiratory infections including COVID-19 with setting-specific information and advice.

In addition to the HPS guidance, the Chief Medical Officer (CMO) has developed targeted clinical advice for nursing home and residential care residents and COVID-19. This is attached here at Annex 1. It will also shortly be published on the Scottish Care, Care Inspectorate, and SSSC websites, and linked to from the HPS guidance. It is recognised that

those who are in care homes are often frail with complex needs. Based on the current emerging picture around COVID-19, CMO advice **suggests that long term care facilities should be subject to 'social distancing',** to reduce the risk of infecting residents and their carers in this vulnerable group. This should operate at 2 levels:

1) reducing visits to care homes to essential visits; and
2) social isolation in rooms.

The long term care and residential care sector is vital to the wider health and social care system. It is essential that it continues to function in an effective way so that people and communities are supported in the right way. It also in some cases provides a safe alternative to more acute settings, including hospital care. It is therefore imperative that care homes continue to take admissions if it is clinically safe to do so.

Further practical guidance for use in different social care settings will be issued in the coming days to support local arrangements.

I understand that the COSLA National Social Care Contingency Planning Group (NCPG) met this week and a number of actions are being taken forward by national and local partners to support the social care sector. These include actions on:

- Changes to regulatory scrutiny
- Changes to local authority duties to assess
- Changes to workforce registration requirements
- Redeployment of staff
- Steps to ensure access to supplies for social care providers
- Workforce terms and conditions
- Commissioning and procurement
- Processes for monitoring the situation

I know that all of you across our health and social care system will be working collectively in this rapidly evolving situation. I want to thank you for all your hard work in preparing for and responding to COVID-19.

JEANE FREEMAN

Annex 1

Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19

This guidance is targeted at providing clinical advice for adults in long term care such as residents of nursing home and residential care settings. It is recognised that those who are in care are often vulnerable or frail with complex needs and varying levels of dependence. Current estimates are that there are over 40,000 residents in care homes across Scotland. The average age is estimated to be 84 years. 50% of residents have a formal diagnosis of dementia although the real numbers may be far higher. Ordinarily mortality rates for these residents is between 13 and 17% illustrating the vulnerability of the group. The long term care/residential care sector is vital to the wider health and care system and it is essential that it continues to function in a safe and effective way as it provides a safe and appropriate alternative in some cases to more acute settings such as hospital care. It is therefore imperative that care homes continue to take admissions if it is clinically safe to do so.

Measures to prevent and prepare for infection in residents

1. It is recommended that long term care facilities be subject to **'social distancing'** to reduce the risk of infecting residents and their carers and most significantly aims to reduce the mortality in this group. This needs to operate at two levels:
Reducing visitors to the home apart from essential visits. This should seek to reduce external visitors by 75% as with other guidance. This might need to consider visits from appropriate health and care staff as essential. Thought should be given to having a named relative as contact. There may need to be consideration given to a named relative as an essential visitor, but the frequency and duration of visiting will need to be reduced. Obviously there needs to be flexibility where appropriate such as in end of life settings. Where residents are affected it will be appropriate for visitors to don PPE in order to be able to spend time with them. It would also be reasonable to ask visitors for symptoms on arrival and to ask symptomatic people to stay away. As with previous experiences it may be wise to exclude visits from children as potential carriers of infection.
Social isolation in rooms. There is a high risk within a long term care facility that infections are spread between residents through communal areas such as lounges and dining areas. Residents should be isolated within their rooms as much as is practical and ideally reducing time in communal areas by 75% also. Meals should be served in residents rooms where possible and communal sitting areas avoided. It may be practical to stagger meal times to allow staff to manage this and to allow adequate time for cleaning. If communal areas do have to be used it is advised that the distance between residents should be two metres where possible.

2. **Handwashing between contacts** should be maximised and the regular use of liquid soap and paper towels.

3. **Appropriate PPE** should be used for positive cases and long term facilities should ensure that they have access to adequate stock and that they know where to access additional supplies if needed. Advice on what PPE to use, how to obtain equipment and dispose of it is available through HPS. All staff (of any grade) must be made aware of the guidance. https://www.hps.scot.nhs.uk/a-to-z-of-topics/wuhan-novel-coronavirus/#publications

4. **Anticipatory Care Plans** should be in place for as many residents as possible (and ideally all residents) in these settings. Clear documentation of 'What matters to me' is helpful in the event of changing circumstances. In many cases the staff in the Residential or

Nursing Home settings are able to start these conversations. Healthcare Improvement Scotland are adapting ACP documentation to a 1-2 page summary tailored to dealing with the current situation. Do Not Resuscitate paperwork should be in place where appropriate and communicated appropriately with patients or carers. It may be judicious to ensure that just-in-case medication is prescribed for high risk residents. Similarly verification of death paperwork for appropriate ill patients may help staff to anticipate and manage death and minimise clinician contacts.

5. **NHS Near Me** technology to provide access to GPs and community teams may help to reduce the number of visits whilst providing access to support and occasional clinical opinions.

6. **Cleaning** of communal areas, particularly hard surfaces and rooms should be a priority to reduce the risks of transmission.

7. **Staffing levels** need to be considered in relation to higher dependency of residents and care provision in the isolation of their own room coupled with higher staff sickness levels. This will need to be considered in the context of business continuity planning of NHS Board's and Health and Social Care Partnerships where staff may be deployed to support care homes.

Mitigating factors to consider while caring for residents in long term care.

Implementing these measures including social distancing may have adverse effects that need to be considered. These could include:

- Increased immobility and higher falls risk for particular patients.
- Low mood from social isolation
- Boredom
- Loss of contact with families.

These factors may be more marked for residents with dementia. Deploying measures to address and mitigate these factors will be important. This may be best addressed using volunteers or third sector charitable organisations to support the work of activity coordinators adapting to engaging with individuals and to be seen as part of essential contacts. It is of course crucial that they are trained in the correct hygiene precautions. Access to spiritual care may be also be helpful. Use of video technology for accessing relatives and others (some homes are supplying iPads to residents to allow face time) or 'playlist for life' music.

Transitions from hospital.

There are situations where long term care facilities have expressed concern about the risk of admissions from a hospital setting. In the early stages where the priority is maximising hospital capacity, steps should be taken to ensure that patients are screened clinically to ensure that people at risk are not transferred inappropriately but also that flows out from acute hospital are not hindered and where appropriate are expedited.

Managing COVID-19 cases in long term care settings.

Patients suspected of having symptoms of COVID-19 should be managed in line with other HPS guidance and specifically should be isolated in their own room. PPE equipment should be used as in line with other guidance for droplet spread precautions. Handwashing should continue rigorously in line with guidance elsewhere.

It is not advised that residents in long term care are admitted to hospital for ongoing management but are managed within their current setting.

Where a long term care facility is affected we should aim to deploy in-reach to bring care to residents. That may mean members of the community such as district nursing AHPs, GPs or where appropriate hospital at home. This will be considered in the context of business continuity planning of NHS Board's and Health and Social Care Partnerships where staff may be deployed to support care homes.

Where a long term care facility has a resident who has tested positive for coronavirus, further admissions should be halted.

In relation to dealing with a death it is crucial to abide by guidance on the preparation of the body and transportation in line with existing guidelines.

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Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19

Version History

Version	Date	Summary of changes
1.1	13/03/20	First version of document
1.2	26/03/20	Updated to include: HPS advice on care home admissions, shielding advice, visiting

1. Introduction

This guidance provides targeted clinical advice about COVID-19 to support those working with adults in long term care such as residents of nursing home and residential care settings (care homes). It should be read in conjunction with infection control guidance developed by Health Protection Scotland (HPS) for Social or Community Care & Residential Settings.

It is recognised that those who are in care are often frail with complex needs and varying levels of dependence. Current estimates are that there are over 40,000 residents in care homes across Scotland. The average age of residents is estimated to be 84 years. 50% of residents have a formal diagnosis of dementia, although the real numbers may be far higher. Ordinarily mortality rates for these residents is between 13 and 17% illustrating the vulnerability of the group.

Most of those in care homes will be at greater risk if they were to contract COVID-19 due to conditions such as frailty, cognitive impairment including dementia, physical disability, neurological and other conditions, and learning difficulties or multiple comorbidities. For many, hospital admission may be inappropriate – this means additional support within the care home setting may be necessary for the acutely unwell.

The long term care/residential care sector is vital to the wider health and care system and it is essential that it continues to function in a safe and effective way as it provides an appropriate alternative in some cases to more acute settings such as hospital care. It is therefore imperative that care homes continue to take admissions if it is clinically safe to do so. This guidance will support you in doing this.

2. Measures to prevent and prepare for infection in residents

2.1 Presentation

COVID-19 should be suspected in residents with influenza-like illness such as a fever of at least 37.8°C and at least one of: new persistent cough, hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing or sneezing.

To support diagnosis in residents, it is important that care home staff take residents temperature and where necessary are supported to take other vital signs including blood pressure, heart rate, pulse oximetry and respiratory rate. This will enable external healthcare staff to triage and prioritise support of residents according to need.

While such monitoring will be helpful for diagnosis, it is important to note that for many older people living with frailty, their presentation when unwell may be very different to younger people. They may not have a cough and a temperature but may have a decline in function, falls or increased confusion as a symptom that they are unwell. Staff and family members will often be able to provide information on changes of health, behaviour or mood. The most important thing is simply to be vigilant that someone who is frail may experience health challenges in a different way and being aware of that may provide an opportunity to flag up when someone needs medical or nursing assessment.

2.2. Social distancing and shielding

Long term care facilities be subject to **'social distancing'** and **'shielding'** to reduce the risk of infecting residents and their carers.

Social Distancing: This measure reduces social interaction between people in order to reduce the transmission of the virus. It is intended for those situations where people are living in their own homes with or without additional support from friends, family or carers.

Shielding: This is for people (inc. children) who are at very high risk of severe illness from COVID-1 when an extremely vulnerable person is living in their own home, with or without additional support and those in long term care settings. The aim of shielding is to minimise interaction between individuals and others to protect them from coming into contact with the virus, thereby aiming to reduce mortality in this group. Information on which people are in this category and what to do are on the NHS Inform website

Within a long term care setting, this needs to operate at two levels:

- **Routing visiting should be suspended** – Only **essential visitors** permitted in line with HPS guidance. Local risk assessment and practical management should be considered, ensuring a pragmatic and proportionate response. Visits from appropriate health and care staff would be classed as essential. For family and friends, **visits should be restricted to end of life care situations or people with dementia who are distressed.** In such instances there should be a named contact for visiting, and ideally visits should involve one person at a time; no children should be permitted. These visitors must not visit any other care areas or facilities. Where a resident has COVID-19, it will be appropriate for visitors to wear PPE in order to be able to spend time with them. Visitors should also be asked about symptoms on arrival; symptomatic people should stay away. A log of all visitors should be kept**.** Consideration should be given to alternative measures of communication including phoning or face-time. Visiting may be suspended if considered appropriate.

- **Residents to remain in rooms as far as possible** - There is a high risk within a long term care facility that infections are spread between residents through communal areas such as lounges and dining areas. Residents should stay within their rooms as far as possible. Meals should be served in residents rooms where possible and communal sitting areas avoided. It may be practical to stagger meal times to allow staff to manage this and to allow adequate time for cleaning. If a communal area

does have to be used on occasions, then it is advised that the distance between residents should be approximately two metres where possible. Where a home has people with infections, communal activities should be avoided.

2.3 Handwashing between contacts should be maximised and the regular use of liquid soap and paper towels (see hand washing advice in appendix 2 of HPS guidance).

2.4 Appropriate Personal protective equipment (PPE) should be used for positive cases and long term facilities should ensure that they have access to adequate stock and that they know where to access additional supplies if needed. Advice on what to wear and how to don the PPE is available in Appendix 3 of the HPS guidance and all staff must be made aware of it. This includes the disposal of the equipment. All staff (of any grade) must be made aware of the guidance.

2.5 Anticipatory Care Plans (ACP) should be in place for as many residents as possible (and ideally all residents) in these settings. Clear documentation of 'What matters to me' is helpful in the event of changing circumstances. In many cases the staff in the care home settings are able to start these conversations with involvement of families. Healthcare Improvement Scotland are adapting ACP documentation to a 1-2 page summary tailored to dealing with the current situation. Do Not Resuscitate paperwork should be in place where appropriate and discussed appropriately with residents or carers. It may be judicious to ensure that just-in-case medication is prescribed for high risk residents. Similarly verification of death paperwork for appropriate ill residents may help staff to anticipate and manage death and minimise clinician contacts.

2.6. NHS Near Me video consulting (powered by Attend Anywhere) can be used to reduce exposure to coronavirus. It provides care homes with access to GPs, community teams and clinicians to help to reduce the number of visits whilst providing access to support and occasional clinical opinions. Scenarios where video consulting may be beneficial in homes include:

- To protect residents from potential exposure to coronavirus from visiting clinicians in situations where non hands-on care can be given.
- To avoid transporting residents to hospital for outpatient type clinic appointments.
- To maximise clinician capacity by avoiding travel time.

2.7 Cleaning of communal areas - there should be vigilance around cleaning in communal areas, particularly of frequently touched areas such as door handles, light switches and chairs arms where the virus can persist for up to 72 hours.

2.8 Staffing levels need to be considered in relation to higher dependency of residents and care provision in the isolation of their own room coupled with higher staff sickness levels. This will need to be considered in the context of business continuity planning of NHS Board's and Health and Social Care Partnerships where staff may need to be deployed to support care homes.

3. Mitigating factors to consider while caring for residents in long term care.

Implementing these measures including social distancing may have adverse effects that need to be considered. These could include:

- Increased immobility and higher falls risk for particular residents.
- Low mood from social isolation

- Boredom
- Loss of contact with families.

These factors may be more marked for residents with dementia who may be at increased risk of becoming anxious, frustrated and distressed by social distancing measures. Therefore the use of appropriate language will need to be carefully considered.

The use of personal protective equipment may also increase anxiety and distress in someone who is confused or evoke an unexpected reaction. Staff should be aware of this, where possible explain their appearance in ways that the person understands, be thoughtful and try to minimise any negative reaction.

Family members and friends who may not be permitted to visit will also need reassurance and understanding. Many will be anxious about the wellbeing of the person they care about and worry about the impact on their relative or friend of measures to reduce contact with others. Utilising and proactively facilitating alternative ways that they can continue to stay in contact using phone or digital technology will be essential for both the resident, their family and friends. Access to spiritual care through this means may be also be helpful.

4. Admissions, discharges and transfers involving social or community care and residential settings

As stated above the care home sector is a vital part of the health and social care system. It is imperative that the care homes continue to take admissions if it is clinically safe to do so in order to prevent flows out from acute hospital being hindered and where appropriate expedited.

The HPS guidance on social care settings includes updated advice on measures to be put in place prior to an admission to a care home from the community or hospital setting to ensure that individuals across the entire facility are managed appropriately and safely. This advice summarised below.

4.1 Admissions from the community to care home facilities

HPS guidance states, prior to admissions the care home facility should:

- source information on NHS Inform for current symptom and isolation advice, using the symptom and isolation checker
- discuss with local senior facility healthcare staff and or a designated senior decision maker in the community prior to planned admission, including consideration of current isolation advice for that individual or the household from which they are being admitted.

HPS guidance also states that people being admitted from home / the community do not need to be tested for COVID-19 and should be managed based on symptoms.

4.2 Admissions/transfer from hospital to care home facilities

HPS updated guidance states that if the individual is deemed clinically well and suitable for discharge from hospital, they can be admitted to the facility after:

- appropriate clinical plan.
- risk assessment of their facility environment and provision of advice about self-isolation as appropriate (See NHS Inform for details).

- there are arrangements in place to get return them to the facility

Decisions about any follow-up will be on a case by case basis.

If a patient being discharged from hospital is known to have had contact with other COVID-19 cases and is not displaying symptoms, secondary care staff must inform the receiving facility of the exposure and the receiving facility should ensure the exposed individual is isolated for 14 days following exposure to minimise the risk of a subsequent outbreak within the receiving facility.

Individuals being discharged from hospital do not routinely need confirmation of a negative COVID test. Facilities will be advised of recommended infection prevention and control measures on discharge. It is recommended that this includes a documented clinical risk assessment for COVID-19. Annex A contains a new admissions/ transfer form to provide a means for safely admitting a new resident and identifying that where possible they have been deemed clinically safe for transfer.

4.3 Advice on care home admissions where there are COVID-19 cases in homes

The updated advice from HPS states that social or community care and residential settings may remain open to admissions in the following situations:

- Where a single case of laboratory confirmed COVD-19 has been identified and all appropriate infection prevention and control procedures are in place.
- Where more than 1 laboratory confirmed case has been identified and following risk assessment and discussion with the local Health Protection Team (HPT), it is possible to manage cases and ensure all appropriate infection prevention and control measures are in place.

Where there is evidence of a cluster or outbreak of COVID-19, senior facility staff should discuss this with the local HPT. An outbreak is defined as two or more clinical or laboratory confirmed cases of COVID-19 in a 24 hr period which have occurred as a result of cross transmission. In this situation the facility should close to admissions day care facilities and visitors. Any derivation from this should be done following a risk assessment with HPT as there may be exceptional circumstance where for example the schematic layout of the facility may allow for partial closure.

4.4 Transfer from social or community care and residential settings to hospital

If a transfer from a Social or Community Care and Residential Settings to hospital is required, the ambulance service should be informed if the individual is a suspected or confirmed COVID-19. Staff in the receiving ward/department should be notified of this in advance of any transfer.

5. Managing COVID-19 cases in long term care settings.

Residents suspected of having symptoms of COVID-19 should be managed in line with other HPS guidance and specifically should be isolated in their own room. PPE equipment should be used as in line with other guidance for droplet spread precautions. Handwashing should continue rigorously in line with guidance elsewhere.

It is not advised that residents in long term care are admitted to hospital for ongoing management but are managed within their current setting.

Where a long term care facility is affected it may be necessary to deploy in-reach healthcare support for residents. That may mean community staff such as district nursing, Allied Health Professionals, GPs or where appropriate hospital at home services. This will be considered in the context of business continuity planning of NHS Board's and Health and Social Care Partnerships where staff may be deployed to support care homes.

In relation to dealing with a death, it is crucial to abide by guidance on the preparation of the body and transportation in line with existing guidelines.

6. Access to supplies

Social care providers who are registered with the Care Inspectorate, who are dealing with confirmed or suspected cases of COVID-19, and have urgent issues with obtaining PPE (disposable gloves, disposable aprons, fluid repellent surgical face masks) should contact the NHS National Services for Scotland (NHS NSS) triage centre for social care supplies for COVID-19.

Please note that in the first instance, the triage centre is to be used only in cases where there is an urgent supply shortage after business as usual routes have been exhausted and a suspected or confirmed case of COVID-19 has been identified.

The following contact details will direct registered providers to the triage centre:

Phone: 0300 303 3020

When contacting the helpline, providers will be required to:
a. Answer a series of short screening questions.
b. Confirm they have fully explored business as usual procurement routes
c. Confirm they have a suspected or confirmed case of COVID-19 and therefore have a need for Personal Protective Equipment (PPE)
d. Provide their Care Inspectorate registration number

The helpline will be open (8am - 8pm) 7 days

This helpline is for all social care providers registered with the Care Inspectorate.

This helpline is not for NHS staff or for NHS providers who have an NHS business as usual supply route.

Where providers report issues with supplies of products other than PPE, this information will be recorded and fed into wider work on supplies.

Professor Graham Ellis, Senior Medical Adviser to the Chief Medical Officer
Scottish Government
26 March 2020

Annex 1

New admission/transfer form.

(must be completed within 24 hours or admission or transfer)

Name:
Date of Birth/CHI:
Date of form completion:

The purpose of this document is to provide a means for safely handing over a resident and identifying that where possible they have been deemed clinically safe for transfer.
Swab testing for coronavirus is not recommended for patients who do not have symptoms or are not unwell and so a clinical judgement on an individual's safety to be admitted into a nursing or residential home environment is key.

NEWS Score: ☐

Does the patient have symptoms of:
New and enduring cough?
Y / N
(Chronic cough does not count)
Fever?
Y / N
In the clinical judgement of the most senior medical decision maker this person does not have new medical or infective problems. **Y / N**

Residents on admission should be isolated for 7 days to ensure that they do not develop new symptoms. This isolation period can include days in hospital spent in isolation. If they have already been in protective isolation, number of days:_____

Directorate for Chief Medical Officer
Dr Gregor Smith
Interim Chief Medical Officer for Scotland

The Scottish Government
Riaghaltas na h-Alba

For Action
GP Practices

For information
Chief Executives NHS Boards
NHS Board Primary Care Leads
Practice Manager Network
Practice Nurse Network

17 April 2020

Dear Colleagues,

CARE HOMES AND COVID 19

We thought it would be timely to write to you in support of your role in continuing to provide a high level of care to the residents of care homes at this time.

GP Practices continue to be critical in supporting frail and elderly residents in care and nursing homes. We realise that some of you will be more involved with care homes than others depending on local arrangements but we urge you to reach out to these settings, where appropriate, to offer reassurance and support during what is a worrying time for this sector.

It is important to remember that even at this time decisions on the care of patients should always be made on an individual basis. If it is in the best interests of an individual that they be admitted to hospital, then this should be arranged. In some cases, a hospital admission may not be appropriate and in those instances additional support may need to be provided within the care home depending on availability of local services. Decisions on the appropriate management choices should only be made after discussion with the patient, their next of kin or welfare guardian (if lacking capacity) and with the lead nurse or carer in the home.

The way we provide patient care has changed during the pandemic, with increased use of telephone and Near Me assessments where possible to minimise potential transmission of infection through face to face contact. However there are still times when a face to face consultation is clinically necessary, and an expectation that health and care professionals will continue to enter care settings such as care homes to provide ongoing care and support when required, with appropriate safety measures such as PPE in place.

Anticipatory care planning is an important but difficult part of the work we do even in ‘normal’ times. We recognise there are additional challenges to doing this during the pandemic and that it is invoking anxiety for many patients and GPs. These conversations would normally happen face to face, over a series of conversations, with family present to support. These supportive factors are not usually possible at the

current time but it remains crucially important that patients are offered the opportunity to have these discussions about what matters to them should they fall ill whether with Covid or otherwise. There is no specific requirement to have a DNACPR discussion as part of this conversation, unless the patient raises this and wishes to discuss it, or the clinician feels strongly that they need to discuss it. This guidance was included in the ACP letter to practices last week.

Finally we would like to emphasise the crucial role you play as a general practitioner at this difficult time. Your leadership within the health and social care system and your involvement as an expert medical generalist is a key part of the response to this pandemic. This is particularly true in the relationship between your practice and your local care homes in working together towards the mutual aim of providing safe and high quality care for your most vulnerable patients.

We've attached a short set of frequently asked questions and answers on the practice's role on the provision of timely and appropriate clinical care to care homes which we hope is helpful.

Thank you for all the vital work that you are doing.

Yours sincerely,

Dr Gregor Smith
Interim Chief Medical Officer

Andrew Buist
Chair of the Scottish General Practitioners
Committee of the BMA

Carey Lunan
Chair of the Royal College of General
Practitioners

Chief Nursing Officer Directorate
Fiona McQueen, Chief Nursing Officer

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T: 0131-244 2314 F: 0131-244 3465
E: fiona.mcqueen@gov.scot

NHS Territorial Board Chief Executives (by email)

CC: Scottish Directors of Public Health

16 April 2020

Colleagues,

Firstly, please let me start by thanking you for the extraordinary work you are doing to support our vulnerable and elderly population across Scotland's care homes.

I write to make you aware of the First Minister's announcement yesterday, 15 April 2020, that Scotland will move to a system where any symptomatic patient in a care home will be clinically assessed and, were appropriate, offered testing for COVID-19. This is a departure from existing infection management procedures of only testing initial cases in order to establish whether an outbreak has occurred. We are making this change in acknowledgement of the unprecedented pressures on our care homes, in order to offer this additional level of reassurance during what will be a deeply unsettling time for both our vulnerable elderly population and their families.

Health Protection Scotland will be updating their guidance to reflect the changes, and I would be grateful if you could liaise with your local NHS Health Protection Teams to ensure care homes are supported in the transition to this new increased testing regime. Further to this, I would also be grateful if you could be alert to the fact that we are looking to Boards to collate data on the number of care home residents tested and provide this to Health Protection Scotland.

The Scottish Government continues to work closely with NHS National Services Scotland and Public Health Scotland to rapidly increase our testing capacity across Scotland. We have already increased our capacity to over 2,000 tests per day and are on track to increase to 3,500 by the end of April. As we increase our capacity, we will further develop our testing prioritisation strategy.

Fiona McQueen

Fiona C McQueen

Chief Nursing Officer

Directorate for Chief Medical Officer
Catherine Calderwood
Chief Medical Officer
Directorate for Chief Nursing Officer
Fiona McQueen
Chief Social Work Adviser
Iona Colvin
E: cmo@gov.scot

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To :
Social Care Providers
Chief Social Work Officers
Local Authority Chief Executives
Integration Authority Chief Officers
NHS Board Chief Executives
Primary Care Leads
NHS Board Medical Directors

Dear Colleagues

Coronavirus (COVID-19) Guidance for Social Care:
1. Updated Health Protection Guidance for Social or Community Care and Residential Settings
2. Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19
3. Guidance for Care at Home, Housing Support and Sheltered Housing

Firstly, I would like to thank you for your response in providing care and support to so many of our most vulnerable citizens in these unprecedented times. Your commitment and dedication in providing quality care during these most difficult circumstances is greatly valued. I am writing to provide you with an update on infection control and clinical care guidance on COVID to support the safe and effective provision of health and social care in social care settings.

1. COVID-19: Health Protection Scotland Guidance for Social or Community Care and Residential Settings

Health Protection Scotland has today published updated infection control guidance for Social or Community Care and Residential Settings. It is based on the National Infection Prevention & Control Manual and includes advice on how to prevent spread of all respiratory infections including COVID-19 with setting-specific information and advice.

The updated guidance is available here:
https://www.hps.scot.nhs.uk/web-resources-container/covid-19-information-and-guidance-for-social-or-community-care-residential-settings/

The care home sector is a vital part of the health and social care system so it is imperative that the sector continues to take admissions if it is clinically safe to do so. The updated guidance includes further advice on managing safe care home admissions and on social distancing.

Alongside the HPS guidance, we have published two clinical care guides providing targeted clinical advice on COVID in different social care settings:

2. COVID-19: Clinical Guidance for Nursing Home and Residential Care Residents
We have updated our clinical care guidance for care homes following the additional advice from HPS on care home admissions. The guidance aims to support measures to prevent and prepare for COVID.

This revised guidance is available at:

3. COVID-19: Clinical Care Guidance for Care at Home, Housing Support and Sheltered Housing

We have also published clinical guidance for the management of clients accessing care at home, housing support and sheltered housing and is available at:

The clinical guidance should be read in conjunction with infection control guidance developed by Health Protection Scotland (HPS) guidance for Social or Community Care & Residential Settings.

We will continue to review the guidance taking account of changes in the emerging picture around COVID-19

I hope this is useful.

Yours sincerely

Catherine Calderwood
Chief Medical Officer

Fiona McQueen
Chief Nursing Officer

Iona Colvin
Chief Social Work Adviser

Office of the Chief Executive NHSScotland and Director General of Health & Social Care Directorates
Malcolm Wright

The Scottish Government
Riaghaltas na h-Alba

To: Health Board Chief Executives
CC: Directors of Public Health
Chief Officers
Chief Executives of Local Authorities

17 April 2020

Dear Colleague

I recognise the significant work that NHS Boards have already done in response to the COVID-19. We have placed NHS Scotland on an emergency footing and I want to take this opportunity to thank you for the enormous work you have already done to transform the delivery of services, including very significant pivoting of staff and repurposing of facilities. I am writing to you today with a further ask in relation to care homes.

We know that this virus is highly virulent and has the hardest impact on the most vulnerable older people in our society. Close to half of our care homes in Scotland either have active or have had active cases of COVID and I recognise and appreciate all that has been done, working with the Care Inspectorate and others to support care home residents.

Much has been done, but we need to do more. The First Minister and Cabinet Secretary for Health and Sport have requested that Directors of Public Health take immediate action to deliver an enhanced system of assurance around the safety and wellbeing of care home residents and staff during these extraordinary times.

Directors of Public Health are uniquely well placed to lead, plan, initiate and co-ordinate this work locally. Cognisant of significant local work already underway, I am therefore writing to ask you to mobilise immediately those directors and your health protection teams to undertake the necessary action, working with local Infection Prevention and Control Teams, the Care Inspectorate, primary care teams and others. In broad terms, I am asking Directors of Public Health to oversee the provision of local support and assurance to all care homes so that they can provide a safe setting for their residents and staff throughout the Covid 19 incident.

Exactly what will be involved in this work and how it will be delivered will vary between NHS Boards. However, in all cases it will need to involve early substantial contact between DsPH and their teams and every care home in their area. The principal purpose of such contact will be to provide multi-disciplinary support and assurance to enable each home to follow in practice the range of national guidelines on Covid 19. As a minimum, this work must cover an assessment in respect of each home of:

1 knowledge and implementation of **infection prevention and control measures** (NHS guidance 1234).
2 knowledge and observance of **social distancing** measures, both for staff and residents.
3 **staffing** levels at all times and for all functions
4 the availability and quality of **training** for all staff in particular on infection control and the safe use of PPE (NHS guidance 5678).
5 the effective use of **testing.**

In taking this work forward, you should seek both to respond effectively to reported cases of covid-19 and to take preventative action to shield those homes where there have been no such cases.

DsPH should report on a weekly basis providing an update on the progress of the assessment outlined above for the care homes within your geographical boundary along with any good practice to be shared. We shall provide you with more details shortly, including a sample template. All such reports should also be sent to the relevant Chief Officers and Public Health Scotland. We in turn will be providing the First Minister with weekly updates of progress

This work will involve considerable joint working between teams and disciplines. Whilst I am tasking DsPH with particular responsibilities, there will be important roles for other teams, such as nursing and other staff including GPs. It will also be very important to collaborate closely with other local partners, in particular Chief Officers and care inspectorate (CI) teams. You will want to consider how to make best use of the many and varied assets at your disposal and you should not limit your ambitions by lack of access to clinical or other assets.

I am conscious that this emergency is requiring many of us to act in new ways and circumstances. With that in mind, I am anxious to ensure there continues to be as much support as possible for those delivering locally.

Health Boards and HSCPs, in collaboration with Local Government, have already drawn up mobilisation plans which of course reference the need to provide safe care home and care at home provision. Chief Officers have now provided a response to the Scottish Government on the work that local systems are doing to support the care home sector. Health Boards and HSCPs, in collaboration with Local government, have already drawn up mobilisation plans which of course reference the need to provide safe care home and care at home provision. Chief Officers have now provided a response to the Scottish Government on the work that local systems are doing to support the care home sector and there is evident good practice to draw upon including system-wide wrap around support for Care Homes. We will collate and promulgate good practice.

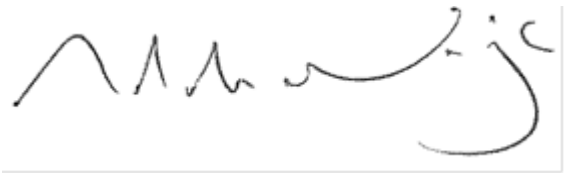
The Care Inspectorate and Public Health Scotland will play important roles in supporting you as well. I will be asking Public Health Scotland to continue to develop national standards and to identify potential support measures, building on the work that is already ongoing locally.

We are working with you to finalise educational material including algorithms to support infection prevention and control, reporting of suspected COVID-19 cases, segregation and cohorting requirements and escalation measures. It is our intention to share this material with you in the next week.

Finally, the CMO will shortly be setting up a short life task force of professionals with relevant expertise drawn from across government departments, charged with identifying urgently those interventions which will be most effective to combat the spread of Covid 19 in Scotland's care homes. This group will providing advice, guidance and support and engagement with the professions involved in local support measures. This will also include guidance to support the provision of staff required to meet the growing needs of residents in these settings.

Thank you very much for the contributions you and your teams will make to this extremely important task.

Yours sincerely



Malcolm Wright
Chief Executive of NHSScotland and Director General of Health and Social Care

Chief Nursing Officer Directorate
Fiona McQueen, Chief Nursing Officer
Chief Medical Officer Directorate
Dr Catherine Calderwood MA MRCOG FRCP(Edin), Chief Medical Officer

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To:

Chief Executives NHS Scotland
Chairs NHS Scotland
Workforce Senior Leadership Group
HR Directors
National Staffside Representatives
Medical Directors
Nursing Directors
Employee Directors
Chief Officers (NHS Boards and Local Authorities)
Local Authority Chief Executives
Chief Social Work Officers
Chief Officers H&SCP
Care Inspectorate H&SCP
Scottish Social Services Council (SSSC)
Scottish Care
Coalition of Care and Support
Funded Health and Social Care Partners
Directors of Public Health

2 April 2020

Colleagues

Revised PPE guidance

In response to the emerging epidemiology and evidence, urgent work has been under way to review the existing UK-wide Personal Protective Equipment (PPE) guidance and today the revised guidance will be published.

This guidance is issued jointly by the Department of Health and Social Care, Health Protection Scotland (HPS), Public Health Wales, Public Health Agency Northern Ireland, Public Health England (PHE) and NHS England as official guidance and is hosted on the PHE website.

The guidance can be accessed via the COVID-19 section of the Health Protection Scotland (HPS) website. It outlines what PPE frontline health and social care workers should be wearing in different settings and scenarios. The guidance has had input from Royal Colleges and is endorsed by expert scientific groups.

The updates reflect the fact that COVID-19 is now widespread in the community, meaning clinicians and care workers are more likely to see people with the virus, some of who will not have symptoms yet.

The guidance itself recommends the safest level of PPE to protect health and social care workers and it specifies the type of PPE that should be worn in the various healthcare and social care settings where patients or residents could be cared for.

New tables have been added to the guidance, which clearly explain the PPE required for different common clinical and care scenarios. The first table relates to acute hospitals and the second and third are for primary care, outpatient and community care, ambulance staff, paramedics, first responders and pharmacy. There is an additional table that describes when to use PPE when caring for any patient or resident. This last section is important at a time when we are aware that there is sustained community transmission of COVID-19, and the likelihood of any patient or resident having COVID-19 without any of the recognised symptoms is raised.

Given the recognised sustained community transmission of COVID-19, the guidance importantly includes detailed advice around risk assessing use of PPE, including aprons, gowns, Fluid-Resistant Surgical Masks and eye protection, in a range of different clinical and care scenarios, including community settings, such as care homes and caring for individuals in their own homes. The guidance also asks that organisations themselves undertake risk assessments to ensure that they provide the correct PPE for the safety of their staff.

The guidance is also clear that, in line with agreement from the Health and Safety Executive, in certain circumstances, some PPE – particularly masks and eye protection - can be worn for a full session, and doesn't need to be changed between patients. This will ensure that health and social care workers can safely carry out their work; particularly when they are working in areas where there is a high risk of COVID-19 transmission such as Emergency Departments or intensive care units. The Health and Safety Executive has reviewed the guidance and agreed the appropriate sessional use of some PPE.

Importantly, in terms of shielding the extremely vulnerable in our society, the guidance advises that secondary, primary and community care workers should wear a surgical mask when providing care to any individuals in the extremely vulnerable group.

As outlined in earlier guidance, the highest risk of transmission of this virus occurs when it is aerosolised - therefore when carrying out aerosol generating procedures (AGPs) clinicians are required to wear a higher level of protective equipment. These are detailed in the guidance and subject to continual review based on emerging evidence by the UK National Emerging Respiratory Virus Threats Advisory Group. When aprons are used for non-aerosol generating procedures, it is vital that clinicians and social care workers thoroughly wash their forearms if there is a risk of exposure to droplets. This is consistent with the UK policy of bare below the elbows and evidence reviews on the risks of healthcare acquired infections.

Please be aware that we have tried to highlight some specific key updates, however, this letter does not cover all changes. As such, we urge you and your frontline staff to read the revised guidance in full on the COVID-19 pages of the HPS website.

Health Protection Scotland Posters

To provide absolute clarity on what these changes mean for health and social care staff working on the frontline, HPS has helpfully produced visual posters specifying what kind of

PPE should be worn in which setting or scenario. A poster has been produced for each of the following settings:

1. Healthcare settings: Caring for patients not suspected or known to have COVID-19
2. Community settings: Caring for patients or residents not suspected or known to have COVID-19
3. All health and social care settings: Caring for patients who are confirmed or suspected to have COVID-19
4. High risk acute areas: Caring for patients who are confirmed or suspected to have COVID-19

The posters have been made available on the COVID-19 section of the HPS website so that they can be printed and displayed in each of the respective settings.

Guidance with national standing

It is important to reiterate that in Scotland, guidance produced by HPS, PHE and the Scottish Government Health and Social Care Directorate (SGHSCD) has national standing. Royal Colleges and other professional organisations producing supplementary IPC guidance are encouraged to use the HPS guidance as a single source of information.

We are aware that some guidance has been produced which diverges from that published by HPS, particularly regarding what is and isn't classified as an Aerosol Generating Procedure (AGP). Again, I would like to take this opportunity to request that Health Protection Scotland's list of AGPs is used as the single source of information. This can be accessed via the National Infection Prevention and Control Manual and via the COVID-19 pages on the HPS website under 'Aerosol Generating Procedures'.

World Health Organisation (WHO) Guidance

This weekend (28-29 March), the WHO confirmed that UK guidance is consistent with WHO recommendations for protecting healthcare workers against COVID-19.

The HSE conducted a rapid review of the guidance which concluded that aprons offer a similar level of protection to gowns and that FFP2 respirators offer protection against COVID-19 and can therefore be used during high risk procedures, if FFP3 respirators are not available.

Secondly, WHO recommends full arm gowns when seeing any suspected or confirmed case of COVID-19. The UK guidance also recommends full arm gowns in high risk procedures and aprons for other procedures, which is consistent with the UK 'bare below the elbow' policy as part of our long-term strategy to reduce healthcare associated infections and effective hand hygiene.

COVID-19 is not airborne, it is droplet carried. We know the cross contamination from gowns for infection can be carried by the gown sleeves and the advice therefore is bare below the elbows and you scrub your hands, your wrists and your forearms.

PPE supply and distribution

We continue to work tirelessly with NHS National Services Scotland, Health and Social Care Partnerships, the social care sector, and with colleagues in other UK nations to procure and

distribute necessary supplies of the types and levels of PPE required to safeguard frontline health and social care workers.

We have introduced new measures to improve the distribution of PPE, including a single point of contact for all health boards to manage local PPE supply and distribution.

A helpline has also been set up for registered social care providers having problems accessing PPE, with extra staff to prepare orders for social care, additional delivery drivers, longer delivery hours and use of more external delivery companies to increase capacity. Work continues to source further PPE and ensure there is an appropriate supply for all our workforce.

The contacts are as follows:

NP NHS COVID - 19 enquiries: NSS.covid19resilience@nhs.net
NHS NSS social care PPE triage: **0300 303 3020**

The Scottish Government also has a new dedicated email address for staff, MSPs or members of the public to raise specific supply issues. This is covid-19-health-PPE@gov.scot. It will be monitored continuously and allow us to act to resolve any specific supply issues more quickly.

We ask senior leaders to deal with local concerns and escalate PPE local supply and guidance issues to NSS in the first instance.

We recognise that there are many unpaid carers who are providing care and support to friends and family members in the vulnerable groups and therefore may need PPE. We would like to reassure you that we are working with NHS NSS to quickly put in place a system to support unpaid carers to access PPE if they need it.

Leadership

Senior clinical and care leaders are asked to ensure that compliance with PPE is in line with the updated PPE guidance. We also ask that clinical leadership is provided to board procurement teams in this difficult time, to ensure local distribution is effectively managed to those areas which require it, and there is no over-ordering or stock piling at local level.

We welcome your support in ensuring the health and social care workforce is signposted to this vital information.

I trust that this information is helpful and, on behalf of the Scottish Government, I would like to thank you all for your tireless, essential and important work.

PROFESSOR FIONA MCQUEEN
Chief Nursing Officer

DR CATHERINE CALDERWOOD
Chief Medical Officer