NHS VALE OF YORK CCG

COVID-19

MANAGEMENT OF AN INFECTED STAFF MEMBER OR PATIENT IN A PRIMARY CARE SETTING

This SOP, and supporting documents, replaces all previous versions which should be destroyed.

Version History Log				
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Contents

Glossary

CCG	Clinical Commissioning Group
HPT	Health Protection Team
IMT	Incident Management Team
IPC	Infection Prevention & Control
PHE	Public Health England
PPE	Personal Protective Equipment
SPOC	Single point of contact
TnT	Test and Trace

1. KEY CONTACTS

PUBLIC HEALTH ENGLAND	
Yorkshire & the Humber Health Protection Team	0113 386 0300
HPT email	phe.yorkshirehumber@nhs.net
VALE OF YORK CCG	
Switchboard	01904 555870
SPOC contact number (On-call director)	0844 5895915
SPOC email	voyccg.covid19tandt@nhs.net
Community Infection Control Team	01423 557340
YORK HOSPITAL	01904 631313
York Hospital COVID Lab	01904 721725

2. BACKGROUND & SCOPE OF THIS PROTOCOL

2.1 Background

Covid-19 was first identified in late 2019 and over six months has spread to cause a global pandemic including the UK. The first epidemic wave in the UK occurred in March 2020, peaking in early April. Since then, the number of new cases, hospital admissions and death from Covid-19 have all fallen steadily over several weeks. It is anticipated further epidemic waves are possible, hence a need for disease control measures to mitigate this. Initial experience in the first few months of the epidemic have indicated that healthcare settings are a high risk setting where outbreaks of COVID-19 have been reported both in the UK and worldwide. The implications of a health professional getting infected are significant, not just for the individual concerned but the wider health team and patients.

This is exemplified by a case report where a GP was identified as a COVID19 positive case. Contact tracing revealed he had had significant contact with most of the primary care team and several patients while infectious. This included a visit to a COVID19-free care home where he had not worn PPE, a full clinical session where no PPE was worn, and a face-to-face partnership meeting. Over 20 staff were identified as contacts and needed to self-isolate for 14 days. This resulted in practice closure for several weeks, thereby disrupting delivery of care to patients registered at that practice.

2.2 Scope & Purpose of this document

In view of the potentially serious impact of infection occurring in primary care settings on business continuity and clinical safety, this document sets out to:

a) Provide advice to primary care settings on mitigation measures that can be taken in order to ensure they are "COVID19-secure".
b) Outline the steps to be taken in the event of case of infection occurring in a primary care setting to investigate, risk assess and manage the incident.

2.3 SARS-CoV-2 / COVID-19 Epidemiology

Table 1. SARS-CoV-2 / COVID-19 characteristics

Mode of transmission	The main mode of transmission of the SARS-CoV-2 virus is believed to be through *droplet spread* but there is increasing evidence of aerosol spread.
Incubation period	Those infected have a period when they are incubating the virus of 1-11 days.
Infectious period	Infectivity is believed to be greatest between 2 days before symptom onset, up to 7 days after symptom onset. It is thought most infected persons become symptomatic during this time. However, cases of asymptomatic carriage and transmission of SARS-CoV-2 have been reported.
Case definition	Anyone presenting with - a new persistent cough - fever (temperature above 37.8^{o}C) - or new anosmia.
Prognosis	For most people of working age with no other co-morbidities this is a mild illness. However, the risk is higher with increasing age, for males, for those with significant comorbidities and in some BAME populations.
Risk settings	Significant transmission has been seen in health and social care settings following contact where PPE is not used- this includes time in common areas.
Key prevention & control measures	Hand hygiene and respiratory precautions, including physical distancing, are needed to reduce transmission. Appropriate PPE, in line with current guidance, is effective in preventing the spread of the virus.

3. NHS Track & Trace Programme

As part of the national response, the NHS Test and Trace Service[1] (TnT) was set up to detect individuals with Covid19 infection (Cases) and to trace others (Contacts) whom they have had significant contact with during their infectious period. The contacts would then be instructed to self-isolate for 14 days in order to break the chains of transmission. It is hoped that NHS Test and Trace will help move the country out of the more severe lockdown restrictions and help prevent a second wave of cases

The approach to reducing the number of cases back to manageable numbers starts with widespread availability of testing for all with symptoms suspicious that fit the case definition[2]. The test used in this case is a PCR test of nasopharyngeal specimens to detect viral RNA. A positive test in the presence of case defining signs and symptoms indicates current infection. Any person that received a positive test result through Pillar 1 and Pillar 2 test schemes will be included in NHS Test and Trace.

Of note, antibody (serology) testing, which would indicate past infection, is not part of TnT. Antibody testing is now available to NHS staff and will be rolled out to the public. At present this has no part in management of cases and contacts.

The sequence is as follows:

1. Persons with suspected Covid19 infection are tested (either through Pillar 1, 2 or hospital testing schemes)

2. Those testing positive (CASES) will be reported automatically to TnT

3. TnT will then contact the cases to identify high-risk contacts whom they have had significant contact with during the infectious period. A list of contacts will be compiled and risk assessed.

   The cases will receive either a text or phone call asking them to go online to complete an online form which includes information about them and the people they have been in contact with. If they do not have access to the internet this form will be completed on the phone by a call handler. In this way,

4. TnT will contact the contacts by text or a phone call to inform them that they are a contact of a known case of Covid-19.

5. The contacts will be advised to self-isolate for 14 days, advised to look out for symptoms of the disease, and how to get tested if they become symptomatic

[1] https://www.gov.uk/guidance/nhs-test-and-trace-how-it-works

[2] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection

4. Management of cases and contacts involving a primary care setting

In the event TnT identifies healthcare workers as a case or contact in healthcare settings, the process will be escalated to the local PHE Health Protection Team (HPT) as further measures are required.

When the local HPT is notified of a case who is a healthcare worker, the social contacts will normally have been traced through the national process. Social contacts include household contacts and other persons whom the infected person has had contact with outside work.

The HPT will also talk to the case to gather more information about their work and their contacts in the workplace during the infectious period. For a healthcare worker, the setting is likely to include staff and patients.

There is also the possibility of an asymptomatic patient who subsequently tests positive after being seen in primary care for a non-COVID19 condition. Consequently, the healthcare worker whom they had contact with may be identified as a significant contact requiring isolation.

The HPT will then pass on the information about the case and any primary care setting contacts to the relevant CCG. The CCG, working with local partners, will investigate and risk assess healthcare setting exposures.

4.1 CCG planning and preparations checklist

- □ CCG should provide a SPOC email for CCG (16 hours per day, 7 days) to allow communication with the HPT
- □ CCG should communicate to primary care to advise of the SPOC and when to use it
- □ Have a tested and functioning escalation procedure for primary care to contact the CCG
- □ CCG should contact the local Director of Public Health (DPH) to ensure representation on COVID19 Outbreak Control Board (OCB)) and have a clearly identified CCG lead officer for partners
- □ CCG to work with the DPH to review healthcare aspects of the COVID19 Outbreak Control Plans
- □ CCG incident management plans and arrangements need to be reviewed in light of COVID19 risks
- □ Review infection prevention and control support available to primary care
- □ CCGs should ensure that all practices are familiar with local arrangements for possible incidents, reporting/escalation mechanisms and how to access support
- □ CCG communication to practices reminding them of the need to plan and prepare, including business continuity planning
- □ Ideally the practice planning will ensure that when cases are identified, all appropriate precautions had been taken such as appropriate IPC measures, physical distancing etc.
- □ Data sharing by email should be from nhs.net to nhs.net accounts.

4.2 CCG actions in the event of an infected primary healthcare worker

Table 2. Definitions

Case definition

Anyone presenting with

- a new persistent cough
- fever (temperature above 37.8°C)
- or new anosmia.

Definition of a contact

The definition of a contact is any of the following without appropriate PPE being used (as per national PPE guidance):

- Direct face-to-face contact (e.g. talking) for any length of time; or
- Being within 1m for 1 min or longer; or
- Being within 2m for 15 mins or longer.

Infectious period

The infectious period for the index case is from 2 days before the onset of symptoms (or when the case was identified by testing) up until 10 days after symptom onset.

Immediate actions (first few hours)

a) Verification of notification

On receipt of information regarding a case or contact in a primary care setting, ***verify that the information received is factually accurate***. Results from testing laboratories, PHE HPT or the case/contact's clinician can usually be relied on. For all other source of notification, it would be useful to verify the case/contact status with the local HPT.

Notification of COVID19 positive cases may be through TnT of anyone who has tested positive for COVID-19, or via the practice or practice employee may contact PHE or CCG seeking advice. Although the TnT system will flag confirmed cases linked with a healthcare setting to the HPT, ***the CCG should also notify the HPT of these healthcare associated cases.*** The HPT will pass single cases to the CCG for the CCG/practice to jointly manage.

b) Identify cases and contacts

The CCG should then liaise with the primary care setting to ***identify all potential contacts in the workplace setting*** using the definitions above. Contact tracing should cover all contacts the index case had during the infectious period. Consider all staff and visitors on the premises. The latter include not only patients (and people accompanying them) but also delivery staff, visiting health and social care workers, etc… Workplaces as part of statutory Fire Regulations should have a timed and dated log of all staff and visitors.

Primary care provider to collate the list of contacts to send to the HPT details of contacts requiring follow up should this be requested (Use a spreadsheet e.g. Appendix 2 template). Return this as soon as possible. Data sharing should be via nhs.net to nhs.net email only for security. (NB: It is likely that these will be sent back to NHS Test and Trace Tier 3 for individual follow up.)

c) **Risk Assessment**

Staff who have a work-based exposure to a patient with COVID-19 without adequate PPE should be subject to a ***risk assessment***. This should take into consideration:

- the severity of symptoms the case has,
- the duration of exposure,
- the proximity of the case,
- the activities that took place when the worker was in proximity (such as aerosol-generating procedures, monitoring requiring physical contact, personal care, etc…)
- and whether the member of staff had their eyes, nose or mouth exposed.

d) Isolate the index case for 10 days

The infected case should be advised to self-isolated for 10 days.

e) Isolate high-risk contacts for 14 days

If the risk assessment concludes that there has been a "significant close contact without PPE" with a confirmed case (as per Table 2. Definitions), the contact should self-isolate for 14 days at home. Where a staff member has had contact with another staff member in the workplace setting during their infectious period, this should be treated in the same manner as a social contact; i.e. the staff should self-isolate for 14 days at home. Caveat: Contacts of confirmed cases should isolate for 14 days from last exposure (as above) unless they become symptomatic before in which case they should isolate for 10 days from onset of symptoms.

f) Infection prevention and control advice

Consider whether there is any more that can be done to ensure or enhance infection prevention and control practice in the primary care setting. For example, social distancing for staff at work in order to reduce any potential impact of all of the above (e.g. thinking about shared areas, cleaning regimes, regular handwashing etc.)

g) Consider and identify other infection risks

As part of the risk assessment, also consider whether there are other infection transmission risks. For example, has the infected staff member as part of their duties visited a care home or sheltered housing during the infectious period.

h) Consider whether escalation is required to HPT for discussion and joint risk assessment regarding next steps

Depending on the circumstances, escalation may be required to the HPT and other system partners (e.g. local authority, local acute trust or community service provider). Escalate:

- ***Where there are concerns with the management of a single case, or***
- ***There have been 2 or more cases associated with the setting within 14 days, or***
- ***It is a complex situation,*** for example, if another setting is involved, e.g. care home.

If CCG is content with risk assessment, then continue to follow up the practice providing advice as required and monitoring compliance with it. Continue to monitor number of cases and contacts. If concerns, then discuss with HPT for possible escalation.

i) Staff and public communication in the first few hours

Provide advice to contacts via text, phone messaging and letters on exclusion/isolation. Consider whether any wider communications may be needed. Is there any media interest?

Further actions within 24 hours

j) Arrange follow up assessments and on-going monitoring.
k) Consider an incident management meeting if required following discussion with HPT.
l) Prepare reactive comms in case of any media or public interest.
m) Consider whether the practice website information needs to be updated.

4.3 Primary care planning and preparations

Primary care should read and implement the national workplace guidance[3] on making workplaces "COVID19 secure". Practice planning should cover:

- □ Managing increased patient visits to the premises e.g. distancing in waiting areas, limiting those who accompany patients into the practice unless necessary
- □ Continuing telephone and online appointments where safe and possible to do so
- □ Ensuring social distancing, necessary precautions at work between staff at work, including in shared spaces and social areas at work
- □ Wearing a surgical face mask when not in PPE or in a part of the facility that is COVID-secure
- □ Making infection prevention control messaging clearly visible, e.g. around staff restrooms, easy-read posters in communal areas
- □ Procedures in place to enable identification of patients, staff and visitors attending the premises and rapidly gathering information for risk assessments , e.g. signing in procedure
- □ IPC and environmental cleaning measures. Refer to and implement the relevant national guidance on infection prevention and control4.
- □ Staff working across different settings
- □ Data sharing by email should be from nhs.net to nhs.net accounts.
- □ Practices should explore new ways of working that reduce or eliminates the risk of infection transmission. For example, consider use of common rooms, reception and other high use areas, how meetings are conducted, and cleaning arrangements.
- □ Mutual aid: Many practices are already working within PCNs or have other buddy type agreements to enable continuation of services if affected by a major incident. Practices should review their business continuity plans to ensure that mutual aid is available should a COVID-19 outbreak occur within the practice.

Current advice from Regional PHE is that wearing a mask is not full PPE when in contact with a confirmed case and will not reduce the risk of a member of staff being identified as a contact should another member of staff test positive. Therefore, **social distancing is the most important factor** (along with workplace changes) to protect staff and to reduce the risk that practices have to close because critical numbers of staff are identified as contacts and required to isolate. Whilst the national guidance does not mandate it, practices may wish to consider advising patients and staff to use face coverings where possible on a precautionary basis. This decision is up to individual practices' discretion at this time.

[3] https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19
[4] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

4.4 Primary care actions in the event of an infected staff or patient

Immediate actions (First few hours)

a) Send home the infected staff member

If a member of staff is symptomatic at work, they should immediately go home and self-isolate. If they develop symptoms at home, they should not come to work.

b) Arrange testing

Arrange testing for any staff member with symptoms of COVID19. Remind staff to inform their line manager of a positive result as soon as they receive it so that relevant actions can be undertaken immediately by the practice.

How to get tested:

1. Through the CCG as per protocol in Appendix 1
2. Or via the government link: https://www.nhs.uk/conditions/coronavirus-covid-19/testing-and-tracing/ask-for-a-test-to-check-if-you-have-coronavirus/
3. Or by ringing 119 (between 7am and 11pm)

c) Isolate the infected staff member for 10 days

Staff should be advised that if the test is positive, they will be contacted by NHS Test and Trace Service, and they should isolate for 10 days.

Since the NHS Test and Trace Service is not quick, it is likely that the earliest PHE will notify the CCG or practice of staff who have tested positive will be 48hrs after the positive result.

d) Notify the CCG and HPT

The practices should then inform the CCG and HPT.
Please inform the CCG through voyccg.covid19tandt@nhs.net

e) Assist in the identification of contacts and risk assessment

Working with the CCG, the practice should identify persons who have come into contact with the infected healthcare worker.

Points to consider:

- If a patient was tested and tests positive: Did they have contact with other staff or patients during their visit? Was PPE used when the patient was swabbed?
- Staff member (non-clinical) tests positive: Have all staff been socially distancing? What was the contact with patients and other persons on the premises?
- Staff member (clinical): Consider what contact the staff member has had with patients, other clinical staff, and non-clinical staff when not in PPE. Review how PPE was used.

f) Isolate contacts

Isolate contacts of confirmed cases for 14 days from last exposure (unless they become symptomatic before in which case they should isolate for 10 days from onset of symptoms).

Refer to *COVID-19 management of staff and exposed patients or residents in health and social care settings* guidance[5] for more detailed advice.

[5] https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings

5. Health protection management of outbreaks

5.1 Outbreak definition in this setting

Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days

AND

Identified direct exposure between at least two of the confirmed cases in that setting (e.g. within 2 metres for >15 minutes) during the infectious period of the putative index case

The CCG and HPT should discuss the management of settings where there have been 2 or more cases within 14 days, and identify an incident lead.

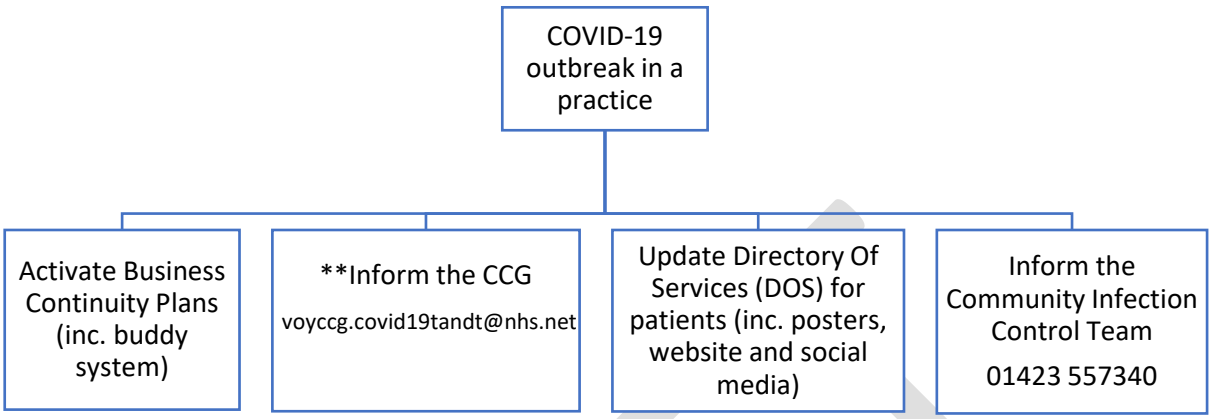
An incident management team (IMT) is likely to then be convened. The CCG, IPC, local authority Public Health and HPT should be part of the IMT

5.2 Roles and responsibilities

Role	Responsibility
Gathering initial information (as detailed above for single cases)	General practice, supported by the CCG
Providing appropriate information to the contacts on exclusion/ isolation	General practice, supported by the CCG
Context specific risk assessment *e.g. Do the partners have previous concerns about the practice and their ways of working:*	General practice supported by the CCG/ IPC
Convening an IMT	CCG/ HPT
Providing advice on control measures, isolation/ exclusion and IPC	CCG/HPT
Ongoing management, follow up with setting and ongoing monitoring	CCG with updates to HPT
Further investigations including options/ routes for testing	CCG/ HPT
Public/Media communications	CCG/ HPT

5.3 Primary care action in the event of an outbreak

In addition to the actions above, if a practice identifies a COVID-19 outbreak, the following should be initiated by the Practice:



It would be helpful if when informing the CCG that a telephone number (preferably a mobile) is supplied to enable the CCG to contact the practice to understand the support required.

6. Guidance documents

- COVID-19 management of staff and exposed patients or residents in health and social care settings guidance.
- National infection prevention and control guidance including in staff areas
- Practices should be fully familiar with when PPE is required: https://www.gov.uk/government/collections/coronavirus-covid-19-personal-protective-equipment-ppe
- Practices and all primary care settings should consider workplace guidance on making businesses COVID19 secure
- Standard operating procedure for general practice in the context of coronavirus (COVID-19):https://www.england.nhs.uk/coronavirus/publication/managing-coronavirus-covid-19-in-general-practice-sop/
- Additional Health and Safety guidance useful for non-clinical areas: https://www.hse.gov.uk/coronavirus/working-safely/index.htm
- Guidance on Test and Trace, as set out at https://www.gov.uk/guidance/nhs-test-and-trace-how-it-works

APPENDIX 1: Covid-19 Antigen Testing for Primary Care

Pillar 1 testing using swabs from the acute trust is now available for *symptomatic* primary care staff and their households (including sessional GPs and out of hours).

Staff can still choose to access the Pillar 2 services via the national portal

https://www.gov.uk/get-coronavirus-test

or by ringing 119 or the NHS Covid app and you can still 'walk-in' to mobile testing units (MTUs) if you are *clinical* staff (not available for non-clinical staff or household members) by showing your ID badge. These mobile testing units are in various sites across the county as described on the North Yorkshire County Council website via the link below.

https://www.northyorks.gov.uk/book-coronavirus-covid-19-test

There is no guarantee you will be swabbed by the MTUs if you 'walk-in' as capacity is very limited and is still reliant on the national Pillar 2 laboratories processing of your result. Advice is to get there early!

Process for Pillar 1 testing via YHFT

The referral criteria

The test will be carried out if any of the following criteria is met and you must be in *days 1-5* since symptoms started:

 Self-isolating because only the staff member in primary care is symptomatic

In this instance only the staff member in primary care will be eligible to receive a COVID-19 test

 Self-isolating because staff member in primary care and household members are symptomatic

In this instance the staff member in primary care and household members who have symptoms will be offered a test

 Self-isolating because someone in their household is symptomatic, but the staff member in primary care is not

In this instance only the household member(s) of the staff member in primary care who has (have) symptoms is (are) eligible to receive a COVID-19 test. The staff member in primary care will not receive a test. If more than one household member is symptomatic, but not the staff member in primary care, then all household members with symptoms should be tested.

Your symptoms must be in line with possible COVID-19:

i.e. a high temperature, a new continuous cough, a loss or change to your sense of smell or taste.

Applying for a test:

Please complete the referral form on the next page and send to the CCG who will approve the test. The CCG will allocate a slot for you at a NIMBUS practice and will email you back with that date and time together with instructions on how to take the test and an instructional video should you wish to view this.

Where to go for a test:

You will be asked to attend a NIMBUS practice in your car at the time slot allocated to you by the CCG. You will need to drive and park in a parking space at the practice and wait in the car with your windows up. Please be on time as there are limited slots and limited parking. By completing the referral form you are consenting for your details to be passed from the CCG to the NIMBUS practice.

Administering the test:

You will be given a test kit by the NIMBUS practice staff member through your car window. You will need to self-administer the test following the instructions emailed to you by the CCG. If your symptomatic household member is the one who needs a test, and that person is a child, you will need to administer the test to the child if they cannot do it themselves.

The NIMBUS practice staff member will return to your car to collect the swab. You are then free to leave.

Processing your test:

The test is collected from the practice each day by YHFT transport and processed in their labs. By completing the referral form you are consenting for your details to be passed from the NIMBUS practice to YHFT labs.

Your results:

The Occupational Health (OH) Department at YHFT will text your result back to you. By completing the referral form you are consenting for your details to be passed to the OH department.

Prioritising requests:

The CCG may have to decide on priority for testing given swab and lab capacity depending on demand.

Request form for a COVID-19 test (primary care and household members)

Send your completed form to – VOYCCG.patientrelations@nhs.net

Date of request				
Name of the GP practice where staff member is employed				
Name of person with symptoms who requires testing				
Date of birth of person with symptoms				
Is the person with symptoms	NHS staff	Yes / No	Householder member	Yes / No
Role of primary care staff member				
When did symptoms commence? (date)				
Household address				
Mobile phone number				
Email address				
Car registration number (so Nimbus staff member can recognise you)				
Please note by completing and submitting this form you are giving consent to pass on your details to the NIMBUS practice and YHFT				
CCG use only:		Date and time of slot allocated: Venue:		
Approved:	yes / no	Approved by:		
Reason for not being approved:				

APPENDIX 2: Covid-19 Contact Tracing in Primary Care Form

(Example contact tracing template to be used by primary care)

Person completing contact tracing form: Date completed:

Index case interviewed: Contact number for case:

Question to ask the index case:
In the 48 hours before your symptoms started, or when you had the positive test (if you did not have symptoms), who did you have contact? Work backwards from then.

Possible contact person & contact number	**Date & Time of exposure**	**Duration of exposure**	**Proximity of exposure**	**Was PPE used?**	**Any additional notes**
e.g. Joe Bloggs 07711223344	*25/05/20 ~4pm*	*10 minutes*	*Same room, about 1 metre apart*	*Face mask only*	*Sat in the same office, used the same kitchen*

Possible contact person & contact number	Date & Time of exposure	Duration of exposure	Proximity of exposure	Was PPE used?	Any additional notes