Llywodraeth Cymru
Welsh Government

COVID-19 preparedness and response: framework for the health and social care system in Wales

COVID-19 preparedness and response: guidance for the health and social care system in Wales

Issued by: Samia Saeed-Edmonds, Head of Covid-19 NHS and Social Services Response Cell, Welsh Government.

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Framework Review

The Contents of this Framework are dynamic and subject to review and amendment. Any suggested amendments or updates to be sent to:

HSS - COVID-19 - Planning Cell / IGC - COVID-19 - Cell Gynllunio HSS.COVID-19.PlanningCell@gov.wales

Government Marking Scheme: OFFICIAL – SENSITIVE

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1 Introduction

1.1 All organisations with responsibilities for health and social services must fulfil their emergency preparedness and response duties as set out in the Civil Contingencies Act 2004. The principle of **subsidiarity** acknowledges that decisions and actions should be taken at the lowest appropriate level, with coordination at the highest necessary level. Local planners and responders are the building block of response for an incident of any scale.

1.2 This Framework sets out key principles and issues to consider in the development of specific policies, guidance and actions needing to be addressed. It also sets out the structure in place now to co-ordinate COVID-19 health and social care sector response planning to and outlines some key national decisions taken to support that response.

2 Purpose of this document

2.1 This document provides a framework for health and social services in Wales in responding to the outbreak of COVID-19. It outlines some of the roles and responsibilities of different health care and social care agencies in Wales, while providing an overview of the whole system response at both national and local levels. It should be read in conjunction with other guidance particularly the Wales Health and Social Care Influenza Pandemic Preparedness & Response Guidance 2014, which can be accessed via the following link:
http://extranet.wales.nhs.uk/howis/sites3/Documents/331/2013-08-21%20-%20Wales%20Pandemic%20Preparedness%20and%20Response%20-%20February%202014%20-%20pdf%20for%20HOWIS.pdf

3 Background

3.1 Coronaviruses are common across the world, and cause illnesses in people that range from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). COVID-19 is the illness seen in people infected with a new strain of coronavirus not previously seen in humans.

3.2 Based on current evidence, the main symptoms of COVID-19 are a cough, a high temperature and shortness of breath. As it is a new virus, the lack of immunity in the population means that COVID-19 has the potential to spread extensively; the extent of this is currently uncertain. Among those who become infected, some will exhibit no symptoms. Of those who develop an illness, many will have a mild/self-limiting illness.

3.3 Some will require hospital care (approximately one in twenty). A portion of those admitted to hospital will require intensive care and some will inevitably die despite the best efforts of our healthcare system. These have so far been older people or those with underlying conditions.

3.4 As we learn more about the virus, its effects and its behaviour, we will be able to revise estimates of its potential spread, severity and impact. At present, there is neither a vaccine against COVID-19 nor any specific medication. The overall objective is to manage symptoms and provide support to patients, the wide public and healthcare workers.

3.5 It is entirely expected that health and social care workers could become infected or unwell as well as those having care responsibilities for friends and family members. Their care will need to be considered, managed and delivered along with the wider population.

4. UK Coronavirus Preparedness and Response Action Plan

4.1 This framework is aligned to the UK **Coronavirus Preparedness and Response Action Plan** which follows a sequence of **contain, delay, mitigate and research** (throughout).

Contain Phase: managing the initial cases

4.2 When there are initial cases and small clusters, the focus is on containment through following up close contacts and trying to prevent the disease from taking hold in the country for as long as possible. Gaining an understanding of the epidemiology of the virus through this period helps to inform the ongoing response.

4.3 The NHS is largely concerned with supporting sampling and testing, managing the worried well and those impacted by the health response, and establishing the systems that will be used during most of the response by preparing for increased impact, demand, and disruption.

Delay Phase: managing community transmission

4.4 Widespread and sustained community transmission will lead to changes in the response at all levels. The focus will continue to be on slowing the spread in the country, and lowering the height of the peak impact and pushing it into the future to enable more time for readiness.

4.5 The impact will be felt across Wales, and all NHS and social care organisations will be responding to the situation. National oversight will aim to ensure that the healthcare functions operate cohesively across Wales to provide the best care for patients, and as consistently as possible.

4.6 A key aspect is the need to understand the impact on operational capacity. Processes employed across the system to manage capacity and demand during periods of increased activity are the basis for this. Actions from the previous stage of the response remain relevant, although they may require increased implementation across wider areas or for longer durations.

Mitigate Phase: escalating to a national epidemic

4.7 As the number of cases continues to increase changes will be required to the way healthcare is maintained and delivered to those at greatest need, be they COVID-19 patients or with other conditions.

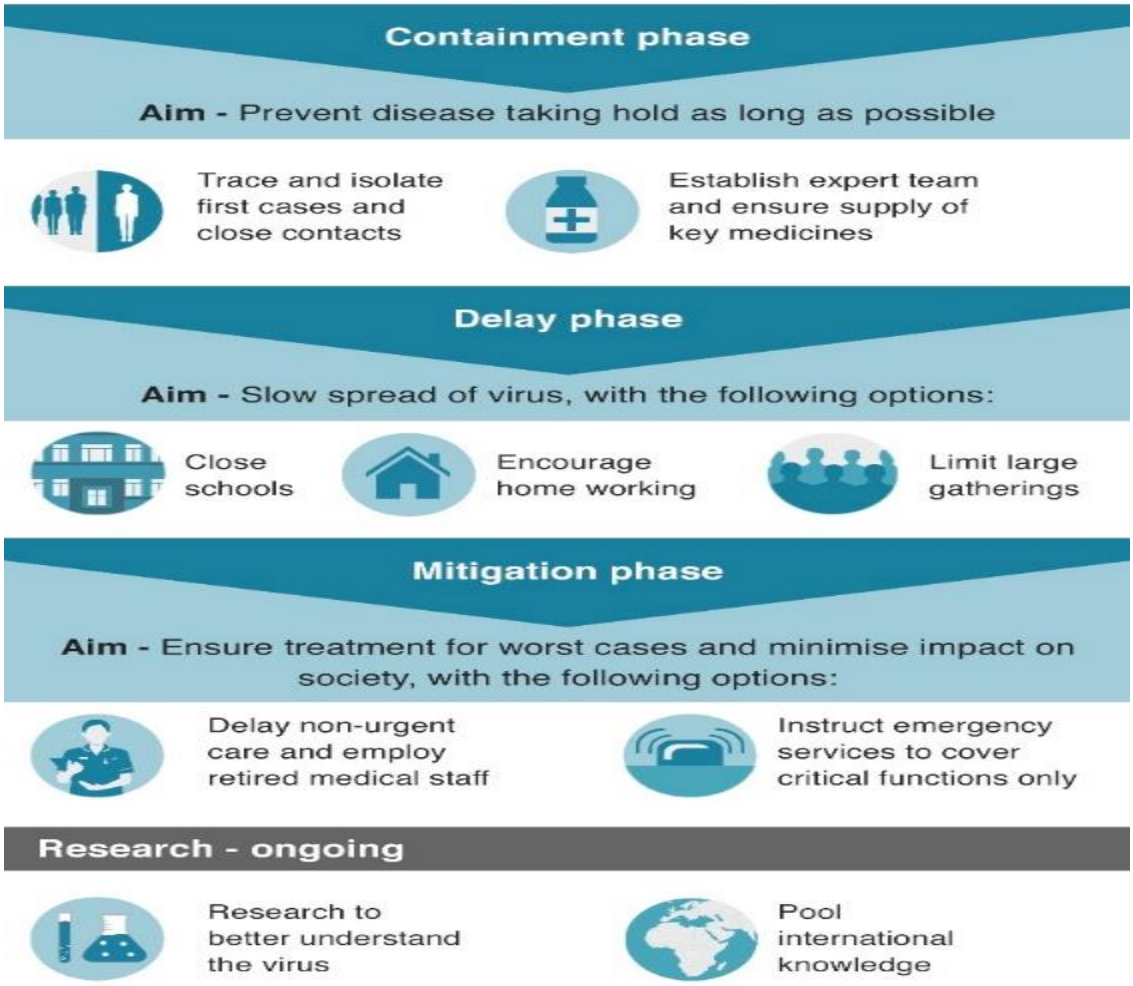
4.8 The focus is on providing the best care possible for people who become ill, supporting hospitals to maintain essential services and ensuring ongoing support for people who are ill in the community to minimise the overall impact of the disease on society, public services and the economy.

4.9 This may require significant changes to healthcare service provision, particularly if there is a move into extreme surge, prioritisation and triage. ***The details of the actions that might be needed in the event of extreme pressures on the NHS will be published separately as needed.***

Research

4.10 The UK action plan describes the need for research throughout the response to COVID-19. This will help us to better understand the virus and the actions that will lessen its effect on the UK population and inform innovation.

4.11 The overarching aims of these four phases are illustrated in this Public Health England illustration shown below.



5. Healthcare System Management of COVID-19

5.1 The aim of an integrated healthcare system response to COVID 19 is to enable those that are affected, whether in the NHS or social care, to receive the most appropriate care and ensure the staff providing that care are supported throughout.

Key Objectives:

- identify gaps, mitigate residual risks, and develop and deploy plans that are tested, appropriate and up to date;
- ensure planned and tested emergency preparedness command, control and communications procedures and facilities are used to oversee and manage the response;
- use established channels to communicate with professionals and the public in an open and timely fashion appropriate to any major incident response;
- provide treatment and care to patients with COVID-19;
- minimise the impact on the population and NHS and social care services;
- maintain and support staff health, safety and welfare throughout and after the response;
- maintain timely and appropriate situation reporting to inform decisions;
- restore normal service provision as soon as possible and practical;
- evaluate the response and identify lessons for subsequent outbreak; and
- build on existing collaborative working to re-balance health and social services pressures across Wales on services and associated delayed transfers of care issues.

6. Principles in responding to COVID-19

6.1 Much of our response to COVID-19 is based on established learning and planning for pandemic influenza. The UK Pandemic Strategy sets out three principles that underpin planning and response which are appropriate to COVID-19:

- **Precautionary:** plan for an initial response that reflects the level of risk based on information available at the time, accepting that uncertainty will initially exist;
- **Proportionality:** plan appropriate arrangements for response scale up and de-escalation in the light of emerging epidemiological, clinical and virological information and national advice and policy matters relating to the containment, isolation, testing and treatment; and
- **Flexibility:** plan for the capacity to adapt to local circumstances that may be different from the overall UK picture, for instance in ‘hotspot’ areas

7. Leadership of Wales Healthcare System

7.1 NHS Wales Chief Executive Officer (with the Chief Medical Officer, Chief Nursing Officer and Director of Social Services and Integration) is accountable to the Minister for Health and Social Services for providing the leadership and coordination of the NHS Wales and Social Services COVID 19 preparedness and response. Strong leadership by NHS Wales CEOs, Medical and Nursing Directors and local authority Directors of Social Services are an essential part of this leadership response.

7.2 To help provide leadership and co-ordination, the Welsh Government's, Health & Social Services Group has put into place a COVID 19 Planning and Response Structure aimed at ensuring we are well placed to respond to the developing situation and provide the best possible care for all patients and impacted individuals within available resources.

7.3 Through this process, Wales Ministers have agreed a number of immediate decisions to provide a framework for local decision making and to support the front line services response to COVID 19, these include:

1. The release of appropriate pandemic health countermeasures to front line health and social care.
2. Suspend non-urgent outpatient appointments and ensure urgent appointments are prioritised.
3. Suspend non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery).
4. Prioritise use of Non-Emergency Patient Transport Services to focus on hospital discharge and ambulance emergency response.
5. Expedite discharge of vulnerable patients from acute and community hospitals.
6. Relax targets and monitoring arrangements across the health and care system.
7. Minimise regulation requirements for health and care settings.
8. Fast track placements to care homes by suspending the current protocol which gives the right to a choice of home.
9. Permission to cancel internal and professional events, including study leave, to free up staff for preparations.
10. Relaxation of contract and monitoring arrangements for GPs and primary care practitioners.
11. Suspend NHS emergency service and health volunteer support to mass gatherings and events. Strong leadership by Wales NHS CEOs, Medical and Nursing Directors and local authority Directors of Social Services are essential to our response. The H&SSG COVID-19 Planning & Response Group and sub groups will work to support national guidance and strategies to support across the health and social care sector. It is, however leadership and integrated working at the local level that are needed now.

Additional actions will be added to the above framework as and when required to support further national and local decision making.

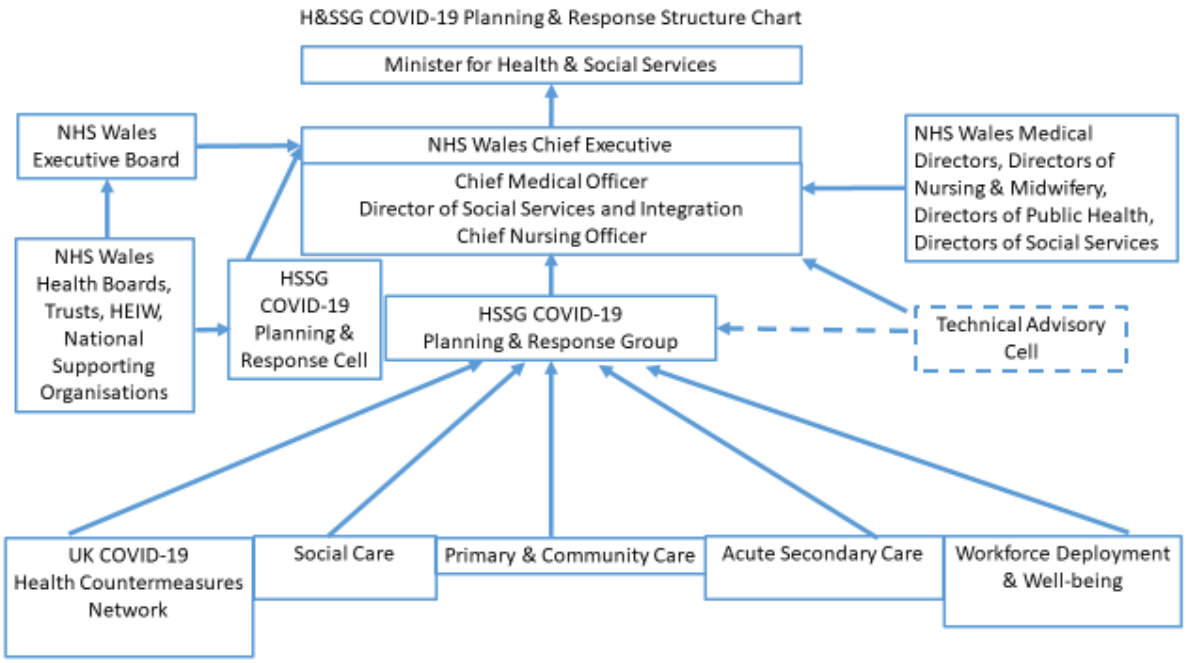
7.4 The H&SSG COVID-19 Planning & Response Group and sub groups described in the structure below are in place and working to develop and implement strategies in their areas of responsibility in order to support front line services across the health and social care sector. It is, however the leadership and integrated working at the

local level that is needed if we are going to deliver the health and social care services that will be needed to meet the challenge posed by this pandemic.

8. COVID-19 Planning & Response Structures

Welsh Government Health & Social Services Group

8.1 The Health and Social Services Group structure for managing coordination of health and social services planning and response to COVID-19 is set out below. A description of the key elements of the Structure follows the diagram. This Structure is dynamic and it is likely will be adapted to respond to changing risk assessments and challenges.



Health and Social Services Planning and Response Group

8.2 The HSSG Planning and Response Group for COVID-19 comprises of strategic representatives from across NHS Wales organisations and Social Services. The Group provides the means for strategic co-ordination across Wales NHS and Social Services. It will continue to operate through the phases of COVID 19 taking reports from its sub groups, considering risk assessments and scientific information, monitoring preparedness and identifying issues and initiating actions and contingency measures going forward.

H&SSG COVID-19 Planning & Response Cell

8.3 The COVID-19 planning and response Cell has been established as an externally facing unit to provide clear direction and support to NHS Wales and social services preparedness.

The Cell's remit is to ensure that key actions in relation to the Planning and Response Group and sub groups are delivered as quickly as possible and that there is co-ordination and consistency across the various activities. The Cell will also provide a key point of contact for information flows and actions for the H&SSG Desk in the Welsh Government's Emergency Co-ordination Centre (ECCW).

The functions of the Cell includes:

- leading and co-ordinating the HSSG Covid-19 Planning and Response Group and its sub groups and also to initiate any necessary actions;
- ensuring timely reporting from the sub groups;
- considering risk assessments information;
- monitoring and supporting NHS and social care response; and
- identifying issues and initiate contingency measures going forward.

Specific tasks will include (the list is not exhaustive and will change):

- Provide links with DHSC, NHS England, PHE to support UK co-ordination;
- Engage with PHW and Shared Services on their key activities;
- Consider upcoming national plans and actions arising from COBR meetings;
- Provide an assurance mechanism for implementing ministerial actions;
- Provide ministerial briefing informed by NHS and SS contacts and Group Structure;
- Establish regular briefing mechanism for subgroups, NHS and social services;
- Work with the Communications team and the Helpdesk to ensure that up to date information is available; monitor situation to pre-empt queries where possible;
- Collate database of current offers of support (eg accommodation, procurement, workforce etc);
- Provide a link to each COVID-19 subgroup to ensure that actions and risks are escalated up to the Planning and Response group, and information from the Planning and Response group is passed to the subgroups as needed;
- Manage cross-cutting issues;
- Provide out of hours cover – as a contact for urgent issues from each subgroup; ensuring timely alerts to Planning and Response Group members;
- Co-ordinate and ensure support to national conference calls; and
- Establish a communications directory of key contacts.

<u>UK COVID 19 Health Countermeasures Network</u>

8.4 The Welsh Government has put in place a Health Countermeasures Sub Group that is linked into a UK Countermeasures Network. This UK Network is taking forward procurements of supplies and is working on a 4 countries basis to maintain essential supplies to the NHS and social care. The Sub Group's focus is to:

- access essential supplies and prioritise their deployment;
- ensure timely mechanisms are in place to deploy stock;

- monitor and respond to potential supply issues;
- manage the deployment of pandemic stock (and other stock, as appropriate); and
- work with the other UK countries and supplies network.

Social Care

8.5 The Social Care Sub Group consists of vital stakeholders from across the social care sector including Directors of Social Services, WLGA, SCW and CIW. The group also includes members that provide significant input from co-dependent areas such as housing, British Red Cross, WCVA, Care Forum Wales, CHCs and therapies. The purpose of the group is:

- to share national information with all key stakeholders;
- gather intelligence of sector concerns to feed upwards, as appropriate;
- co-ordinate guidance and implementation of contingency measures; and
- promote integration of the social care and NHS response to COVID-19.

Primary and Community Care

8.6 The Primary and Community Care Sub Group co-ordinates COVID 19 planning and response across the primary and community care sectors, including for the reasonable worst case scenario. The sub group provides the point of contact and communications with those sectors for COVID 19. The Sub Group's focus is to:

- share national information, including latest risk assessment and advice;
- examine and seek to address sector concerns;
- clarify and set out key planning and response structures;
- identify appropriate contingency measures going forward; and
- advise on strategic operational response requirements.

Acute Secondary Care Sub Group

8.7 The Acute Secondary Care Sub group provides leadership and oversight in relation to services normally provided in hospital settings. The aim of the work is to free up as much capacity as possible in hospitals for those patients most severely affected by Covid-19 as well as the maintaining services for other people with life threatening conditions. The group will support NHS in Wales in its preparations across a number of pathways, including consideration of whether and how certain patients can be managed at home, what criteria should be used to decide whether people should be admitted to hospital and what treatment will be provided.

Workforce Deployment and Wellbeing

8.8 The Workforce Deployment and Wellbeing Group will coordinate COVID 19 planning and response for the workforce, working in social partnership with unions and employers. The sub group provides the point of contact and communications with those sectors for COVID 19. The Sub Group's focus is to:

- share national information with all key stakeholders;
- clarify and set out key planning and response structures;
- gather intelligence about workforce issues and examine and develop responses;
- identify appropriate contingency measures going forward; and
- advise on strategic operational response requirements.

Local Response Structures

8.9 NHS and local authorities have well established response structures that will have already been activated along with the Local Resilience Fora arrangements to ensure multi-agency partners are engaged and preparing to deliver the COVID-19 response.

8.10 Local responders in LRF areas have their pandemic plans to draw on in relation to COVID 19 and Wales exercises have been undertaken to ensure that LRF multi-agency plans have been considered in the context of the COVID 19 pandemic. An essential aspect of NHS and social care response will be the co-ordinating arrangements and support that can be mobilised from other agencies in the LRF.

8.11 Due to the anticipated longevity and the potential impact this pandemic is likely to have on normal business, organisations should aim for dedicated emergency response teams in place to oversee the COVID 19 response. Although this may not always be possible, having these arrangements in place will help ensure that the COVID 19 response and a concurrent major incident response can be managed.

9. Business Continuity

9.1 Given the potential duration of the response to COVID-19, business continuity arrangements are an essential element to underpin the health and social services response. Plans need to consider the impact of increased patients, reduced staffing, and supply chain disruption.

9.2 Existing plans to maintain services for those who are already known to be in vulnerable groups should be reviewed and enacted as appropriate. There may be a need to rapidly identify newly or temporarily vulnerable people during the response, this should be undertaken with local partners wherever possible to ensure broadest coverage.

9.3 The on-going ability of health and social services to assess and accept referrals should be closely monitored. This will be informed by information on levels of infection, staffing status and other emerging issues.

10. Workforce

10.1 The response to COVID-19 is likely to be protracted over months.

Consequently, staff support and resource from across the whole system should be identified to deliver the response and protect essential functions.

10.2 Staff will come under considerable pressure, particularly if conflicts arise between the professional obligations and personal responsibilities. Support should be made available for individual staff and professional groups to address ethical dilemmas that may arise out of their work.

10.3 Staff may be asked to work outside their normal role or in unfamiliar situations. In such instances, it is important that this work remains within their scope of competence. Prior discussions with local staff organisations, appropriate protection, training, supervision, and indemnity for the role will all be important.

10.4 Any changes to normal working patterns must include adequate time off work to reduce absence due to exhaustion or stress caused by pressure over a sustained period or the cumulative impact of the emergency such as bereavement, additional care responsibilities or ill health.

10.5 Staff welfare, of those working full-time on the response as well as those supporting elements, must be considered and supported throughout. Not only is this a direct duty of care of the organisation, but will also help ensure the best possible response by the system for patients and the public.

11. NHS Wales

11.1 NHS Wales has tried and tested response arrangements (including escalation and capacity management processes) as well as infectious disease arrangements and responsibilities. They maintain business critical processes and emergency plans to respond to any concurrent incidents or events. Welsh Government Health & Social Services Group (H&SSG) is expected to provide strategic co-ordination and a system of communication and information flows in times of national emergency.

11.2 NHS Wales and social services regularly and routinely work in partnership to manage patient demand across the system. In the event of an extended period of disruption or increased demand some services will need to be delivered differently at different times. Close working with social services/care providers to help manage flow across the wider system will be essential.

11.3 The NHS response will be delivered across health board areas by a range of service providers, including primary care, pre-hospital care (WAST including Wales NHS Direct/111 services) secondary care and community care. These will all underpin the health response by providing care to patients with COVID-19 as well as managing those without COVID-19.

11.4 All Wales NHS and social services organisations will by now have structures in place to respond with partners to increased levels of demand from healthcare during a COVID-19 outbreak. Business continuity processes are a key underlying element of this whilst maintaining their core services and delivering any additional services

required of a COVID-19 response, and support to their staff.

11.5 Examples of things that may be considered to build capacity and capability might include use of ring fenced or approved additional funding to address priority issues and develop ways to build more capacity into the system or better use of existing resources e.g. review hospital admissions policy, signpost patients to other parts of the health and social care system to reduce demand for hospital services.

- Scale down non-urgent elective activity to release capacity, allowing for beds to be reconfigured and staff to be redeployed and retrained.
- Discharge vulnerable patients from acute and community hospitals to suitable alternative placements in the community.
- Plan now to manage the extra challenges relating to bed capacity shortages and high levels of long-stay patients, delayed transfers in care and poor social care infrastructure.
- Plan now for enhanced national and local intelligence gathering, data management, system reporting and briefing Ongoing monitoring, production of daily situation reports, briefings on system pressure (includes hand-over and evening briefing note for on call managers).

12. Social Care

Local Authority Social Services

12.1 Local authority Directors of Social Services (DoSS) have an essential role in ensuring a flexible and efficient local social care system to maintain business as usual services and support the NHS to manage demand and facilitate effective patient flow.

12.2 Most social care services are delivered by independent (private sector) providers, who may be commissioned by a local authority to provide state-funded or personally-funded care. A small portion of service users directly purchase their own care using personal budgets provided by the local authority.

12.3 The number of people requiring support from local authority social services is expected to increase as a direct result of COVID-19. Plans will be required to manage the fact that:

- normal carers may not be able to provide support due to personal illness or caring responsibilities and alternative provision may be needed; and
- increasing numbers of people in the community with non-COVID-19 conditions if NHS providers change their assessment, admission and discharge criteria.

12.4 Additional assistance, in supporting independent, voluntary and third sector providers could include (but is not limited to):

- supporting nursing and residential care homes to help people remain in their homes;
- supporting NHS and social care providers to provide domiciliary care to service users in their own homes;
- creating local support networks to collect medicines for patients; and
- collecting shopping and basic supplies.

Independent social care providers and the voluntary sector

12.5 Independent social care providers and the voluntary sector are a vital part of the health and social care system in Wales and are an important part of a local authority's provider network. Care Inspectorate Wales has oversight of these providers, as well as the comparable local authority provision.

12.6 Independent and voluntary sector care providers also have an important role in helping the NHS response and effective communication is needed across all providers and the regulatory bodies to ensure this.

12.7 Specific guidance on COVID-19 for social or community care and residential settings was issued on 6 March and is available at:

https://gov.wales/coronavirus-covid-19-guidance-social-or-community-care-and-residential-settings

Welsh Government, through the COVID-19 Sub Group will continue to consider the implications for the social care sector as the situation develops and will provide additional advice as required.

13. Escalation of specific elements of Healthcare

13.1 This section sets out some information on specific aspects of NHS service escalation.

NHS 111/NHS Direct Wales

13.2 Concerned people have been advised to contact the NHS through 111 to be assessed via bespoke pathways. They are then directed to healthcare advice or to swabbing and testing. This is delivered across the country in recognition of local arrangements and services.

13.3 The 111 Coronavirus Service provides a front-end online and telephony service that directs callers to identify if they have the relevant diagnostic symptoms for COVID-19. Emphasis is being placed on directing the general public to the on-line symptom checker before they call the 111 number. If symptomatic and very ill then a

caller can dial 111, where their demographic information is taken and triaged for further consultation by a clinician. The caller can then be offered further support /advice at this stage or directed to alternative services. Language Line also provides translation support to 111 Wales services to support to non-native English speakers.

13.3 Contact tracing and home isolation for people who are contacts of confirmed cases can present some local challenges to the NHS, particularly where healthcare workers are among the exposed or confirmed as cases themselves. Processes should be implemented to ensure that people who are self-isolating can access support and advice.

Infectious diseases capacity and capability

13.4 Initial cases in the UK have been cared for in high consequence infectious disease (HCID) settings, irrespective of the criticality of the level of healthcare required based on their symptoms. The cases have been largely 'well', however this is no longer the position as more cases are confirmed across the population. Escalation into wider infectious disease units (IDU) and ultimately into cohort wards and community care will be required.

13.5 The response requires high levels of personal protective equipment (PPE) (including facemasks and FFP3 respirators). Areas where people have been assessed for COVID-19 swabbing or testing require deep cleaning ahead of the results being available 24-48 hours later. As more cases have been found and we begin to move from the containment phase, changes to PPE guidance have been made to ensure that healthcare workers are protected and all hospitals remain safe, now and in the future.

13.6 Different PPE and mask and respirator combinations are being recommended now for different clinical scenarios and settings; this includes consideration of the infection status (confirmed versus possible cases) and the risk of exposure to aerosols containing the virus.
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/wuhan-novel-coronavirus-wn-cov-infection-prevention-and-control-guidance

13.7 As the number of confirmed cases has increased, the capacity in dedicated HCID has been surpassed. If confirmed cases are 'well' and do not need inpatient care, there is a need for the NHS to 'care' for these 'well' patients in a different way – either through infection control setting, ward cohorting or in the community. For this latter group of 'well' patients, clear information about isolation and avoiding hospital attendance is necessary.

High Consequence Infectious Diseases (HCID) Beds

13.8 There are 10 commissioned airborne HCID beds across five adult and paediatric centres in the UK. The provision of care is such that paediatric cases are treated in adult HCID estates but by paediatric staff (either from the same Trust or from another Trust). There are other HCID beds for other pathogen types, which could be used, but there is a need to retain ability to respond to other incidents.

13.9 Up to a further 600 beds could potentially be created in other ID centres commissioned by NHS England where services can meet key criteria set out in the HCID service specification. This will include negative pressure rooms (with and without ante-chambers, side rooms without negative pressure and ward based IDU beds. However this would be limited by staffing and consumables availability.

13.10 Paediatric surge capacity would initially be identified at the two HCID organisations that directly host paediatric HCID services. Other vulnerable or specialist groups may need consideration in line with existing guidance or bespoke pieces drafted for the response. These include pregnant women and patients requiring extra corporeal membrane oxygenation (ECMO) or dialysis treatment.

Care outside of specialist infectious diseases beds

13.11 Once HCID and IDU surge capacity has been passed, cases will need to be cared for using ward-based cohort nursing. There will likely be a change in the overall response and wider considerations required around changing service delivery models and identifying other potential care facilities.

Infection control

13.12 The meticulous use of infection control procedures including segregation, isolation and cohort nursing is fundamental in limiting transmission of the virus. Local risk assessment for required levels of infection control should be regularly performed in hospitals, communal living environments such as residential homes, social care environments and supervised mental health residences. Stringent attention to hand and respiratory hygiene should be observed in all care settings.
IP&C guidance is reviewed constantly as the outbreak of COVID-19 evolves, current guidance is available via the link below:
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/wuhan-novel-coronavirus-wn-cov-infection-prevention-and-control-guidance

13.13 The generation of aerosols, including through some dental procedures, requires risk assessment and effective risk-management to avoid exposure. In addition to ensuring appropriate usage of PPE, this may mean rescheduling treatment.

13.14 Employers will need to undertake risk assessments to determine whether the provision of facemasks or respirators is appropriate for their staff. Workers who need to wear a facemasks or respirator will need to receive training in their safe use, removal and disposal to minimise the risk of cross contamination. The responsibility for providing advice on the use of facemasks and respirators, as well as their provision and training, for non-health workers in the public, private and voluntary sectors rests with the employers.

13.15 Guidance on the correct usage of PPE for COVID 19 has been published and specific advice on FFP3 fit testing (testing that the respirator correctly fits the individual) is available from the Health and Safety Executive (HAS).

Critical Care Escalation

13.16 The baseline NHS Wales's capacity for critical care is around 145 ventilated (i.e. critical care) beds. Increased demand for these beds could be met by using areas within hospitals that are not usually used for long-term provision of this such as theatre recovery areas and operating theatres. It is estimated that this could double capacity, but that this could only be maintained for up to two weeks due to the available capacity of skilled staff and the high resourcing required (e.g. clinical consumables, medicines, and physical space).

13.17 This would be a lower level of critical care than is usually provided, as these areas are not normally set up, or fully resourced with equipment and staff, to provide such care for extended periods of time.

13.18 Maintaining full staffing of these areas with staff who possess the appropriate skill set will be a challenge. Critical care often requires high levels of training which cannot be covered by staff from other areas (including those who work in theatres and recovery). This is especially true of patients requiring respiratory interventions and other organ support, such as haemofiltration.

13.19 Occupying these areas will also have a significant impact on the services normally provided in those areas. Elective operations would have to be relocated, or most likely postponed, and emergency operations which cannot be avoided would have to find other recovery areas. Any other services giving up space would face similar challenges.

13.20 Surge areas created to increase critical care capacity may not always be able to provide the services expected of a normal critical care service. For example, haemofiltration, and advanced ventilation protocols (requiring high-tech ventilators usually not seen away from critical care units) may not be available due to staffing and equipment capacity.

14 .Excess Deaths

14.1 A severe outbreak of COVID-19 could result in significant numbers of excess deaths, particularly among those who are most vulnerable to the infection. The early indications are that these are older people and those with some underlying health conditions. The modelling assumptions remain fluid, however current thinking suggests 1% of cases could prove fatal. A Wales guidance document on excess deaths planning is being consulted on through Wales LRFs for issue as soon as possible as an aid to planning.

14.2 Excess deaths planning and response must be joined up across multi-agency partners. A partnership approach with involvement of the local HM Coroner will be vital to ensure the processes involved in death management are efficient in order to negate capacity issues caused by excess deaths. Hospitals that have mortuary provision will need to ensure they have robust business continuity arrangements to manage additional hospital deaths from COVID 19 having regard to any legislative requirements.

15. Recovery

15.1 Organisations will need to consider recovery early in the response and will need to have a recovery group, chaired by staff empowered to make decisions and allocate funds if needed. This group will manage the return to business as usual; recognising this could be a 'new normal' if the outbreak is severe. Following an extended response, irrespective of severity, recovery across the NHS and social care will be challenging and take a significant period. Not all services will be able to restart at the same time, and support will be required from the Welsh Government's Health & Social Services Group who will consider establishing a Wales NHS & Social Services Recovery Group should this be needed.

15.2 This local and national recovery structure will need to consider ways to rebuild a health and social services infrastructure which can allow prioritisation of care to meet demand (such as psychosocial support) with a planned approach to returning to business as usual or a new way of working. The nature of primary care, operating as a relatively small business and employing more part time/ locum workers than other sectors of the NHS, means that a significant outbreak may have a lasting impact on infrastructure. Secondary and community care providers may also experience a prolonged period before resuming normal business (such as fully reinstating cancelled elective programmes) while the system normalises.

15.3 Healthcare recovery activities are likely to include (but not be limited to):

- identifying lessons, especially those that can be applied to other scenarios
- supporting staff who may have been unwell, lost families/ friends, and worked above and beyond
- re-establishing pathways
- considering the establishment of call centre(s) to provide psychosocial support to bereaved preparing to re-instate any cancelled/ postponed interventions, and then reinstating delayed/ suspended services in a phased manner
- undertaking any catch-up immunisation or screening campaigns

Business Continuity Plans identify priority activities and it will be for organisations to review those priorities in order to produce an appropriate phased recovery.

15.4 It is expected that each Local Resilience Forum will consider setting up a multi-agency recovery process in line with their Recovery Plans. The NHS and Social Services are likely to be involved in this recovery work.

16. Communication

16.1 Robust communications are an important part of the response. Communications colleagues are an intrinsic component of response teams and need to function in a fully integrated manner with the wider response. The latest updates and information can be found from the following links:

Public Health Wales - https://phw.nhs.wales/

Welsh Government - https://gov.wales/coronavirus-covid19

16.2 For COVID-19 the overall health and social services communications strategy is led by H&SSG with Public Health Wales and NHS communication leads. Enhanced communication activity is necessary with the NHS, Local Authorities, partners, stakeholders and the public that build on existing mechanisms and good practice. Good liaison and coordination between local and national communications teams is essential so that messages are aligned and supportive. Where appropriate, national messages will be developed and delivered in partnership. The key communications priorities for the response are to:

- support operational delivery;
- keep staff well informed;
- ensure that the public know how, where and when to access services;
- reassure the public to maintain confidence in the NHS and wider health; and social services system's ability to manage the situation.

16.3 A wide range of channels will be used, as appropriate to the audience and message, including traditional print and broadcast media, as well as social media and marketing tools. Messaging will include aspects of:

- providing accurate and timely information to inform people about the outbreak;
- supporting staff to perform their roles and care for patients appropriately;
- establishing and maintaining confidence in the response;
- minimising the risk of infection and wider impacts through supporting the public to protect themselves and others; and
- describing any changes to the delivery of health care services.

17. Reporting

17.1 Assurance is already being sought from the NHS and social services of readiness to respond to the situation, as well as that interventions have been established and embedded. It is recognised the need to provide this assurance adds to the burden of delivering the required action that is being assured, however this is an essential part of confirming system readiness.

17.2 There is now a daily multi-agency LRF reporting arrangements into the Welsh Government Emergency Co-ordination Centre (ECCW) which reports upward to UK Government 7 days a week. The NHS and Social Services will need to feed in to this process, as appropriate to support a daily schedule or 'daily/ battle rhythm'. It is essential the burden of operational reporting on the NHS and social services is minimized, and as such should be as joined up as possible. The information coming into ECCW will be assessed, where appropriate by the H&SSG Response Cell. The use of the daily NHS pressures telephone calls, regular calls with Chief Executive

Officers and Directors of Social Services and dedicated communication channels into the H&SSG Desk in Emergency Co-ordination Centre Wales will also aid reporting processes.

18. Stockpiles

18.1 Stockpiles of clinical and non-clinical countermeasures for health and social care settings in the event of a pandemic are held in Wales for deployment when needed. These are composed of key items of personal protective equipment (PPE) (including hygiene consumables) as well as antivirals and antibiotics.

18.2 The PPE and antibiotics are relevant in the response to COVID-19 and will be issued as necessary to support the NHS and Social Services. Arrangements are in place through Shared Services for the timely issue of supplies, including from the pandemic stockpile. The amount of the pandemic stock held is based on modelling undertaken in relation to the reasonable worst case scenario pandemic. The need is for robust and timely management in distributing this stock and ensuring it is used only when necessary in order to conserve supplies.

Personal Protective Equipment (PPE)

18.3 The bulk of the stockpile consists of PPE designed to protect healthcare workers from contracting the virus while caring for patients. This includes surgical facemasks, FFP3 respirators, eye protection, gloves and aprons, plus hygiene consumables. This PPE will protect healthcare workers when used correctly and in conjunction with other infection control practices, such as appropriate hand hygiene. These will be released to the system when business as usual supplies are affected.

18.4 Surgical facemasks provide a physical barrier and minimise the risk of contamination of the nose and mouth. Respirators provide respiratory protection against the inhalation of fine or very small airborne particles, which may contain viruses and other micro-organisms. Respirators should be worn when performing procedures that have the potential to generate infectious aerosols such as intubation and bronchoscopy.

18.5 FFP3 respirators are not routinely used in general healthcare settings, therefore there will be a need for fit testing and training if these are rolled out extensively to meet the infection control needs of COVID-19.

Antibiotics

18.6 A range of antibiotics have been stockpiled to treat anticipated secondary complications of pandemic influenza. These may be useful if secondary bacterial pneumonias are a feature of COVID-19. These are largely for use in secondary care although there may well be some primary care demand. It is intended that antibiotics for primary care will be made available through the usual distribution mechanisms, i.e. through the wholesaler networks. In Wales, antibiotics for secondary from the pandemic stockpile will be distributed to hospitals should that become necessary

19. Surveillance

19.1 Surveillance at the start of the outbreak and throughout the response is essential to understand the evolution of the virus, including the demographics of patients affected, duration and severity of illness and effectiveness of countermeasures and interventions. Much of this will be delivered through existing or enhanced established measures in primary and secondary care and co-ordinated by Public Health Wales working with Public Health England.

20. Equality and Diversity

20.1 This document has given regard to the need to:

- eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

21. Ethics

21.1 Ethical considerations are important in determining how to make the fairest use of resources and capacity. Decisions should be in proportion to the demands and pressures and should be aimed at minimising overall harm caused. Many people will face personal dilemmas such as tensions between their personal and professional obligations. Decisions are more likely to be understood and the need accepted if these have been made in an open, transparent and inclusive way and based on widely held ethical values. A national Moral and Ethical Advisory Group (MEAG) exists to provide guidance on health and social aspects of responses such as to COVID-19.

22. Finance and legal

22.1 COVID-19 related expenditure incurred by the NHS and Social Services will need to be tracked throughout the phases of the response and the legal protocols underpinning the response are in line with established legal responsibilities and frameworks.

22.2 Now that COVID 19 has been declared a pandemic, changes in legislation are possible to enable continuation of services. This is unlikely in all but the most extreme scenarios. Given the unpredictable nature of a pandemic any possible measures would need to be tailored to meet the circumstances and the needs of the response.

Annex A. Escalation scenarios across NHS and Social Care

The phases in the UK action plan (Contain, Delay, Research and Mitigation) do not follow a normal escalation of severity, therefore contain and delay can take place at the same time, research is current in all stages. The following table shows potential escalating actions that may be implemented in health and social care settings as the number of cases increases across Wales. They are not aligned to specific phases in the UK action plan

111/ NHSD Wales	Ambulance	Acute	Primary care	Community care	Mental health	Others (e.g. social care, LRFs, voluntary sector)
• Review pandemic influenza plans and consider parity for COVID-19 • Review readiness for cases – assurance process • Support people who meet the case definition, provide advice and direct to services as appropriate	• Review pandemic influenza plans and consider parity for COVID-19 • Review readiness for cases – assurance process • support arrangements for transport of confirmed cases • support swabbing of people who meet the case definition (if required)	• Review pandemic influenza plans and consider parity for COVID-19 • Review readiness for cases – assurance process • support swabbing of people who meet the case definition	• Review pandemic influenza plans and consider parity for COVID-19 • Review readiness for cases – assurance process • Direct people to use 111 for assessment	• Review pandemic influenza plans and consider parity for COVID-19 • Review readiness for cases – assurance process • Direct people to use 111 for assessment	• Review pandemic influenza plans and consider parity for COVID-19 • Review readiness for cases – assurance process	• Review pandemic influenza plans and consider parity for COVID-19 • Review readiness for cases – assurance process • LRF planning
• Awareness and monitoring • System wide readiness confirmation to WG H&SSG re capacity, IPC and PPE etc • Potentially support PHW contact	• Awareness and monitoring • System wide readiness confirmation to WG H&SSG re capacity, IPC and PPE etc • Potentially support PHW contact	• Awareness and monitoring • System wide readiness confirmation to WG H&SSG re capacity, isolation, IPC and PPE etc • Potentially support PHW contact	• Awareness and monitoring • System wide readiness confirmation to WG H&SSG re capacity, IPC and PPE etc • Potentially support PHW contact	• Awareness and monitoring • System wide readiness confirmation to WG H&SSG NHS re capacity, IPC and PPE etc • Potentially support PHW contact	• Awareness and monitoring • System wide readiness confirmation to WG H&SSG re capacity, IPC and PPE etc	• Awareness and monitoring • System wide readiness confirmation to WG H&SSG re capacity, IPC and PPE etc • Support messaging to vulnerable

111/ NHSD Wales	Ambulance	Acute	Primary care	Community care	Mental health	Others (e.g. social care, LRFs, voluntary sector)
tracing / monitoring as appropriate – until no longer sustainable/ valuable • Use of 111 to direct people to information/ testing if needed • Front end messaging • Specific algorithm • Bilingual clinical assessment in a few centres to support more robust consolation • Consideration of specific call centre to manage worried well concerns • Access to translation services for non-English speakers	tracing / monitoring as appropriate – until no longer sustainable/ valuable • Specific algorithm • Transport confirmed cases to HCID centre • When capacity is exceeded, patients to IDU • Support local arrangements for testing (including potentially transporting people to hospital), support return home for isolation to await results • Access to translation services for non-English speakers	tracing / monitoring as appropriate – until no longer sustainable/ valuable • Establish isolation areas and pathways to manage self-presenters as well as those presenting for swabbing • Establish pathway/ process for transfer of any confirmed inpatient to HCID or IDU or remain in isolation at home • Regular reporting to H&SSG and PHW re confirmed patient • Isolation Rooms readiness HCID readiness • Accept confirmed case • Testing as identified / present: held in hospital isolation or sent to self-isolation as	tracing / monitoring as appropriate – until no longer sustainable/ valuable	tracing / monitoring as appropriate – until no longer sustainable/ valuable		groups and non-English speaking communities • Support people in isolation

111/ NHSD Wales	Ambulance	Acute	Primary care	Community care	Mental health	Others (e.g. social care, LRFs, voluntary sector)
		appropriate while await results				
	• Changes to community swabbing	• Review future case load – consider prioritisation, what could be stopped if needed • Use HCID centres, and ID Units if needed to care for confirmed cases • Use of home isolation for confirmed cases who are well enough to remain in situ • Local identification and readiness to use dedicated escalation areas in as necessary • HCIDs to provide support to patients being cared for in other locations • Continue swabbing and ED /admission management pathway for self-presenters	• Review future case load – consider prioritisation, what could be stopped if needed • Review BC arrangements across the primary care networks • Prepare for potential cases/ worried well presenting in practices • Increase telemedicine activity	• Review future case load – consider prioritisation, what could be stopped if needed • Consider home isolation of cases if well enough, but unlikely to be politically acceptable	• Review future case load – consider prioritisation, what could be stopped if needed	• Consider home isolation of cases if well enough, • Support people in isolation (e.g. awaiting swabbing results (24-24hours) or post repatriation (14 days))
• Review thresholds for transferring	• Transfer confirmed cases from DGH to	• Focus on facilitating discharge to home	• Increase telemedicine	• Increase telemedicine	• Increase telemedicine	• Review future case load, with primary and community

111/ NHSD Wales	Ambulance	Acute	Primary care	Community care	Mental health	Others (e.g. social care, LRFs, voluntary sector)
patients to 999 other NHS settings • Promote/use alternative care pathways to reduce/ adjust demand profile across NHS • Increase capacity to provide telephone support (use retired clinicians, trainees etc?)	IDU or HCID if beds become available • Reduced testing in secondary care therefore reduced support to the process • Review thresholds for reaching patients in the community • Promote alternative care pathways to reduce/ adjust demand profile across NHS • Increase clinical hub capacity to provide telephone support (use retired clinicians, trainees etc?)	from trusts as rapidly as possible so have capacity for anticipated increases in cases • Wider treatment of patients into non-specialist centres • Consider admission of children to adult ICU where appropriate • Care for cases in HCID and IDU, prepare for cases in DGH setting • Children potentially cared for in adult beds/ wards • Continue swabbing and ED management pathway for self-presenter • Review/postpone future case load re outpatients, non-urgent electives etc • Increasing use of private care • Support/ training staff to undertake additional roles above usual	• Support increasing patients self-isolating at home if don't need inpatient care • Support potentially increasing number of patients being seen in primary care who would normally be seen in secondary care • Review future case load, with community and social care, and prepare to reduce visits • Support nursing / care homes to reduce admissions to secondary care • Reduce non-urgent appointments and bring appointments forward where appropriate • Support/ training staff to undertake additional roles above usual competencies where appropriate	• Support increasing patients self-isolating at home if don't need inpatient care • Support potentially increasing number of patients being seen in community care who would normally be seen in secondary care • Review future case load, with primary and social care, and prepare to reduce visits • Support nursing / care homes to reduce admissions to secondary care • Increasing support from voluntary sector • Support/ training staff to undertake additional roles above usual competencies where appropriate	• Support staff to undertake additional roles above usual competencies where appropriate	care, and prepare to reduce visits • Consider altering arrangements to increase appropriate social care places

111/ NHSD Wales	Ambulance	Acute	Primary care	Community care	Mental health	Others (e.g. social care, LRFs, voluntary sector)
		competencies where appropriate				