19 March 2020

To:

CEOs of NHS and Foundation Trusts

CEOs of Clinical Commissioning Groups

Directors of Public Health

CEOs of Community Health Providers

CEOs of private and not-for-profit community providers

CEOs for community interest companies

Cc:

NHS England and NHS Improvement Regional Directors

Chief Executives of Councils

COVID-19 Prioritisation within Community Health Services

Following on from Sir Simon Stevens' and Amanda Pritchard's letter of 17 March 2020, this letter and annex set out how providers of community services can release capacity to support the COVID-19 preparedness and response. These arrangements will apply until 31 July 2020 in the first instance.

The current priorities for providers of community services during this pandemic are:

1. Support home discharge today of patients from acute and community beds, as mandated in the new Hospital Discharge Service Requirements, and ensure patients cared for at home receive urgent care when they need it
2. By default, use digital technology to provide advice and support to patients wherever possible
3. Prioritise support for high-risk individuals who will be advised to self-isolate for 12 weeks. Further advice on this will be published shortly.
4. Apply the principle of mutual aid with health and social care partners, as decided through your local resilience forum.

Thank you for your support and the important work you are undertaking.

Yours faithfully

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NHS England and NHS Improvement

1. Children and Young People Services

#	Services	Commissioner	Location	Plan during pandemic	Details
Stop Full service					
1.	National child measurement programme	NHS England	Home and school	**Stop**	
2.	Audiology	Clinical Commissioning Groups	Clinic based	**Stop**	
3.	Friends and Family Test	NHS England	Provider based	**Stop**	Cease data submission and collection with immediate effect
Partial stop of service					
4.	Vision screening	Clinical Commissioning Groups	Home and clinic based	**Stop except**: • New-born visual checks (within 72 hours of birth) cannot be stopped as neonatal cataracts need to be spotted early • 6 week check can safely be conducted at 8 weeks • Pre-school checks can be delayed until major incident response is over	See also separate guidance to be published

5.	Pre Birth and 0-5 service (Health visiting)	Local Authorities	Home visits and clinic based	**Stop except:** • Stratify visits and support for vulnerable families • Safeguarding work (MASH; statutory child protection meetings and home visits) • All new Birth visits • Follow up of high risk mothers, babies and families • Antenatal visits and support (consider virtual) • Phone and text advice- digital signposting • Blood spot screening	Providers to work with their Designated Professionals for Safeguarding Explore voluntary sector support Prepare staff for redeployment Consider signposting families to online information if appropriate
6.	School nursing	Local Authorities/ CCG for specialist school nurses	Home visits, school and clinic based	**Stop except:** • Phone and text service • Safeguarding • Specialist school nursing	Consider redeployment if schools shut / support vulnerable at home
7.	New born hearing screening	NHS England	Maternity unit, clinics and home	**Stop except:** • maternity unit based screening	See also separate guidance to be published
8.	Community paediatric service	Clinical Commissioning Groups	Home visits, school and clinic based	**Stop except:** • Services/interventions deemed clinical priority • Child protection medicals • Telephone advice to families • Risk stratify Initial Health Assessments (urgent referrals need to continue however some routine referrals may be delayed with appropriate support e.g. initial basic advice to parents/carers	

9.	Therapy interventions (Physio, speech and language, occupational therapy, dietetics, orthotics)	Clinical Commissioning Groups and/or Local Authorities		• Segmentation needed to prioritise urgent care needs • Medium and lower priority work stopped	Prepare to increase to support admission avoidance and support discharge
10	Looked after children teams	Clinical Commissioning Groups and/or Local Authorities	Home visits, school and clinic based	**Stop except:** • Segmentation to prioritise needs (e.g. increased risk of harm from social isolation) • Safeguarding work- case review not routine checks • Telephone advice – could be undertaken regionally • Initial assessments	NHS Trusts to work with their Designated Professionals for Safeguarding Consider using virtual platforms to facilitate attendance by key staff eg GPs who may be at the front-line of COVID-19 response.
11	Child health information service	NHS England	Office base	**Prioritise based on clinical judgement, including:** • Child protection information system transfers • Support failsafe for the newborn bloodspot screening tests • Support the call and recall function for routine childhood immunisation working in liaison with local GP practices	Consider skeleton service, where appropriate, sustaining call/recall programmes
12	Community nursing services (planned care and rapid response teams)	Clinical Commissioning Groups	Home or clinic	• Segmentation needed to clinically prioritise urgent care needs • Monitor rising risk of deferred visits	

13	Nursing and therapy teams support for Long term conditions	Clinical Commissioning Groups	Home or clinic	• Segmentation needed to clinically prioritise urgent care needs. • Routine reviews of respiratory LTCs can be delayed EXCEPT in people with known frequent exacerbations e.g. asthma • Routine annual review of CVD based LTCs (diabetes/IHD/CKD) need to continue given the biochemical testing involved to identify end-organ damage • Medium and lower priority work stopped but monitor rising risk of deferred work if disruption continues	
14	Wheelchair, orthotics and prosthetics	Clinical Commissioning Groups and/or Local Authorities	Home and clinic	• Segmentation needed to clinically prioritise urgent care needs • Medium and lower priority work stopped	Consider use of private providers/ shops to supply
	Continue				
15	Safeguarding	Clinical Commissioning Groups and/or Local Authorities		Continue- direct safeguarding Reduce time spent on SCRs	Isolation may increase safeguarding risks for some families/households NHS Trusts to work with their Designated Professionals for Safeguarding
16	Continuing care packages	Clinical Commissioning Groups	Home or clinic	• Continue (whilst considering delay to routine reviews of CHC packages) • Move CC CCG teams to provision where possible • Write to parents with support to develop contingency	Move CHC CCG teams to provision Write to parents with support to develop contingency

17	Children End of life care	Clinical Commissioning Groups and/or Local Authorities	Home or hospice	Continue	
18	Rapid response service		Home or clinic	Continue	
19	Sexual assault services		Clinic and police stations	Continue – may need to organise a provider pan regional approach with less bases operating	
20	New Born Bloodspot screening	NHS England	Home visit	Continue offer of New born Bloodspot Screening (Guthrie tests)	
21	Emotional health and wellbeing /mental health support	Clinical Commissioning Groups and/or Local Authorities	Home visits, school and clinic based	Continue	Isolation may increase requirement for services for some individuals Consider virtual support

This service will be more comprehensively covered by separate guidance from NHS England and Public Health England soon:

	Immunisation and vaccination	NHS England	Home visits, school and clinic based

2. Adult and Older People Services

	Services	Commissioner	Location	Plan during pandemic	Details
Stop Full service					
1.	Wheelchair, prosthetics and orthotics service	Clinical Commissioning Groups	Clinics, inpatient wards and home	**Stop** Consider link to acute vascular services re amputation and supporting discharge	
2.	Audiology services	Clinical Commissioning Groups	Clinic based	**Stop** Patients with suspected foreign body in ear(s) or sudden unexplained hearing loss should be directed to 111/urgent treatment centres	Consider use / referral of private clinics which provide microsyringing and are managed by nurses and CQC at least good May be a need for supply of batteries through NHS community audiology services where these are a specialist item linked to the type of hearing aid prescribed
3.	Friends and Family Test	NHS England	Provider based	**Stop** Cease data submission and collection with immediate effect	

Partial Stop					
4.	Outpatient clinics	Clinical Commissioning Groups		**Stop except:** • Review of post-surgical high risk cases e.g. diabetic foot	
5.	Podiatry and podiatric surgery	Clinical Commissioning Groups	Clinics, inpatient awards and home	**Stop except:** • Other than high risk vascular/ diabetic e.g. Diabetic foot clinics cannot be stopped. • Non-diabetic corrective procedures e.g. bunion surgery etc can be stopped • Tele triage could be utilised before any home visits	Could redeploy to provide wound care
6.	Wheelchair, prosthetics and orthotics service			**Stop except:** • Consider link to acute vascular services re amputation and supporting discharge. • Prioritise pressure ulcer management	
7.	Community nursing services (including district nurses and homeless health)		Home and clinic based	• Continue but clinically prioritise urgent needs and ensure dynamic case load management. Reduce regular review work through appropriate risk assessment. • Monitor rising risk of deferred work if disruption continues • Continue support in last days of life of or high complexity palliative care – syringe drivers and symptom management and any other identified clinical need • Prioritise Rapid Response teams response to rapidly deteriorating	Agree roles across health and social care to avoid duplication of segmentation Consider support for homeless and rough sleepers who cannot self isolate Prepare for increased demand

				patients to facilitate admission avoidance.
				• Prioritise early supported discharge from acute settings and community neurorehabilitation which can be supported by “non-registered” staff with professional support
				• Tele-rehabilitation access should be supported and developed
				• Prioritise visits for:
				  ○ Complex wound management
				  ○ Diabetic foot
				  ○ Urgent Catheter care
				• End of Life/Palliative Care
				• Rehabilitation for Activities of Daily Living visits where options for self-management and/or alternative support have been exhausted
				• Insulin administration
				• Non molecular weight heparin injections
				• Medication prompts
				• Wound care where there are immediate concerns regarding the patient’s condition e.g. infected wounds, heavily exuding wounds and compression bandaging that has been in situ for more than 7 days
				• Bowel care where this is required on a regular basis (although this would normally be undertaken through specialist continence nursing input
				• Disconnection of Chemotherapy
				• Patients at high risk of falls – consider installation of falls monitors and pendant alarms
					Actively coach patients/carers to self-administer
					
					Consider how to support care homes more fully

				• Patients where there is a newly identified moving and handling risk which could result in immediate risk to the patient or carer	
8.	Specialist nurses for specific conditions • Heart failure, • Continence/ Colostomy • Tissue Viability • TB • Parkinson's • Respiratory/ COPD • Stroke • MS • MND • Falls • Lymphoedema • Diabetes			• Stop routine QOF associated activities • Continue but clinically prioritise urgent needs and reduce regular review work through appropriate risk assessment including working with Primary Care Networks • Increase the use of telemedicine options wherever clinically safe to do so. • Routine annual reviews of respiratory LTCs can be delayed EXCEPT in people with known frequent exacerbations e.g asthma/COPD. • Routine annual review of CVD based LTCs (Diabetes/IHD/CKD) need to continue given the biochemical testing involved to identify end-organ damage • Community diabetes nursing teams to stop clinics and education courses and support acute teams to help with inpatient diabetes advice. • Monitor rising risk of deferred work if disruption continues	Agree roles across health and social care to avoid duplication of segmentation Consider using of Pharma nurses and specialist appliances who may be able to offer more support – eg stoma care
9.	Rehabilitation services (integrated and unidisciplinary) (physio, OT, Speech and language therapy etc.)	Clinical Commissioning Groups and/or Local Authorities		• Segmentation needed to prioritise urgent care needs • Medium and lower priority work stopped. Monitor rising risk of deferred work if disruption continues beyond 48 hours • Options for Virtual Pulmonary Rehabilitation • Prioritise Respiratory Physiotherapy • Prioritise Tele-swallowing for Speech and Language Therapy	Prepare to increase to support admission avoidance

10.	Neuro-rehabilitation (multi-disciplinary) – stroke, head injury and neurological conditions	Clinical Commissioning Groups		• Segmentation needed to prioritise urgent care needs e.g. early supported stroke discharge work • Medium and lower priority work stopped. Monitor rising risk of deferred work if disruption continues • Access to tele-swallowing services for Neuro rehab	Prepare for increased demand
11.	Therapy interventions (Physio, speech and language, occupational therapy, dietetics, orthotics)	Clinical Commissioning Groups and/or Local Authorities		• Segmentation needed to prioritise urgent care needs (malnutrition and enteral feeding support) • Needs to continue for people at high risk of aspiration pneumonia due to difficulty with swallowing eg people with progressive neurological conditions (MS/PSP/MND etc) • Swallowing assessments to prevent aspiration pneumonia • Early supported stroke service to avoid loss of rehabilitation potential. • Dietetics support for people with significant malnutrition and increased risk of frailty and functional disability • Medium and lower priority work stopped. Monitor rising risk of deferred work if disruption continues	Prepare to increase to support admission avoidance and support discharge
12.	Weight management and obesity services Tier 2 and 3	Clinical Commissioning Groups	Home and clinic based	• Stop behavioural interventions for weight loss • For Tier 3 weight management services where also providing management of associated co-morbidities (eg. type 2 diabetes, obstructive sleep apnoea), then clinicians should appropriately triage clinic lists to assess which patients may need ongoing support, ideally remotely.	

13.	Contraception	NHS England and Local Authorities	Clinic based	**Prioritise:** • Urgent work only for terminations; contraception; GUM and HIV treatment	For contraception, consider signposting to pharmacies, channel shift and changing e.g. for contraception from LARCs to other forms Further guidance on ensuring service continuity expected from Royal College of Obstetricians and Gynaecologists shortly
14.	Sexual transmitted disease services				
15.	HIV services	NHE England			
16.	Musculoskeletal service	Clinical Commissioning Groups	Clinic based	• Aligned with orthopaedic and rheumatology planning MUST prioritise triage to enable continued referral of emergency and urgent MSK conditions to secondary care services (Guidance to be provided). • Rehabilitation MUST prioritise patients who have had recent elective surgery, fractures or those with acute and/or complex needs including carers with a focus to enable self-management • All other rehabilitation work stopped with patients enabled to self-manage (this includes rehabilitation groups). • Where appropriate virtual and telephone consultations to be implemented • Introduce telephone triage to assess risks of serious complications e.g. Cauda Equina syndrome	Service provision delivered by specialist MSK clinicians (e.g Consultant / advanced practitioners, senior physiotherapists / AHP's) Advanced Practitioners in First Contact Practice roles supporting primary care work force is encouraged Junior staff (e.g AFC band 6 and 5) made available to assist with secondary and/or community care provision based on local need

17.	Specialist dentistry	NHSE England	Clinic and home visits	• Segmentation needed to prioritise urgent care needs- of normal cohort • Medium and lower priority work stopped- of normal cohort • Potential support to wider response for acute dental care, triaging problems and management of the cases where someone is known to be infected with COVID-19.	
18.	Minor oral surgery		Clinic based		
19.	Day Case surgery				
20.	Primary dental work				
21.	GP	NHS England	Prisons	• Continue but prioritise according to urgent care needs. • Medium and lower priority work stopped • Stop QOF	
22.	Dentistry				
23.	Sexual health				
24.	Alcohol and addiction service	Local Authorities	Home and clinic based	**Prioritise:** • Where possible skype or telephone calls for detox, reduced opportunities for urine testing. May need to stop new detox starts but consider impact on primary care • May need to maintain as vulnerable cohort/ risk stratification • Consider whether non-NHS provided services can increase	With increasing levels of isolation, drug use may increase with potential health service and other consequences. May be opportunity to prioritise alcohol service staff in acute trusts to work on ambulatory pathways with community addictions service support
25.	Drug and addiction service				
26.	Radiography services			• Excluding 2 week wait referrals or trauma associated referrals • Consider diagnostic and therapeutic	Prepare for redeployment

27.	Ultrasound			• Excluding 2 week wait referrals/antenatal cases • Possibility for Acute imaging in community	Prepare for redeployment
28.	Continuing care packages	Clinical Commissioning Groups	Home based and care homes	• Move CHC CCG teams to provision where possible • Write to adults in domiciliary care and asking them to develop contingency for 24/7 if no staff • Contingency plans to be developed with care provider for 24/7 if no staff	Delay to routine reviews of CHC packages
29.	Screening, Immunisation and vaccination	NHS England	Home visits, school and clinic based	**This will be covered by separate guidance**	
30.	Diabetic Eye Screening	NHS England	Clinic based	Stop **Routine Digital Screening** • If patients notice any change in vision advise to attend emergency eye centre. • Consider whether newly diagnosed patients may require screening Continue **Digital surveillance** but prioritise according to need e.g. pregnant women.	See also separate guidance to be published
Continue					
31.	Endoscopy	Clinical Commissioning Groups	Clinic based	• Excluding 2 week wait referrals and inpatients requiring investigation prior to discharge if a community service • Continue to proceed along pathway for screen FIT positive individuals	

32.	National Bowel Cancer Screening programme 60-74 year olds)	NHS England	Initial test self administered Secondary test for screening positives	Continue at present but prepare for stopping/reducing activity if Gov. decision Continue as 8-10% screen positives covert to cancer; Specialist Screening Practitioner clinics to convert to telephone service Screening Colonoscopy to continue	Prepare to slow down rate of invitation to maximum of -6 weeks standard See also separate guidance to be published
33.	Breast Cancer Screening	NHS England	Provider trusts and mobile screening vans in the community	1. Pause (including Age X) but continue to proceed along pathway for screen positive individuals Continue high risk women where possible (12 months recall). Pause clinical review process for women impacted by incident	See also separate guidance to be published
34.	National Bowel Screening Programme (**bowel scope** for 55 year olds)	NHS England	Clinic based	Continue.	See also separate guidance to be published

35.	Urgent Community Response/Rapid Response team	Clinical Commissioning Group		Continue	Prepare for increased demand
36.	Out of hours GP services	Clinical Commissioning Groups	Clinic and home based	Continue	Prepare for increased demand
37.	111 service		Clinic based	Continue	Prepare for increased demand
38.	Walk in centres			Continue	Prepare for increased demand
39.	Urgent treatment centres			Continue	Prepare for increased demand
40.	End of life and hospice care (including non-specialist end of life care delivered by community / district nursing teams)	Clinical Commissioning Groups	Home, registered care home or clinical based, bed based care, hospice	Continue	Prepare for increased demand Prepare to take lead role in organising “fast track” patients from hospital and co-ordinate their care at home or in a hospice
41.	Urgent dental access work	NHS England	Clinic and home visits	Continue	
42.	Rehabilitation bed based care	Clinical Commissioning Groups and/or Local Authorities, NHS England	Home, registered care home or clinical based, bed based care, hospice	Continue and consider where domiciliary input is clinically appropriate/Explore other options e.g. sports facilities with therapy equipment in situ. Prioritise freeing up community beds to support acute bed capacity	Increase capacity to assist hospital flow

43.	Intermediate care and re-ablement	Clinical Commissioning Groups and/or Local Authorities		Continue	Increase capacity to assist hospital flow
44.	Adult safeguarding	Clinical Commissioning Groups	Home	Continue case management but not SARS	Prepare to support isolated individuals and increased risk
45.	Phlebotomy	Clinical Commissioning Groups	Home/ Clinic	Home visiting phlebotomy services LINKED to INR monitoring services often run by GPs Pharmacists from GP or Community trusts be key to continued safe monitoring of patients on warfarin. Risk stratify on basis of clinical need for example in terms of INR measurement, patients with mechanical devices, which may be prosthetic valves or LVADs	Prepare for increased demand/ redeployment. For example cancer services are likely to seek additional phlebotomy support, in order to reduce visits to hospital and assist protective isolation of at-risk group with cancer receiving treatment
46.	Home oxygen assessment services	Clinical Commissioning Groups	Home	May involve community services as part of an integrated or standalone team. Continue to support capacity for oxygen meeting the demand.	
47.	Clinical support to social care, care homes and domiciliary care	Local Authorities and Clinical Commissioning Groups	Home and Care Home	Continue to provide necessary clinical support to social care, care homes and domiciliary care	Including medication support

48.	Sexual assault services	Clinical Commissioning Groups and/or Local Authorities	Clinic and police stations	Continue – may need to organise a provider pan regional approach with less bases operating	